UNIVERSITY OF BIRMINGHAM

Health Services Management Centre

Mapping a complex landscape: A literature review of English mental health care and support, 2014 – 2017

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About the author

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This document reports on independent research by the University of Birmingham commissioned and funded by the Department of Health and Social Care Policy Research Programme. It draws on research undertaken for two projects: PR-R14-1215- 21004 Shifting-Shapes: How can local care markets support quality and choice for all? and PR-ST-1116-10001 Shaping Personalised Outcomes - how is the Care Act promoting the personalisation of care and support?.

This is an interim report and has not been peer reviewed. The final report from the research projects will be peer-reviewed prior to publication.

Executive summary

This report presents the findings of a review of literature on mental health care and support published from 2014 to 2017. The analysis forms part of wider Policy Research Programme research at the University of Birmingham, which examines how local authorities are meeting the requirements of the Care Act 2014. The Care Act places two overarching requirements on local authorities: (1) ensuring the provision of good quality and cost-effective information and care; (2) supporting the development of personalised services that facilitate individual choice and contribute to good care outcomes.

The literature examined for this report provides an overview of key issues highlighted from 2014 to 2017. Much of the empirical work reported here predates the Care Act, but highlights elements of care market development that have relevance to Care Act duties. Overall the literature in this review indicates that local authorities are struggling to meet Care Act 2014 market shaping duties for people living with long-term mental health problems, especially those with protected characteristics under the Equality Act 2010, and those with multiple or complex needs. The literature from 2014 to 2017 suggests that for mental health market shaping to be effective, a conceptual shift towards outcomes is required, focusing on building local community capacity, personalisation and, in particular, personal recovery and social inclusion.

Key findings

- Mental health market shaping and commissioning require integrated, coherent and system-wide market shaping strategies for local populations. Commissioning and market shaping with the genuine involvement of local populations and communities who use and provide services and support has the potential to be effective.

- Mental health commissioning and market shaping is significantly oriented towards hospital-aligned services, and in some cases influenced by a continued tendency towards block contracting. This can exclude innovative local mental health services and community support initiatives from the commissioning process.

- Collaboration, co-production, quality improvement and building community capacity, particularly using joint investment approaches, are key elements of effective market-shaping.

- Existing mental health care markets do not appear to be responding adequately to the diversity within local populations. Local authorities should adopt a market shaping and commissioning framework based on Equality Act 2010 duties, and develop local inequality reduction strategies informed by accurate local population and socio-economic data and in partnership with relevant local communities, service users, carers and their organisations.

- People with mental health problems and multiple needs can 'fall through the gaps', experience fragmentation and a lack of continuity between support and services. The provision of a range of stable, safe and supported accommodation options should be integral to mental health care market shaping by local authorities, particularly for people eligible for after-care under Section 117 of the Mental Health Act 1983.

- Public sector infrastructure and funding reforms have had a negative effect on market shaping in mental health. A specific example is the impact of the loss of ring-fenced local authority Supporting People funding on accommodation and support for people with mental health problems with multiple needs.

- Austerity has had negative impacts on local specialist community sector providers, resulting in reduction of services, impaired service quality or service closures. To build community capacity, local authorities should assess the mental health care market using asset-based and social network approaches. Building community capacity should be integral to mental health care market shaping by local authorities.

Introduction

The University of Birmingham is undertaking a study into the implementation of the Care Act (HM Government, 2014), funded by the Department of Health and Social Care, focusing particularly on local authority 'market shaping' and 'personalisation'. This *Shifting Shapes* project has a number of related components to address the central aims of understanding whether local authority market-shaping activities are providing a choice of good quality, cost-effective, information and care provision; and doing so in ways that support personalised services, delivering individual choice, control and good care outcomes.

A central dimension of the research explores the experience of people who use care and support services funded by their local authority. These aspects are being examined through fieldwork in eight local authorities, with a number of literature searches conducted to provide background and context to the research, including this one on mental health provision. The findings from these reviews provide an indication of the key issues in the literature.

The Care Act 2014 creates new duties for local authorities and their partners, and new rights for people who use services, and for their carers. The Act has a number of underpinning objectives and principles, reflected in the creation of new duties on local authorities around care and support, and particularly to:

- promote individual wellbeing;
- prevent needs for care and support;
- promote integration of care and support with health services;
- provide information and advice; and
- promote diversity and quality in provision of services.

Part 1 of the Act provides the legal framework for providing adult social care in England. The general responsibilities of local authorities set out in sections 1-7 embody the aspirations and objectives that were originally set out by the Coalition Government in the 2012 White Paper 'Caring for our future' (HM Government, 2012). The paper set out a 'vision for care and support' in these terms:

> Our vision is one that promotes people's independence and wellbeing by enabling them to prevent or postpone the need for care and support. We will also transform the system to out people's needs, goals and aspirations at the centre of care and support,

> supporting people to make their own decisions, to realise their potential, and to pursue life opportunities (p. 18).

Local authorities already have a statutory responsibility for funding free after-care under Section 117 in the Mental Health Act 1983. After-care is not defined by reference to specific services, but implies a range of services and support that enable eligible individuals to live in the community and avoid readmission to hospital. Therefore, the Care Act 2014 covers those living with long-term mental health problems who may be in need of local authority funded care and support. The Act also introduces new duties and responsibilities on Councils. According to the legislation, local authorities should now ensure that people who live in their area:

- receive services that prevent their care needs from becoming more serious, or delay the impact of their needs';
- can get the information and advice they need to make good decisions about care and support; and
- have a range of provision of high quality, appropriate services to choose from (DHSC, 2016).

The duty to prevent people from developing the need for formal care and support, to delay deterioration or, in the case of mental health, prevent crisis, means that local authorities must consider 'what services, facilities and resources are already available in the area (for example local voluntary and community groups), and how these might help local people' (DHSC, 2016). This applies to mental health service users and their carers, and to information and advice, as well as care and support services. The Care Act 2014 explicitly states that local authorities should focus on the needs of local people when shaping the information, care and support market. For those assessed as eligible for local authority funded care and support, the Act states that they must have suitable and sufficient options for designing an individual, personalised care and support plan, and to have continuity of care if moving area.

Methods

Search strategy

The review search strategy had four components. It built on two reviews undertaken by the Health Services Management Centre into local authority commissioning practice (Williams *et al*., 2013) and social care support provision for people from marginalised groups and/or with protected characteristics under the Equality Act 2010 (Carr, 2014), and adapted the search strategies used in these reviews. Material was identified by using the relevant health and social care bibliographic databases (listed in the appendix). To identify relevant grey literature, targeted searches of mental health organisations in England were undertaken for relevant reports. Finally, a sub-set of papers relevant for mental health derived from the main project literature review was included. The initial stage of screening resulted in a total of 70 potential includes. These 70 articles and reports were then screened using the theory map for Market Shaping and Personalisation (see figure 1 overleaf). This resulted in 37 final includes.

All searches were limited to relevant studies and reports on local authority adult and older people's mental health provision in England published from 2014 until the search date of April 2017. Full details are given in the appendix.

Review methodology

A 'realist review' approach was adopted to analyse the literature using a market shaping theory map. This approach draws on models by Pawson *et al*. (2005), and by Pearson *et al*. (2015). Pawson *et al*. described the approach as one that 'seeks to unpack the mechanism of how complex programmes work (or why they fail) in particular contexts and settings' (Pawson *et al.*, 2005, p. 21). A realist review is theory-driven and 'explanation-building, aiming to produce a contextualised understanding of the mechanisms by which interventions produce different patterns of outcomes' (Pearson *et al.*, 2015, p. 578). The identification and refinement of propositions about how any given programme should achieve its intended outcomes are identified as 'programme theories': 'the theories, the hunches, the expectations, the rationales and the rationalizations for why the intervention might work' (Pawson *et al.*, 2005, p. 26).

Table 1 gives an overview of the types of literature included in the review (N=37). While empirical studies published in peer reviewed journals constituted nearly a third of the total

includes, 40 per cent were voluntary sector reports, suggesting that the charity and voluntary sector (particularly in mental health) has been most active in generating knowledge about mental health care markets and local authority commissioning practice since 2014.

