editorial

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Managed clinical networks – their relevance to mental health services

Finding an appropriate management structure for mental health services is not easy. Traditional approaches often fail to encompass the multi-faceted and democratic aspirations of the psychiatric workforce, its patient groups and the skills that both possess. Managed clinical networks (MCNs) have made an appreciable impact in a number of medical specialities recently (Boon, 1999; Baker & Lorimer, 2000; Collins, 2000; Kunkler, 2000) and are championed in recent Government publications in England (Department of Health, 2001) and especially in Scotland (Scottish Office Department of Health, 1998; NHS Management Executive, 1999). Some agencies (South East Regional Office Working Group, 2000) seem more enthusiastic about the concept, whereas others are perhaps more critical (NHS Confederation, 2001). The purpose of this article is to describe MCNs, their strengths and limitations and possible applications to managing psychiatric services.

Managed clinical networks are a response to the complexity present in contemporary health services. This complexity is twofold. The first is clinical. Diseases are no respecters of managerial boundaries: they have an impact on primary, secondary and tertiary care, and across trust, social services and professional demarcation lines. Second, there is the current working of the NHS itself. Gone are the days when difficult cases from the provinces were sent up to the metropolis for an expert opinion, where they would be treated and returned home. Today expertise is dispersed throughout the NHS, but often is not mobilised in a coordinated fashion in the best interests of the patient: a cancer patient typically may need radiotherapy, chemotherapy, physiotherapy, home care support and counselling. All these treatments are potentially available but are provided by different and often disconnected parts of the health care system. MCNs attempt to streamline the patient's journey through the system, providing services in an intrinsically 'joined up' way.

Further considerations arise from geographically spread-out regions with low population density, where there may be small numbers of specialists in any one discipline. The capacity to build up a critical mass of professionals is limited, and MCNs provide the opportunity for professional collaboration across existing boundaries, real or imagined. Managed clinical networks make sense for supra-regional service provision catering for rare illnesses. Also, many conditions, especially psychiatric illnesses, arise and continue across the age range and patients may drop through the net as they graduate either from child to adult, or from adult to elderly, services. The integrative philosophy of MCNs can help to overcome these barriers, and the recent advent of large merged mental health trusts covering large areas provides an ideal opportunity to develop innovative managerial arrangements. Indeed, it might be argued that only once intra-trust networks are firmly established and funded should regional inter-trust collaborations along cancer network lines be ventured.

What are MCNs?

Managed clinical networks are linked groups of health professionals working in a coordinated manner, not constrained by existing organisational or professional boundaries, to ensure good patient care. The arrangements between the professionals are formalised and managed.

These networks can be of several types: they can cover a specific disease such as anorexia nervosa, a specific speciality such as child and adolescent mental health services (CAMHS), a specific function such as home treatment or research or a specific client group such as forensic patients with mental health problems.

Clearly there are a myriad of networks within the health service, both within and across trusts, with varying degrees of formality ranging from casual contacts to clinicians with similar interests to established clinical groupings. The idea behind MCNs is to build on and formalise these 'natural' associations for the benefit of the patient. The term network might suggest diffused responsibility, but these networks are far from casual or informal. The key point is that they are managed. This ensures that there are defined areas of accountability and relationships between individuals within the network, and that the network boundaries are clearly identified.

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The core principles of MCNs (Scottish Office Department of Health, 1998) include:

(a) The appointment of one person with overall responsibility for the operation of the network, be it a clinician, manager or other professional.

(b) A clearly mapped out structure, which sets out the points at which the service is to be delivered and the connections between the points.

(c) A statement of expected service improvements and the preparation of an annual report. The potential 'to generate better value for money' must have been explored.

(d) Adherence to evidence-based treatment guidelines and formal agreement of all members of the network to participate in the network and practice in accordance with the evidence base.

(e) Quality assurance procedures, including audit.

(f) Patients involved in its management arrangements.

There are several MCNs in existence throughout the UK. The development of MCNs for cancer services is now a government requirement and MCNs also exist in many other medical specialities, such as neurology (stroke), vascular services and diabetes (South East Regional Office Working Group, 2000). Managed clinical networks exist in forensic services and CAMHS but currently we are not aware of any operational MCNs in adult mental health. The Northern part of the Northern & Yorkshire Region is in the process of establishing a local clinical network for eating disorders, and the new National Institute for Mental Health is built around the idea of a managed research network.

The main arguments for MCNs have been described above. As a 'horizontal' network, they contrast with 'vertical' hierarchical management structures, which can be cumbersome and stifle creativity. However, MCNs, if properly constituted, require resources: money (which inevitably will be 'top sliced' from stretched trust budgets), time and personnel. There are possible conflicts where networks meet hierarchies. Managed clinical networks create an 'organisation within an organisation', with their own bureaucracy, and proliferation of meetings that take clinicians away from direct patient contact.

Managed clinical networks in psychiatry – the example of psychological therapies

Despite these caveats, we believe that there is considerable scope for the development of MCNs in psychiatry, especially in areas that do not fit neatly into traditional management pigeon holes. Psychosis services, eating disorder services, psychological therapy services and service for people with personality disorders spring immediately to mind.

In conclusion, then, we will elaborate briefly on the notion of MCNs for psychological therapy services, an area currently under development in the Devon Partnership Trust. Here, the focus is on the delivery of a particular type of care rather than a specific patient group. The diversity of psychological therapies makes them particularly suitable for an MCN approach – they spill over neat managerial boxes in ways that means that their delivery is often idiosyncratic and uncoordinated. Thus, the *National Service Framework (NSF) for Mental Health* (Department of Health, 1999) cites evidence-based psychological therapies across a range of disorders and settings, in both primary and secondary care, including schizophrenia, eating disorders, depression and, as part of a suicide prevention strategy, personality disorders. Despite this, there has been little explicit investment in training for, or the delivery of, psychological therapies in the developing services that have come out of the NSF – early intervention in psychosis, assertive outreach and crisis resolution. The lack of a clear managerial framework for psychological disorders may well lie at the root of this omission.

Features that make psychological therapies suitable for an MCN approach include:

(a) Therapies are delivered by a range of sometimes rivalrous professionals – psychologists, psychiatrists, nurses – who are currently managed in different ways.

(b) There are a number of potentially competing modalities of therapy that need to be coordinated in order to meet the full range of client need.

(c) Psychological therapies have tended to concentrate on adults of working age, but are applicable across the age and ability range if management arrangements existed to ensure their delivery.

(d) There are agreed standards of training, competent practice and outcome evaluation that often are not used.

(e) There are 'silent areas' in which psychological therapies have failed to penetrate, such as acute psychiatric wards.

(f) Psychological therapies are needed at primary, secondary and tertiary care level, and their delivery should be coordinated so that scarce resources are deployed most efficiently.

Another area that lends itself naturally to the MCN approach is services for people with personality disorders. These patients have an impact on forensic and general psychiatric services in ways that often are not coordinated, they are often high consumers of resources, including out-of-area treatments, and they can benefit from facilities such as dedicated personality disorder day hospitals that potentially could accept patients from across different trusts. However, rather than a stand-alone MCN, there is a case here for management to be 'nested' in an MCN for psychological therapies – an MCN within an MCN!

Declaration of Interest

None.

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