Table 1 Literature by Source Type (N=37)

Empirical study journal article	Policy analysis journal article or report	Statutory sector report	Voluntary sector report
12	3	7	15

The broader *Shifting Shapes* project uses a realist approach to understand how market shaping and personalisation are expected to improve outcomes. Figure 1 sets out the programme theory map for the whole project which links contextual factors to a set of mechanisms and planned outcomes. These programme theories are presented within three categories:

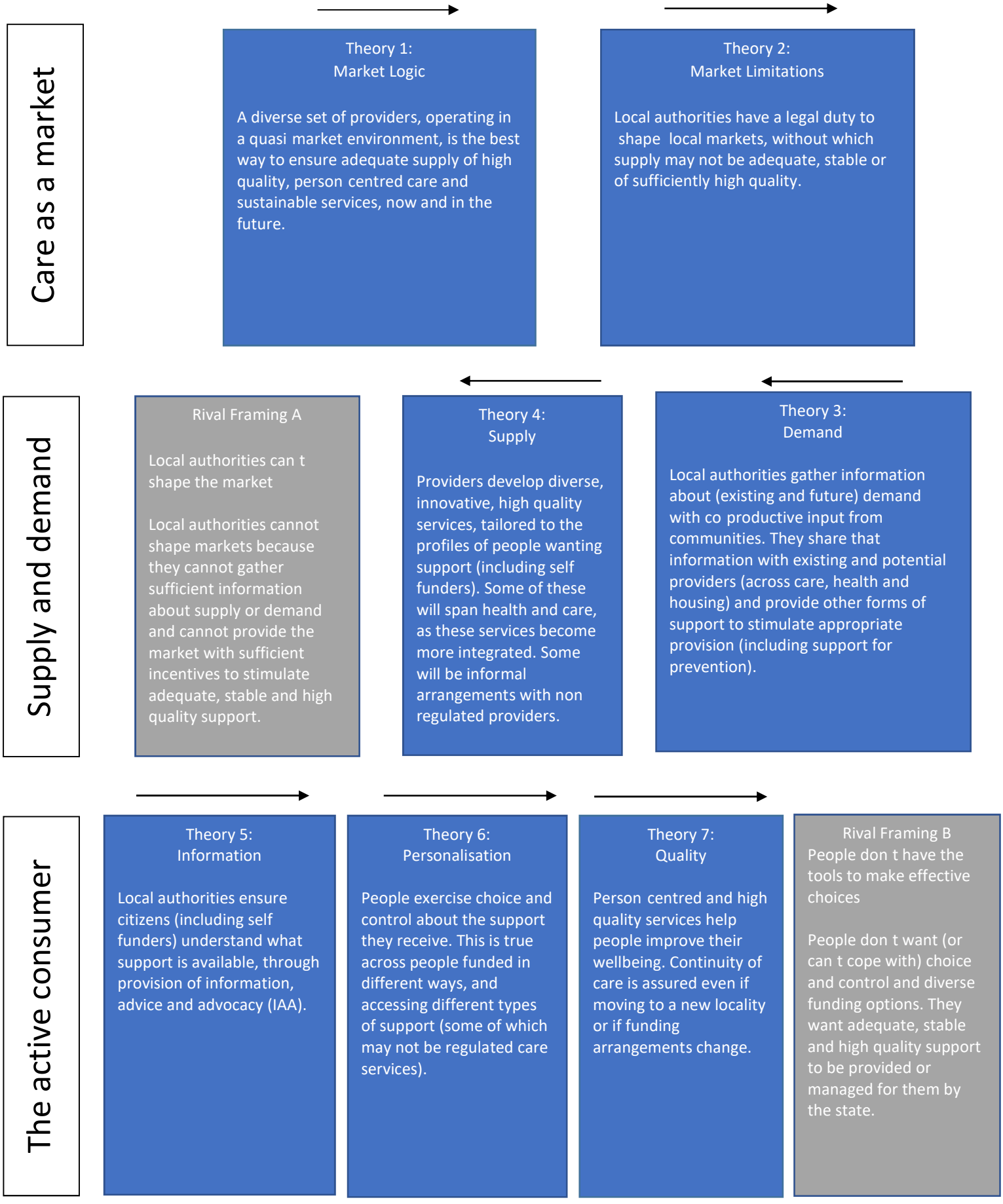
- **Care as a market:** what is the underpinning theory about the operation of quasi-markets in a care setting that supports market shaping and personalisation as intervention mechanisms?

- **Supply and demand:** what are local authorities expected to do to shape care markets and support personalisation and what is the expected response from providers?

- **The active consumer:** what assumptions about the behaviour of individuals and families using care services are embedded within the market shaping logic?

The theories shown below set out an ideal model of care markets. The current paper, focused on mental health, undertook a literature review to explore how far these theories are reflected in the practice of mental health services. Theories 1,3,4,6 and 7 are particularly significant in the mental health literature, and these are the ones that are explored in more detail in the next section.

Figure 1 A Programme Theory Map for Market Shaping and Personalisation



Literature review findings

The findings from the literature review are here explored underneath the relevant headings from the theory map on the previous page.

Theory 1: Market logic

Theory 1 on Market Logic is described as ‘a diverse set of providers, operating in a quasi-market environment, is the best way to ensure adequate supply of high quality, person-oriented care and sustainable services, now and in the future’. The literature was examined to assess the responsibilities of local authorities and NHS providers to ensure that an effective market is operating.

The majority of mental health services are funded and commissioned by the NHS, which is free at the point of delivery. Historically this has resulted in the dominance of a hospital model of provision, a dynamic that still affects contemporary commissioning practice and market shaping in mental health (Brophy and Morris, 2014). However, access to free social care support is subject to eligibility criteria and in mental health ‘Local authorities have a responsibility to ensure that social care is commissioned and provided for those who qualify as eligible in their area and that those who are not eligible for free care have the information they need to buy their own care’ (Crisp *et al.*, 2016, p. 44). Mental health problems as long-term, fluctuating conditions requires particular approaches to assessing need and eligibility under the Care Act 2014 (SCIE, 2015).

Local authorities have a statutory responsibility for funding free after-care under Section 117 in the Mental Health Act 1983. After-care is not defined by reference to specific services, but implies a range of services and support that enable eligible individuals to live in the community and avoid readmission to hospital. According to the Act ‘after-care services, in relation to a person, means services which have both of the following purposes—

(a) meeting a need arising from or related to the person's mental disorder; and
(b) reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder)’ (Legislation.gov.uk, 2017).

Under the Care Act 2014, these after-care provisions must include personal budgets and direct payment options. People who are eligible for Section 117 after-care are those who have been compulsorily detained in hospital under Section 3 of the Mental Health Act; or sentenced by a criminal court to detention in a psychiatric hospital; or transferred to a psychiatric hospital from prison (NHS, 2017). For this population local authorities most commonly fund supported accommodation (Newbigging and Parsonage, 2017; Crisp *et al.*, 2016).

More generally, under the Care Act 2014, local authorities have a statutory responsibility to 'promote wellbeing' (Gov.uk, 2017a) and for 'preventing, reducing or delaying needs' (Gov.uk, 2017b). However, a Freedom of Information request to the 152 upper tier and unitary local authorities (with an 85 per cent response rate) conducted by the mental health charity Mind, revealed that 'on average less than 1 per cent of public health budgets was spent on public mental health in 2015-16. Thirteen local authorities reported no spending on public mental health' (Mind, 2017).

In a comparative analysis between national policies and mental health care systems, the mental health system in England was characterised as still being centralised, predominantly public service with a high policy emphasis on community care and social inclusion and low capacity in acute clinical and residential care services (van Hoof, 2015). In addition to the relationship between health and social care, the emphasis on community support and an increasing drive towards market diversification means that mental health commissioning and market shaping is occurring in a complex landscape. There are separate NHS and local authority commissioning approaches as well as some joint commissioning arrangements; joint health and local authority Health and Wellbeing Boards and GP-led Clinical Commissioning Groups. There is a plurality of providers for both inpatient and community care settings. This complexity is intensified by the context of shifting policy and structural reforms (Newbigging and Parsonage, 2017; Ikkos *et al.*, 2015; Brophy and Morris, 2014). An evaluation of NHS commissioning practice and health system governance, which included mental health, found that: 'Joint NHS and local government commissioning was more co-ordinated at strategic than at operational level' (Sheaff *et al.*, 2015), suggesting this could be an issue for making jointly-commissioned mental health services and support a practical reality.

The relevant literature published during and after 2014 suggests there are a number of overarching current issues for local authorities shaping mental health care and support markets:

- coherent, whole-system approaches;
- supporting innovation and social inclusion; and
- the role of competition.

Coherent, whole-system approaches

The literature suggests that coherent, whole-system approaches to commissioning and care markets should be oriented towards investing in prevention, early intervention and personal recovery for those with long-term mental health problems (Knapp *et al.*, 2014), which is consistent with the Care Act 2014. More fundamentally, it has been argued that such an approach requires a shared 'commitment to a vision of community-oriented mental health and dedicated funding' (Brophy and Morris, 2014, p. 161).

Health economics research shows that local authorities should be investing in cost-effective and person-centred supported housing, personal budgets and welfare advice to support personal recovery for those with long-term, severe conditions such as schizophrenia and psychosis (Knapp *et al*., 2014). However, a 2017 Freedom of Information request investigation identified lack of suitable accommodation and budget disputes as factors causing people with mental health problems to experience delays of six months to three years in being discharged from acute psychiatric settings (BBC, 2017). In order to address such a problem, the Crisp Commission (Crisp, *et al.*, 2016) on improving acute psychiatric care for adults in England advised that 'commissioners and providers in each area need to build links with local authority housing departments where these don't already exist' (Crisp *et al.*, 2016, p. 49). The Commission also revealed further difficulties in operationalising joint commissioning for mental health that supports market innovation and a coherent, whole system approach:

> Health and Wellbeing Boards, commissioners and Local Authorities with devolved responsibility for health have particular responsibilities here. However, there is also scope for far more sharing of operational information, joint planning, and shared approaches to services and innovation…Health and Wellbeing Boards are, however, relatively new and generally have not yet addressed mental health as a whole system. Moreover, mental health – as so often – does not receive the same priority as physical health on their agendas (Crisp *et al.*, 2016, p. 41-42).

The need for integrated and system-wide approaches to commissioning and market shaping have also been highlighted in an analysis of service transformation in mental health: 'the

traditional dividing lines between GPs and hospital-based specialists, hospital and community services, and mental and physical health services mean that care is often fragmented, and integrated care is the exception rather than the rule' (Gilburt and Peck, 2014, p16). Poor communication, inoperable IT systems and siloed working have been identified as barriers to growing a community-oriented mental health provider market (Rodgers *et al.* 2016), with GP commissioners citing the need for 'community service approaches that are co-designed and produced with communities themselves' and envisioning 'a potential crisis…through lack of real involvement by those people receiving services and services therefore not reflecting what people really need' (Brophy and Morris, 2014, p. 161).

In order to address this fragmentation and under-development of co-produced and community services and support in mental health van Hooff *et al.* (2015) describe the need for a social inclusion vision for mental health and 'a national framework of responsibilities, entitlements and services…in particular the responsibility for coordination should be addressed. Also, the entitlements of individuals with severe mental health problems in the fields of housing and work should be made explicit' (van Hooff *et al.*, 2015, p. 205-206). In addition their comparative study between mental health community support in England, Denmark and the Netherlands recommends national policy on 'structural funding and inclusion incentivising reimbursement systems [and] integrated care for the most vulnerable clients' (ibid, p. 206). Reflecting this, Brophy and Morris (2014) refer to the 2014 Commission on the Future of Health and Social Care in England report which said integration requires simpler, more graduated pathways of support, supported by a single ring-fenced budget and a local commissioner. They also point to the use of Section 75 powers to pool budgets across health and social care to create better integration and sustainability (Brophy and Morris, 2014).

Supporting innovation and social inclusion

Investing in and supporting innovation has been identified as being vital for service transformation and market shaping in mental health, but the literature suggests that this is challenging to achieve through the current commissioning systems. Van Hooff *et al*. (2015) argue that '…challenges lie in the vulnerability of community support services that span health and social care systems and the tension between the ambition to involve the wider community and the ambition for coherent and integrated care' (van Hooff *et al.*, 2015, p. 205).

For service transformation based on market shaping and innovation, a 'system-wide' approach has been recommended for investing 'in new capacity before existing capacity can be closed…integration of expertise from independent and voluntary sector organisastions' should be managed in addition to the range of care from acute inpatient to social care support (Gilburt and Peck, 2014, p. 1). In the context of the Care Act 2014 this new capacity for mental health should include innovative, responsive community based and user-led organisations; developing community capacity; social enterprise and micro-providers; access to talking therapies; opportunities for personalised education, training and meaningful occupation; personal budgets; welfare benefits advice and a range of good quality accommodation options (Knapp *et al.*, 2014). Such legislation demands 'a different way of looking at the relationship between communities and services and new ways of capitalising on the value of both when conjoined. This is fundamentally important in mental health where recovery, citizen participation and inclusion are established watchwords' (Brophy and Morris, 2014, p. 162).

The Care Act 2014 continues the post-deinstitutionalisation policy drive to diversify the mental health service market to promote community support and social inclusion: '[English] national policy regarding mental health care has evolved from a prescriptive approach on the desired community mental health structure, to a broader promotion of social inclusion and recovery objectives' (van Hooff *et al.*, 2015, p. 204), with the stimulation of innovative 'non-statutory' services and community-based support provision. However, difficulties have been identified with a continued tendency to commission standard 'hospital aligned community service models' using lump sum, block contract funding, which excludes many smaller, more innovative community support initiatives (Brophy and Morris, 2014). A mixed-methods evaluation of NHS commissioning practice and health governance found that more intelligence is needed about how differently constituted and sized providers respond to commissioners and what implications there will be for market diversifying commissioning practice, a situation that will be reflected for local authority commissioning and market shaping in mental health (Sheaff *et al.*, 2015).

The relevant policy and practice literature included in this review suggests that Care Act-related market capacity building for mental health should also include local innovations to promote wellbeing and prevention more generally. It has been recommended that local authorities and their commissioning partners therefore remain aware that 'while nationally and internationally developed models [of service transformation] are useful, choice of any

particular model should be driven by local need, allowing flexibility for local providers to innovate' (Gilburt and Peck, 2014, p. 1). Mental health policy research literature shows that in order to stimulate and support innovative services that promote participation, personal recovery and co-operation 'it will be especially important to further develop our understanding of effective incentivising measures in the field of community support for persons with severe mental health problems' (van Hooff *et al.*, 2015, p. 206). Research on community-oriented integrated mental health services suggests that this could include incentives for pooling budgets and 'for Health and Wellbeing Boards to become more alive to the needs of people with mental health issues' (Brophy and Morris, 2014, p. 162).

Socially oriented models of support for personal recovery in mental health such as individual placement and support, peer-support and self-management, welfare advice and supported housing are considered to be potentially cost-effective, but researchers identify the 'challenge for local commissioners, providers and practitioners to develop ways which most effectively support and facilitate personal recovery' (Knapp *et al.*, 2014, p. 7). Again, the orientation of local authority and joint mental health service commissioning towards hospital aligned community services can mean that innovative approaches to service redesign, including social and micro-enterprises, do not receive adequate investment and are sometimes not sustained after initial development funding (Brophy and Morris, 2014).

The role of competition

Relevant papers dating from 2014 until 2017 note a number of potential practical, ideological and ethical tensions with the role of competition for local authorities shaping the care and support market in mental health. Ikkos *et al.* (2015) remark that since 2010, Government reforms have changed systems of purchasing 'aiming to strengthen choice and competition between providers on the basis of quality and outcomes as well as price' and argue that 'introducing market-style purchasing and provider-side reforms' could be risky for a mental health system 'in crisis' (Ikkos *et al.*, 2015, p. 181). Further, in their analysis of UK mental health services commissioning and provision they argue the following:

- competition might bring efficiency, but may weaken cooperation between providers, and transparency;
- it is hard to implement necessary governance and control without worsening bureaucracy and inefficiency;

- the pursuit of market efficiencies has been particularly contentious in mental health care, where many professionals are defensive about the risks to vulnerable patients and to traditional ways of professional working (Ikkos *et al.*, 2015, p. 181-182).

Other research findings also highlight possible ethical tensions with market competition for mental health service provision, with one study finding that in England 'recent national reform plans, aiming at transferring responsibilities for health care and social care to the local level and to the market, might increase the vulnerability of many social support services' (van Hooff *et al.*, 2015, p. 205). One evaluation of joint commissioning practice showed that 'commissioning for mental health services to prevent recurrent unplanned hospital readmissions relied more on local 'micro-commissioning' (collaborative care pathway design) than on competition' (Sheaff *et al.*, 2015, p. v).

Research has shown that mental health care market shaping should not only be determined by market-based competition, and suggests that quality improvement; collaboration, co-operation and co-production; building community resources and evidence-based investment models must influence decision making (van Hooff, 2015; Knapp *et al.*, 2015; Sheaff et al, 2015; Brophy and Morris, 2014). For example, one study indicated that 'quality improvement in support services for "difficult" groups is more remunerative than tapping new markets' (van Hooff *et al.*, 2015, p. 206), while another provided an evidence-based business case for 'investing in recovery', utilising 'early interventions and community-based interventions [including supported housing, personal budgets and peer support] proven to generate savings or value-for-money gains through inpatient admission, or through other routes' (Knapp *et al.*, 2014, p. 3).

Ethical tensions could occur with private, for-profit mental health service providers that are funded through public money: 'the income of the commercial sector is largely derived from NHS commissioners and local government authorities. Many are uncomfortable with the large profits made by some private equity owners in this market' (Ikkos *et al.*, 2015, p. 183-184). Others have argued that the free market competition model will not work for achieving community support, personal recovery and social inclusion for people with mental health problems in a complex system:

> This combination of inherent deinstitutionalisation challenges and political-administrative trends [towards 'market incentives and private providers…'] raises concerns that, while diffusion of responsibilities calls for cooperation, system developments might just make individual interests of providers and funding agencies drift away from common interests of the social inclusion of persons with severe mental health problems (van Hooff *et al.*, 2015, p. 205).

Theory 3: Stimulating appropriate provision

Theory 3 on the theory map on p. 10 is described as 'Local authorities gather information about (existing and future) demand and supply with co-productive input from communities. They share that information with existing and potential providers (across care, health and housing) and provide other forms of support to stimulate appropriate provision (including support for prevention)'. The literature was examined to assess the extent to which local authorities were undertaking these activities effectively over the period in question.

The relevant literature highlights a number of marginalised groups (including those with protected characteristics under the Equality Act 2010) within many local authority populations that are not being appropriately considered in mental health market shaping. Much of this literature relates to limitations in how local authorities understand and address the needs of marginalised groups, which we discuss here as limits on market stimulation.

Newbigging and Parsonage (2017) provide evidence from the West Midlands Combined Authority on the populations with 'an increased risk of mental health problems and for whom access to effective help is problematic' (Newbigging and Parsonage, 2017, p. 5). The populations they highlight as being of concern are reflected in the current evidence about the following groups:

- People with multiple and complex needs, including mental health needs
- Black, Asian and minority ethnic populations
- Lesbian, gay, bisexual populations
- Transgender populations
- Women
- Older people
- Younger people

People with multiple and complex needs, including mental health needs

The largest body of research identified for the review concerned those with multiple and complex needs, including mental health needs. Overall, the studies highlight the need for local authorities to consider the following additional issues and needs in the local populations of people with mental health problems when market shaping and commissioning:

- Homelessness or poor housing
- Economic exclusion and poverty
- 'Chaotic lives'
- Women experiencing gender-based, sexual and/or domestic violence
- Substance use and addictions
- Criminal justice interventions
- Acquired brain or spinal injury
- Physical or sensory disabilities
- Learning disabilities and/or autism
- Long-term, complex or life-limiting health conditions, including those relating to older age (JCPMH, 2016; Drinkwater *et al.*, 2014; LGA *et al.*, 2015; Revolving Doors Agency, 2015; Terry, *et al*. 2015; Imkaan *et al*., 2014).

The way support is designed and operates appears to determine that those with mental health problems who have multiple and complex needs often receive fragmented, complicated, inadequate or exclusionary services, where individuals 'fall through the gaps' or experience a lack of continuity of care. In many cases, provision for this group is not cost-effective and results in poorer outcomes for individuals and communities, including women with mental health problems from different backgrounds who experience gender-based, sexual and/or domestic violence (Terry *et al.*, 2015; Imkaan *et al.*, 2014). Terry *et al.* (2015) outline the problem as being located in statutory services which 'tightly defined remits and limited resources, focusing on severity of need and on single issues be they health, housing or drug dependency. People with multiple and complex needs often fail to meet the thresholds set by individual services, despite the fact that in combination their problems result in a high level of need' (Terry *et al.*, 2015, p. 3). Therefore, local authorities should shape mental health care markets to promote 'whole system' care pathways, comprehensive services and specialist support for this group, based on present and future local population need, community resource capacity, the effects of increasing thresholds for eligibility and the consequences of reducing formal support for the carers for local populations of people with mental health problems (Newbigging and Parsonage, 2017; Terry *et al.*, 2015).

The Joint Commissioning Panel for Mental Health's (2016) guidance for commissioners of rehabilitation services for people with complex mental health needs characterises the rehabilitation service user population as a 'low volume, high needs' group, with multiple problems (i.e. addictions, physical health conditions, homelessness, involvement with the criminal justice system) that may impede personal recovery and social inclusion. The Panel are explicit that this group's needs cannot be met by general adult mental health services, and that there is an ongoing need for multi-disciplinary and multi-sector rehabilitation services and specialist supported accommodation, with service users being 'eight times more likely to achieve or sustain community living compared with those using generic community mental health services' (JCPMH, 2016, p. 3). An investment model is recommended as 'a [whole system] local rehabilitation care pathway is cost-effective' (ibid. p. 4). Similarly, a service model for people with learning disabilities, and/or autism as well as mental health conditions (having 'diverse and complex needs') issued by the Local Government Association, the Association of Directors of Adult Social Services and NHS England (2015) recommended that 'commissioners understand their local population now and in the future' (LGA *et al.*, 2015, p. 12) and deploy 'multi-disciplinary and multi-agency working, as well as skilled informed responses from specialist health and social care services, in partnership with the person and those who provide day-to-day support' (ibid., p.11). Specifically, the report tells local authority commissioners to adopt a framework based on Equality Act 2010 duties, and relevant recommendations include:

- commissioning supported employment services that can meet the needs of this group;
- ensuring that service specifications are based on person-centred outcomes;
- working with the local voluntary sector to consider what additional or different local services are needed to ensure people with personal budgets have a range of services to choose from;
- ensuring that advocacy services are independent and provided separately from care and support providers;
- developing Market Position Statements with an explicit focus on this group;
- co-producing local housing solutions leading to security of tenure, that enable people to live as independently as possible, rather than in institutionalised settings;
- ensuring inter-agency, collaborative working, including between specialist and mainstream services; and

- ensuring the availability of specialist health and social care support for people [from this group] who may be at risk of or have come into contact with the criminal justice system (Adapted from LGA *et al.*, 2015, p. 13-25)

Policy reforms, funding and structural changes to local authority mental health and social care commissioning practice can have an impact on market shaping practice for people with mental health problems who have complex and multiple needs (Drinkwater *et al.*, 2014; Revolving Doors Agency, 2015). Research by Drinkwater *et al.* (2014) showed that welfare policy and public sector funding reforms are 'having an overwhelmingly negative effect' on people with mental health problems who have multiple needs, and this is partly due to local authority funding and commissioning practices. Although the majority of commissioners surveyed said they were concerned about 'people with the most complex needs', they reported that 'the greatest negative impact came from the removal of the former Supporting People Programme's ring-fencing and its gradual incorporation into local authorities' wider grants' (Drinkwater *et al.*, 2014, p. 15). Supporting People was a national programme of ring-fenced funding for local authorities to invest in housing-related support, but from 2009 they were free to spend the money more flexibility in response to local needs of vulnerable people. However, 'evidence from recent Freedom of Information requests…revealed that during 2011/12 local authorities withdrew funding entirely from 305 different services, with a further 685 services experiencing some form of funding cut' (ibid, p.15). The loss of the Supporting People funding programme may also have negatively affected the supported housing and accommodation market for people with mental health problems who have been in custody and/or are homeless or at risk of homelessness (CMH, 2014).

A research report on payment by results (PbR) for people with mental health problems who have multiple and complex needs (Revolving Doors Agency, 2015) argued that PbR may not always be the most appropriate commissioning model for this group, and identified potential risks posed by 'perverse incentives' and 'gaming', where people with more intensive support needs are marginalised ('parking') in favour of less complex cases ('creaming') so that targets can be met. Authors emphasise the need for local authorities and joint commissioners to define and set outcomes that:

- incentivise a holistic, person-centred approach;
- [ensure] outcome measurements and targets reflect the need for longer-term, flexible interventions supporting the recovery journey;

- [set] payment structures that support investment in an intensive, assertive approach, and prevent 'parking' and 'creaming';
- [promote] a 'joined-up' approach;
- [consider] alternatives to PbR (Revolving Doors Agency, 2015, p. 3)

A UK scoping review on good practice in social care for disabled adults and older people with severe and complex needs (including mental health problems) highlighted the benefits of: individualised funding; joint commissioning between health and social care; and the importance of information, advocacy and peer support. It also noted that 'personalised services for people with severe and complex needs require intensive support to set up and maintain' (Gridley *et al.*, 2014, p. 245). Again, these findings add to the evidence that local authorities must consider 'whole system' or 'joined up' approaches when shaping markets for mental health care, to understand the diverse needs of the local population and the importance of specialist services for people with multiple and complex needs, and to adopt investment models of joint commissioning.

Black, Asian and minority ethnic populations

Some of the key themes from the literature on local authority mental health care market shaping and commissioning for people with mental health problems who have multiple and complex needs, are also relevant for Black, Asian and minority ethnic populations (BAME). The theme of 'falling through the cracks' between statutory services was highlighted in the 'I Am More Than One Thing' report on women and mental health (Imkaan *et al.*, 2014), which indicated that this can disproportionately affect women from certain BAME populations. A multi-method study of a complex intervention, including community engagement, for increasing access to mental health care for under-served groups emphasised that 'complex problems require multiple local stakeholders to work in concert' (Lamb *et al*., 2014, p. 2865), and the importance of 'community mapping activity' for gathering information to improve quality (Dorwick *et al*., 2016). Their study sites included a South Asian community project in Manchester, the findings from which emphasised the importance of community engagement and by extension, asset-based and community investment oriented approaches:

> Community engagement (CE) can be highly effective in a time-limited intervention as part of a complex intervention. CE brings ownership to stakeholders, can embed gains at the local level and allows for tailoring of other aspects of the intervention for local needs…we would argue the CE has become essential in coordinating interventions

> and engaging [service users], the public and local practitioners in…collaborative mental health care (Lamb *et al.*, 2014, p. 2877).

These findings support the Joint Commissioning Panel for Mental Health's (2014) guidance for commissioners of mental health services for people from black and minority ethnic (BME) communities, which recommends that 'from the outset, commissioners should involve service users, carers as well as members of local BME communities in the commissioning process' (JCPMH, 2014, p. 4). Further, the Panel direct commissioners to 'mobilise local evidence in relation to ethnicity and mental health' (ibid., p. 4) and use local data on ethnicity, service use and outcomes to inform local mental health care commissioning and market shaping decisions. The guidance emphasises the role local authority mental health care market shaping and commissioning activity should play in reducing ethnic inequalities in mental health, which includes 'collecting better data, specialist provision, enhancement or modification of existing services and the scaling up of innovations' (ibid., p. 3).

Lesbian, gay, bisexual (LGB) populations and transgender (T) populations

Qualitative research into the implications of austerity for LGB and T people and specialist services for these populations revealed emerging patterns in mental health care market shaping for this group (Mitchell *et al.*, 2014). In a similar way to the situation for people with mental health problems who have multiple and complex needs, for LGB and T community and specialist mental health and wellbeing organisations 'changes in commissioning structures…also sometimes compounded austerity by creating gaps in and uncertainty about funding' (ibid., p. 9). The research showed that 'a range of specialist and mainstream services used by the LGB and T community were observed to have been cut or curtailed' (ibid., p. 9), which included mental health, wellbeing, information and advice services as well as safe housing for LGB or T people with mental health problems at risk of homelessness. Respondents also reported difficulties with greater localisation of the planning and commissioning of services, and a concern that LGB and T needs were being de-prioritised and marginalised, despite the provisions under the Equality Act 2010. Specifically, cuts to funding for specialist LGB and T mental health and wellbeing support, information and advice was thought to be a 'false economy', with examples being given of 'individuals going untreated or being 'bounced' around the system' (ibid., p. 33).

Findings from a 2017 London Assembly Health Committee investigation into LGB and T mental health also highlighted the same difficulties for mental health care market shaping which is responsive to diversity in local populations. This was most notable in local authorities moving away from investing in specialist services and towards providing generalist services that cannot always serve the needs of local LGB and T populations. They argue that this risks increasing mental health inequality for these groups. Echoing the findings from the literature on BAME communities, the London Assembly report points to the need for population data to inform commissioning and market shaping, because lack of data is often interpreted as lack of need, and the importance of LGB and T community engagement to inform future commissioning and existing service quality. A broader 'whole-system', 'joined-up' approach to local authority mental health commissioning and market shaping is advocated for these groups for promoting wellbeing and preventing, delaying or reducing the need for formal care: 'the responsibility for mental health needs to move from sitting solely with health and social care to other…areas, including housing, community, employment, income and education' (London Assembly Health Committee, 2017, p. 7).

Women

The particular multiple needs of women with mental health problems are surfacing in recent voluntary sector research literature as being of concern for local authorities shaping mental health care markets so they respond to diversity and meet the needs of local populations. Participants of a survey of service providers for vulnerable women with mental health problems and multiple needs reported that 'commissioners failed to recognise the specific needs of this group' (Drinkwater *et al.*, 2014, p. 13). Many of the issues for women are reflected in what the general literature suggests about market shaping and commissioning for people with mental health problems who have multiple and complex needs; however research from England and Wales shows that the following can significantly or disproportionately affect women with mental health problems, and should be accounted for by local authorities when considering their local population needs:

- Violence against women and girls
- Rape and sexual abuse
- Gender-specific issues associated with ethnicity, culture or religion
- Specific issues for women living with HIV
- Specific issues for women who are trafficked (Imkaan *et al.*, 2014).

Age: older people and younger people

There were two studies included in the review that had a focus on age, both of which pointed to the importance of offering person-centred support in local authority mental health care market shaping strategies for older and younger people (Gridley *et al.*, 2014; Belling *et al.*, 2014). Both studies showed that multi-disciplinary and specialist teams and working were important for both younger and older people. Belling *et al.*'s (2014) study explored the effect of organisational resources and eligibility criteria on younger people transitioning from child and adolescent mental health services (CAMHS) to adult services. They concluded that there was a 'lack of clarity on service availability and the operation of different eligibility criteria between child and adult mental health services, with a variable lack of service provision for young people…Adult services [are] not meeting needs beyond severe and enduring mental illness' (Belling *et al.*, 2014, p. 169 and p. 173). This suggests the mental health care market could be perpetuating age inequality in terms of access to mental health care and support.

Theory 4: Supply

Theory 4 from the theory map on p.10 is described as 'providers develop diverse, innovative, high quality services, tailored to the profiles of people wanting support (including self-funders). Some of these will span health and care, as these services become more integrated. Some will be informal arrangements with non-regulated providers'. The literature was reviewed to assess how this theory on supply reflects on local authority mental health care market shaping between 2014 and 2017. This theory appeared most regularly throughout the mental health literature review, with over half of the included reports discussing the challenges for local authorities in nurturing and sustaining supply in order to shape the local mental health care and support market.

The review literature for this topic suggests there could be a problematic cycle of local authorities not adequately investing in and sustaining the type of 'diverse, innovative, high quality' supply of mental health care and support that could enhance local supply sources and provider capacity. There appears to be the potential for local authorities to sustain a diversity of independent, local mental health support initiatives which are often small scale, specialist and community, user or carer led, and could potentially support personalisation, choice and control (London Assembly Health Committee, 2017; MHF/MHPF, 2016b; Needham and Carr, 2015; Imkaan *et al.*, 2014). However this type of 'social capital' based, specialist and local community supply might not be adequately or regularly accounted for in market shaping or commissioning strategies (Newbigging and Parsonage, 2017; NIHR SSCR, 2014; Knapp *et*

al. 2014). The literature suggests a relationship between local provider capacity and local authority market shaping or funding decisions, and between those decisions and sustaining the local supply of mental health care and support to satisfy obligations under the Care Act 2014.

For example, in mental health there is a tradition of small independent and/or specialist local voluntary, community and user-led initiatives that are innovative, responsive and support prevention, personal recovery and social inclusion. This has particularly been the case in services working with and for those who have been marginalised by traditional, mainstream services (such as BAME people, refugees and asylum seeker and LGB and T populations) (Needham and Carr, 2015). However, 'this type of compensatory activity needs recognition and investment. Its existence does not imply the mainstream should not address the needs of these groups' (Carr, 2014, p. 4). There is evidence that this type of market supply and provider capacity could be affected by austerity policies and cuts to local authority funding (Mitchell *et al.*, 2014).

Similarly, the literature recommends investment in a supply of diverse, quality providers of appropriate support for local populations of mental health service users with complex and multiple needs, much of which is supplied by the voluntary and community sector. However local authorities have been slow to shape coherent local markets of specialist, comprehensive and integrated services for complex needs (VODG, 2016; MHF/MHPF, 2016b; Terry *et al.*, 2015; Imkaan, 2014). This situation is also reflected in the literature for the supply and provider capacity of supported housing and safe accommodation for people with mental health problems, especially if they have complex and multiple needs (CMH, 2014). Newbigging and Parsonage (2017) point to the importance of local authorities ensuring that a sufficient number of skilled mental health social workers (including Approved Mental Health Practitioners) are available to work with service users and carers to link up with community-based and specialist services, build social support networks and access safe housing and supported accommodation (NIHR SSCR, 2015). The supply of customers, in this case mediated by skilled and knowledgeable local authority social workers in multi-disciplinary mental health teams, is another potential issue of market shaping and provider capacity and sustainability.

For mental health market shaping, some reports argue that a conceptual shift is required towards outcomes focusing on personalisation and, in particular, personal recovery (Shepherd

et al., 2014; Knapp *et al.*, 2014). Shepherd *et al.* (2014) argue that social care and health commissioners should 'look for evidence that local providers are offering a number of key service developments…which are likely to lead to desirable recovery-focused outcomes' (p. 19). Further the research recommends that, for mental health market shaping, supply and sustainability, commissioners should also 'recognise that supporting recovery is complex…the application of key recovery principles – 'expert patient, personalisation, choice, importance of self-management and shared decision-making – are common to the effective management of long term conditions…[and] these long term condition management models [for mental health] require an emphasis on supporting people to achieve social (life) goals in additional to symptom management' (Shepherd *et al.*, 2014, p. 19-20). A business case for investing in cost effective interventions and support for personal recovery for people with a diagnosis of schizophrenia and psychosis, emphasises the need for a variety of social and therapeutic support and community activities, as well as supported accommodation and personal budgets (Knapp *et al.*, 2014).

Theory 6: Personalisation

Theory 6 on the theory map on p.10 states that 'people who want care and support have access to sufficient information, advice and advocacy to exercise choice and control. This is true across people funded in different ways, and accessing different types of support (some of which may not be regulated care services)'. For mental health, '[English] national policy regarding mental health care has evolved from a prescriptive approach on the desired community mental health structure, to a broader promotion of social inclusion and recovery objectives' (van Hooff *et al.*, 2015, p. 204). Personalisation and personal recovery in mental health have been largely indistinguishable in values and policy intention, although described using different terminology and approaches across health and social care. However, as Knapp *et al.* (2014) and Shepherd *et al.* (2014) clarify, mental health care markets and services should be oriented towards personalisation and personal recovery, defined as being 'about helping people with…mental illness to live ordinary lives, including assistance with the central elements in all our lives – housing, employment, money and so on' (Knapp *et al.*, 2014, p. 7). Some local authorities have developed innovative approaches to alliance and collaborative commissioning for mental health, based on 'personalised recovery packages [including] social housing, personal budgets, and intensive care and support' (VODG, 2016, p. 3).

The literature from 2014 until 2017 selected for this review largely focuses on two themes: a) personal budgets and direct payments as a means of promoting choice and control over care and support and b) the personalisation of mental health social care and support services for personal recovery and independent living.

Studies conducted prior to 2014 give a baseline picture largely indicating that 'the use of personal budgets by people with mental health problems has been consistently lower than for other social care groups', mainly due to operational arrangements for the provision of mental health social care, which are complicated by social care means testing and the separate financial assessments and arrangements between local authorities and NHS Trusts (Webber *et al.*, 2014). However, research has also shown that for mental health, personal budgets and direct payments have the potential to be effective for improving quality of life, could generate better outcomes than standard care and be cost-effective, so a reasonably strong economic case for personal budgets can be made for mental health (Knapp *et al.*, 2014). Based on research about older people and personal budgets, older people with mental health problems may have less positive responses and experiences of direct payments where they have to assume responsibility for budget management (Norrie *et al.*, 2014).

A study by Tew *et al.* (2015) emphasised the potential of personal budgets in mental health and concluded that 'personal budgets can support recovery thinking and processes, and can be used to mobilise relevant resources to make this possible. Key to achieving this can be co-productive and/or peer supported processes of assessment and planning. In addition, resource allocation may need to be flexible to take account of fluctuating levels of mental distress, and budgets should be linked to recovery goals rather than assuming long-term care needs' (Tew *et al.*, 2015, p. 79). The researchers outline a model of fluctuation and flexibility that should inform local authority decision-making about the range of services and support options needed in a local mental health care market: 'actively moving towards recovery; managing relapses and crises; staying well' (ibid., p. 87). One study which examined the use of personal budgets for employment support in the context of local authority commissioning practice for mental health and wellbeing revealed that commissioners had 'mixed views about whether personal budgets should be used for employment support [in mental health]', with the research recommending that 'there should be supported employment provision universally available and accessible for everyone in a local area…Such local supported employment should be funded via a mixed provision of core funding (through, for example, a contract) with

the addition of personal budgets. This is rather than solely funding support employment provision by contract or by personal budgets alone' (Watts *et al.*, 2014, p. 34-36).

The potential efficiencies and positive outcomes of personalising support have been discussed for older people with mental health problems, those with a learning disability and/or autism and mental health problems, for housing and accommodation for people with mental health problems who have been in custody and for comprehensive 'wraparound' services for individuals with complex needs (Gridley *et al.*, 2014; LGA *et al.*, 2014; Terry *et al.*, 2015; CMH, 2014). For older and disabled people with complex needs, including mental health problems, a UK evidence scoping review showed that 'personalised services for people with severe and complex needs require intensive support to set up and maintain. This requirement appears to run contrary to the current emphasis in English adult social care on greater self-management' (Gridley *et al.*, 2014, p245).

Theory 7: Quality

Theory 7 on the theory map on p,10 states that, 'person-centred and high quality services help people improve their wellbeing. Continuity of care is assured even if moving to a new locality or if funding arrangements change'. For mental health, the research shows that consistency and continuity between services and support is important not only for quality and wellbeing, but also for the prevention of crisis and homelessness. Local authorities have been found to have a pivotal role in creating the joint structures, funding and commissioning strategies to ensure that accommodation, community-based and specialist support function together so that people with mental health problems who have specialist, additional or complex needs do not 'fall through the gaps', which could result in the need for hospital, forensic or other higher intensity services or inappropriate placements (JCPMH, 2016; Drinkwater *et al.*, 2014; Imkaan, 2014: LGA *et al.*, 2015; Terry *et al.*, 2015).

The literature included in this review shows a number of factors which can influence mental health care market shaping processes and decision-making: quality improvement; collaboration, co-operation and co-production; building community resources and community engagement initiatives; and evidence-based investment models should (Dorwick *et al.*, 2016; van Hooff, 2015; Knapp *et al.*, 2015; Sheaff *et al.*, 2015; Brophy and Morris, 2014). Quality measures should be determined by broader 'whole-system', local, economic and social factors and co-produced with service users, carers and communities (Knapp *et al.*, 2014), rather than

being overly influenced by generic Payment by Results targets (Revolving Doors Agency, 2015). The importance of 'community mapping activity' for gathering information to improve quality has been evidenced in research (Newbigging and Parsonage, 2017; Dorwick *et al.*, 2016; McPin Foundation, 2015; NIHR SSCR 2014). Commissioning cost-effective interventions for personal recovery has been stressed for mental health specifically (Knapp *et al.*, 2014). Organisational level quality indicators for supporting personal recovery have been recommended, with measures for assessing the 'recovery-orientation' of organisations, including housing providers, which local authorities could utilise in mental health care market shaping decision-making (Shepherd *et al.*, 2014). It is recommended that commissioners 'look for evidence that providers place emphasis on improving the *process* of care (quality of experience) *in addition* to the delivery of evidence-based interventions aimed at securing specific outcomes' (Shepherd *et al.*, 2014, p. 19).

Housing and accommodation have been highlighted as a particular area for improvement in terms of quality and appropriate support for people with mental health problems, and is linked to wellbeing and prevention, particularly for people with complex and multiple needs who may be homeless or at risk of homelessness (MHF/MHPF, 2016b; Drinkwater *et al.*, 2014; CMH, 2014; Knapp *et al.*, 2014; Shepherd *et al.*, 2014). One report on the types of supported accommodation that meets the needs of people with mental health problems concluded that specific aspects of quality and socio-environmental design for mental health were central issues: 'Quality – investment in both Psychologically Informed Environments whose design (i) delivers (future proofed) physical access, (ii) promotes mental health and wellbeing, and (iii) facilitates social interaction; and also services delivering therapeutically innovative, responsive and dynamic care' (MHF/MHPF, 2016b, p. 2).

The review literature suggests that BAME and LGB and T populations may be less likely to experience quality from generic services that do not consult with or consider service users and communities from those local groups (Mitchell *et al.*, 2014; Needham and Carr, 2015). Local authority mental health care market shaping and commissioning funding strategies which disinvest in specialist community-based support may be compromising wellbeing and the quality of support for populations that are underserved or seldom heard. Likewise, local authority data shows that people with mental health problems with a learning disability and/or autism and behaviour that challenges can receive poorer quality responses and support because commissioners do not necessarily understand the different types of need of this local population, resulting in inappropriate services, service responses and inequalities. This

population, their families and informal social support networks require services that are designed to maximise quality of life and choice and control as well as keeping people safe (LGA *et al.*, 2015).

The literature recommends that local authority mental health care market shaping strategies address inequality and promote health and wellbeing for those with specialist or multiple support needs by investing in quality and control as well as choice, particularly in housing and accommodation (Newbigging and Parsonage, 2017; London Assembly, 2016; MHF/MHPF, 2016b; van Hooff *et al.*, 2015; JCPMH, 2014; Knapp *et al.*, 2014).

Conclusion

Overall the literature examined for this report indicates that local authorities have historically struggled to undertake market shaping for people living with long-term mental health problems, especially those with protected characteristics under the Equality Act 2010, and those with multiple or complex needs. From the theory map on p.10, the findings from the literature partially support Rival framing A: 'local authorities can't shape the market, because they cannot gather sufficient information about supply or demand and cannot provide the market with sufficient incentives to stimulate adequate, stable and high quality support'. However, the available literature mainly evidenced issues regarding lack of specialist provision for marginalised groups. There was a gap in the literature on if and how local authorities are gathering and using local information and data for demand-based commissioning and market shaping.

Mental health market shaping and commissioning are occurring in a complex landscape and this poses many challenges for local authorities. Integrated, coherent and system-wide market shaping strategies for local populations are needed. The literature highlights the potential effectiveness of person-centred, personal recovery-oriented approaches to commissioning and market shaping for mental health care and support, with the genuine involvement of local populations and communities who use and provide services and support.

Despite the policies and the progress made with community and social care in mental health, the literature found that much local authority and joint mental health commissioning and market shaping remains oriented towards hospital aligned services and support. This can exclude some innovative local mental health services and community support initiatives from the commissioning process, despite the fact that market shaping should be stimulating innovation and sustaining local providers that promote personal recovery and social inclusion. The literature suggests that competition could be less effective than collaboration for mental health service market shaping, and that co-production, quality improvement and building community capacity using joint investment approaches could be more effective.

Existing mental health care markets might not be responding adequately to diversity with local populations. The literature suggests that those with protected characteristics under the Equality Act 2010 are possibly not being routinely or appropriately considered in local authority mental health market shaping strategies. Local authorities should adopt a market shaping and

commissioning framework based on Equality Act duties, and develop local inequality reduction strategies informed by accurate local population and socio-economic data and in partnership with relevant local communities, service users, carers and their organisations.

The way support is commissioned and designed can mean that people with mental health problems and complex or multiple needs 'fall through the gaps', experience fragmentation and a lack of continuity between support and services, including housing and accommodation. Local authorities most commonly fund housing and supported accommodation for people eligible for after-care under Section 117 of the Mental Health Act 1983. The provision of a range of stable, safe and supported accommodation options should be integral to mental health care market shaping by local authorities.

Public sector infrastructure and funding reforms may have had a negative effect on market shaping in mental health, with a specific example being the impact of the loss of ring-fenced local authority Supporting People funding on accommodation and support for people with mental health problems with complex and multiple needs. Austerity policies and local funding cuts may have negative impacts on local specialist community sector providers, resulting in reduction of services or service quality or closures. To build local community capacity for wellbeing and prevention as well as personal recovery and social inclusion, local authorities should assess the mental health care market using asset-based and social network approaches. Building community capacity should be integral to mental health care market shaping by local authorities. The supply of customers, in this case mediated by skilled and knowledgeable local authority social workers in multi-disciplinary mental health teams, is another issue of market shaping and provider capacity and sustainability. For mental health market shaping, a conceptual shift towards outcomes focusing on personalisation and, in particular, personal recovery and social inclusion is required.

The literature published between 2014 and 2017 offers an emerging picture on local authority market shaping progress and challenges in the context of the Care Act. It also offers indications of ways to address the situation where local authorities have been unable to shape the mental health care and support market in line with the Act. Local authorities need to fulfil their Section 117 duties to provide a range of safe, supported accommodation options for people with mental health problems. They should invest to stimulate local innovation and a variety of support providers using local demographic, social asset and market data, in partnership with service users, carers and communities, and with particular attention to the

requirements of those with multiple or complex needs. Collaborative rather than competitive approaches to local commissioning may help to achieve this, as well as approaches framed within the Equality Act 2010 duties.

References

BBC (2017) Mental Health Patients Stranded in Units for Years, BBC News 3rd August 2017, [Online], Available at: http://www.bbc.co.uk/news/health-40631929 [Accessed: 23 October 2017].

Belling, R., McLaren, S., Paul, M., Ford, T., Kramer, T., Weaver, T., Hovish, K., Islam, Z., White, S. and Singh, S. P. (2014) 'The Effect of Organisational Resources and Eligibility Issues on Transition from Child and Adolescent to Adult Mental Health Services', *Journal of Health Services Research and Policy*, Vol. 19, (3), pp.169–176.

Brophy, C. and Morris, D. (2014) 'Community-Oriented Integrated Mental Health Services', *London Journal of Primary Care,* Vol. 6, (6), pp. 159–163.

Carr, S. (2014) *HSMC Policy Paper 18: Social Care for Marginalised Communities: Balancing Self- Organisation, Micro-Provision and Mainstream Support*. Birmingham: University of Birmingham, [Online], Available at: https://www.birmingham.ac.uk /Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/policy-paper-18-sarah-carr.pdf [Accessed: 14 March 2018].

Centre for Mental Health (2014) *A Place to Live: Securing Stable Accommodation for Offenders with Mental Health Problems*. London: Centre for Mental Health [Online], Available at: https://www.bl.uk/collection-items/place-to-live-securing-stable-accommodation-for-offenders-with-mental-health-problems [Accessed: 14 March 2018].

Crisp, N., Smith, G. and Nicholson, K. (Eds.) (2016) *Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England. Final report.* London: Commission on Acute Psychiatric Care [Online], Available at: http://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf [Accessed: 14 March 2018].

DHSC (2016) *Care Act Factsheet 1: General responsibilities of local authorities: prevention, information and advice, and shaping the market of care and support services* London: DHSC [Online], Available at: https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets#factsheet-1-general-responsibilities-of-local-authorities-prevention-information-and-advice-and-shaping-the-market-of-care-and-support-services [Accessed: 14 March 2018].

Dorwick, C., Bower, P., Chew-Graham, C., Lovell, K., Edwards, S., Lamb, J., Bristow, K., Gabbax, M., Burroughs, H., Beatty, S., Waheed, W., Hann, M. and Gask, L. (2016) 'Evaluating a Complex Model Designed to Increase Access to High Quality Primary Mental Health Care for Under-served Groups: A Multi-Method Study' *BMC Health Services Research* Vol. 16, (58) DOI 10.1186/s12913-016-1298-5.

Drinkwater, N., Graham, J., Kempster, A. and Thomas, S. (2014) *Evidence from the Frontline: How Policy Changes are Affecting People Experiencing Multiple Needs* London:

MEAM [Online], Available at: http://meam.org.uk/wp-content/uploads/2013/04/EvidenceFromTheFrontline.pdf [Accessed: 14 March 2018].

Gilburt, H. and Peck, E. (2014) *Service Transformation: Lessons from Mental Health*. London: King's Fund, [Online], Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf [Accessed: 14 March 2018].

Gov.uk (2017a) *Care Act 2014 Care and Support Statutory Guidance: Promoting Wellbeing.* [Online], Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-1 [Accessed: 23 October 2017].

Gov.uk (2017b) *Care Act 2014 Care and Support Statutory Guidance: Preventing, Reducing or Delaying Needs* [Online], Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#chapter-2 [Accessed 23 October 2017].

Gridley, K., Brooks, J. and Glendinning, C. (2014) 'Good Practice in Social Care for Disabled Adults and Older People with Severe and Complex Needs: Evidence from a Scoping Review', *Health and Social Care in the Community,* Vol. 22, (3), pp.234–248.

HM Government (2012) *Caring for Our Future: Reforming Care and Support* London: HMSO.

HM Government (2014) *The Care Act 2014* London: TSO.

Ikkos, G., Sugarman, P. and Bouras, N. (2015) 'Mental Health Services Commissioning and Provision: Lessons from the UK?', *Psychiatrike = Psychiatriki,* Vol. 26, (3), pp.181-187.

Imkaan, Positively UK, Rape Crisis England and Wales (2014) *'I Am More Than One Thing': A Guiding Paper by Imkaan, Positively UK and Rape Crisis England and Wales on Women and Mental Health* London: Imkaan [Online], Available at: http://cdn.basw.co.uk/upload/basw_111834-7.pdf [Accessed 14 March 2018].

Joint Commissioning Panel for Mental Health (2014) *Guidance for Commissioners of Mental Health Services for People from Black and Minority Ethnic Communities.* London: Joint Commissioning Panel for Mental Health, [Online], Available at: https://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf [Accessed: 14 March 2018].

Joint Commissioning Panel for Mental Health (2016) *Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs.* London: Joint Commissioning Panel for Mental Health, [Online], Available at: https://www.jcpmh.info/wp-content/uploads/jcpmh-rehab-guide.pdf [Accessed: 14 March 2018].

Knapp, M., Andrew, A., McDaid, D., Iemmi, V., McCrone, P., Park, A., Parsonage, M., Boradman, J. and Shepherd, G. (2014) *Investing in Recovery: Making the Business Case for Effective Interventions for People with Schizophrenia and Psychosis.* London: Rethink, [Online], Available at: http://eprints.lse.ac.uk/56773/1/Knapp_etal_Investing_in_recovery_2014.pdf [Accessed: 14 March 2018].

Lamb, J., Dowick, C., Burroughs, H., Beatty, S., Edwards, S., Bristow, K., Clarke, P., Hammond, J., Waheed, W., Gabbay, M. and Gask, L. (2014) 'Community Engagement in a

Complex Intervention to Improve Access to Primary Mental Health Care for Hard-to-Reach Groups' *Health Expectations*, Vol. 18, (6), pp.2865–2879.

Legislation.gov.uk (2017) *Mental Health Act 1983 c.20 Part VIII After-care Section 117*, [Online], Available at: http://www.legislation.gov.uk/ukpga/1983/20/section/117 [Accessed 23/10/2017].

Local Government Association, Association of Directors of Adult Social Services and NHS England (2015) *Supporting People with a Learning Disability and/or Autism who have a Mental Health Condition or Display Behaviour that Challenges.* London: NHS England [Online], Available at: https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf [Accessed: 14 March 2018].

London Assembly Health Committee (2017) *LGBT+ Mental Health.* London: London Assembly Health Committee [Online], Available at: https://www.london.gov.uk /sites/default/files/lgbtreportfinal.pdf [Accessed: 14 March 2018].

McPin Foundation (2015) *Wellbeing Networks and Asset Mapping: Useful Tools for Recovery Focused Mental Health Practice.* London: McPin Foundation, [Online], Available at: https://www.london.gov.uk/sites/default/files/lgbtreportfinal.pdf [Accessed: 14 March 2018].

Mental Health Foundation and Mental Health Providers Forum (2016a) *Demonstrating the Value of the Voluntary and Community Sectors: Mental Health and Criminal Justice.* London: The Mental Health Foundation, [Online], Available at: https://www.mentalhealth.org.uk/site /default/files/demonstrating-value-voluntary-community-sectors.pdf [Accessed: 14 March 2018].

Mental Health Foundation and Mental Health Providers Forum (2016b) *Mental Health and Housing.* London: The Mental Health Foundation, [Online], Available at: https://www. mentalhealth.org.uk/sites/default/files/Mental_Health_and_Housing_report_2016_1.pdf [Accessed: 14 March 2018].

Mind (2017) *Public Mental Health in England 2016*. [Online], Available at: https://www.mind .org.uk/media/5195581/public-mental-health-fois-2016-one-pager.pdf [Accessed 23 October 2017].

Mitchell ,M., Beninger K., Rahim, N. and Arthur, S. (2014) *Implications of Austerity for LGBT People and Services.* London: Unison, [Online], Available at: https://www.natcen.ac.uk /media/205545/unison-lgbt-austerity-final-report.pdf [Accessed 14 March 2018].

Needham, C. and Carr, S. (2015) 'Micro-Provision of Social Care Support for Marginalized Communities – Filling the Gap or Building Bridges to the Mainstream?' *Social Policy and Administration,* Vol. 49, (7), pp.824–841.

Newbigging, K. and Parsonage, M. (2017) *Mental Health in the West Midlands Combined Authority: A Report for the West Midlands Mental Health Commission* Birmingham: West Midlands Combined Authority, [Online], Available at: https://www.wmca.org.uk/media /1419/uob-mental-health-in-the-wmca-report.pdf [Accessed: 14 March 2018].

NHS (2017) *NHS Choices: Mental Health Aftercare.* [Online], Available at: http://www.nhs.uk /Conditions/social-care-and-support-guide/Pages/mental-health-aftercare.aspx [Accessed: 23 October 2017].

National Institute for Health Research School for Social Care Research (2014) *Building Community Capacity: The Economic Case in Adult Social Care in England* London: NIHR SSCR, [Online], Available at: https://www.sscr.nihr.ac.uk/PDF/Findings/RF50.pdf [Accessed: 14 March 2018].

National Institute for Health Research School for Social Care Research (2015) *Evaluation of the Connecting People Intervention: A Pilot Study* London: NIHR SSCR [Online], Available at: http://sscr.nihr.ac.uk/PDF/Findings/RF28.pdf [Accessed: 14 March 2018].

Norrie, C., Weinstein, J., Jones, R., Hood, R. and Bhanbro, S. (2014) 'Early Experiences in Extending Personal Budgets in One Local Authority', *Working with Older People,* Vol. 18, (4), pp.176-185, doi: 10.1108/WWOP-07-2014-0019.

Pawson, R., Greenhalgh, T., Harvey, G., Walshe, K. (2005) 'Realist Review – A New Method of Systematic Review Designed for Complex Policy Interventions', *Journal of Health Services Research and Policy*, Vol. 10, (Supplement 1), pp. S1:21-34.

Pearson, M., Hunt, H., Cooper, C., Shepperd, S., Pawson, R. and Anderson, R. (2013) *National Institute for Health Research Service Delivery and Organisation Programme. Intermediate Care: A Realist Review and Conceptual Framework*. [Online], Available at: http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_10-1012-07_V01.pdf [Accessed: 14 March 2018].

Revolving Doors Agency (2015) *Adding Value? Reflections on Payment by Results for People with Multiple and Complex Needs* London: Revolving Doors Agency, [Online], Available at: http://www.revolving-doors.org.uk/file/1833/download?token=iQRWPEyY [Accessed: 14 March 2018].

Rodgers, M., Dalton, J., Harden, M., Street, A., Parker, G. and Eastwood, A. (2016) 'Integrated Care to Address the Physical Health Needs of People with Severe Mental Illness: A Rapid Review' *Health Services and Delivery Research* Vol. 4, (13).

Social Care Institute for Excellence (2015) *Fluctuating Needs in Assessment and Eligibility for the Care Act 2014* London: SCIE.

Sheaff, R., Charles, N., Mahon, A., Chambers, N., Morando, V., Exworthy, M., Byng, R., Mannion, R. and Llewellyn, S. (2015) 'NHS Commissioning Practice and Health System Governance: A Mixed-Methods Realistic Evaluation' *Health Services And Delivery Research,* Vol. 3, (10).

Shepherd, G., Boardman, J. Rinaldi, M., Roberts, G. (2014) *Supporting Recovery in Mental Health Services: Quality and Outcomes* London: Centre for Mental Health, [Online], Available at: https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=82123340-ed9a-48da-8012-afe66e2614ef [Accessed: 14 March 2018].

Terry, L., Scott, G. and Khan, L. (2015) *Comprehensive Services for Complex Needs: Assessing the Evidence for Three Approaches* London: Revolving Doors Agency, [Online], Available at: https://www.bl.uk/collection-items/comprehensive-services-for-complex-needs-assessing-the-evidence-for-three-approaches-wraparound-multisystemic-therapy-and-the-link-worker-model [Accessed 14 March 2018].

Tew, J., Larsen, J., Hamilton, S., Manthorpe, J., Clewett, N., Pinfold, V. and Szymczynska, P. (2015) 'And the Stuff that I'm Able to Achieve Now Is Really Amazing': The Potential of

Personal Budgets as a Mechanism for Supporting Recovery in Mental Health', *The British Journal of Social Work 45* (suppl_1) pp.i79-i97.

van Hoof, F., Knispel, A., Aagaard, J., Schneider, J., Beeley, C., Keet, R. and van Putten, M. (2015) 'The Role of National Policies and Mental Health Care Systems in the Development of Community Care and Community Support: An International Analysis', *Journal of Mental Health,* Vol. 24, (4), pp. 202-207, DOI: 10.3109/09638237.2015.1036973.

Voluntary Organisations Disability Group (2016) *Thought Leadership: What can the Voluntary Sector do to Encourage Greater Engagement and Collaboration with the Health System?* London: VODG, [Online], Available at: https://www.vodg.org.uk/wp-content/uploads/2016-VODG-What-can-the-voluntary-sector-do-to-encourage-greater-engagement-report.pdf [Accessed 14 March 2018].

Watts, R., Harflett, N., Robinson, C. and Greig, R. (2014) *The Use of Personal Budgets for Employment Support,* Bath: National Development Team for Inclusion, [Online], Available at: https://www.ndti.org.uk/uploads/files/PBs_and_employment_research_report_v2_4th_June_2014.pdf [Accessed: 14 March 2018].

Webber, M., Treacey S., Carr, S. et al. (2014) 'The Effectiveness of Personal Budgets for people with Mental Health Problems: A Systematic Review', *Journal of Mental Health,* Vol. 23, (3), pp.146-155.

Williams, I., Bovaird, T., Brown, H., Allen, K., Dickinson, H., Kennedy, J. and Glasby, J. (2013) 'Designing Whole-Systems Commissioning: Lessons from the English Experience', *Journal of Care Services and Management,* Vol. 6, (2), pp. 83-92.

Appendix – Summary search strategy

Search strategy 1: Local authority mental health commissioning practice

This search included the following bibliographic databases, using the key words and search strings tabulated below:

- HMIC
- Medline
- Assia
- Proquest
- EBSCO
- Social Care Online
- Social Sciences Citation Index
- Social Services Abstracts
- EMBASE
- ISI Citation Index

Search	Results
1. Commissioning AND Mental* AND (outcome OR quality of life OR strategic OR coproduction OR adult* OR older* OR elder* OR local government services OR indicators OR integrated OR joint)	69

Searches 2 - 9 to identify mental health commissioning processes and practices that are not explicitly labelled as such:

Search	Results
2. Needs assessment AND Mental* AND (strategic OR joint OR integrated OR holistic OR outcomes)	244
3. Personalisation OR Personal budgets AND Mental* AND (control OR choice OR recovery) 3. (a) Personalisation OR Direct Payments AND Mental* AND (control OR choice OR recovery) 3. (b) Personalisation OR Self Fund* AND Mental* AND (control OR choice OR recovery)	**A= 20** **B= 13**
4. Recovery* AND Mental* AND (risk OR safe* OR control OR choice OR recovery*)	
5. Procurement AND Mental* AND (strategic OR joint OR holistic OR outcome OR integrated OR adult* OR older* OR elder* OR local government services)	13
6. Planning AND Mental* AND (joint OR care OR outcome OR strategic OR service OR user OR patient OR client)	347
7. Mental* AND (Market management OR market development) AND procurement	
8. Mental* AND (decommissioning OR disinvestment) AND procurement	
9. Mental* AND Performance AND (commissioning OR strategic)	277

Search strategy 2: Social care support provision for people from marginalised groups and/or with protected characteristics under the Equality Act 2010

Search	Results
1. mental* and social* AND (care or support) 2014>current	160 *Limited to title* – 152 *Limited to title* – 19 TOTAL: 331
2. mental* and older* AND (care or support) 2014>current	37 *Limited to title* – 26 395 TOTAL:458
3. mental* and disab* AND (care or support) 2014>current	37 *Limited to title* – 24 311 TOTAL:372
4. (a) mental* AND care or support 2014>current (with additional keywords around ethnicity or race)	*Not limited by year – 533* *Limited to title* – 100 97 TOTAL: 730
4. (b) mental* AND care or support 2014>current (with additional other keywords)	*36* *Limited to title* – 175 231 TOTAL: 442

The additional key words used with mental* AND care OR support were as follows:

Black*
BME
African
Caribbean
Minority ethnic
Asian
South Asian
Chinese
Gypsy
Irish traveller
Mixed ethnic*

Lesbian
Gay
Bisexual
Transgender
LGBT

Asylum seeker*
Refugee*

Religion
Faith

Diversity
Equality
Inequality
Discrimination

Urban
Rural

Search strategy 3: Targeted searches of mental health organisations in England

Organisation	Number of reports identified
Mind	3
Mental Health Foundation	4
Centre for Mental Health	4
Rethink	0
Together	1
Richmond Fellowship	0
National Survivor User Network	2
Mental Health Providers Forum	1
Joint Commissioning Panel for Mental Health	2
Turning Point	0
Revolving Doors Agency	2
McPin Foundation	3
Race Equality Foundation	0
Total	23

Search strategy 4: Sub-set of papers relevant for mental health derived from the main literature review

The mental health literature sub-set included a total of 31 papers and reports. See main literature review for search strategy.

Inclusion and exclusion criteria

After removing duplicates, titles and/or abstracts were initially screened by the reviewer (SC) using the criteria below:

Inclusion criteria

- Focus on local government and mental health commissioning
- Concerning England
- Published in academic journals
- Empirical studies
- Systematic and narrative research reviews
- Surveys
- Case studies
- Evidence-based official guidance
- Published research reports
- Working age adults
- Older people

Exclusion criteria

- Does not focus on local authority commissioning practice or service provision in mental health
- Does not take mental health as a significant focus
- Commentary or journalistic paper
- Published before 2014
- Focus on children and young people

This initial stage of screening resulted in a total of 70 potential includes.

These 70 papers and reports were then screened using the initial theory map for Market Shaping and Personalisation (see figure 1.). This resulted in *37 final includes.*