NHS | **OUR HEALTHIER NATION**

Modern Standards and Service Models

Mental Health

national service frameworks

A National Service Framework for Mental Health

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September 1999

National Service Framework for

Mental Health

Modern Standards & Service Models

Foreword by the Secretary of State

At any one time one adult in six suffers from one or other form of mental illness. In other words mental illnesses are as common as asthma. They range from more common conditions such as deep depression to schizophrenia, which affects fewer than one person in a hundred. Mental illness is not well understood, it frightens people and all too often it carries a stigma.

Despite its prevalence and importance mental illness hasn't had the attention it deserves. That's why the Government is determined to give it a much higher priority. That is why we decided that mental health should have the same priority as coronary heart disease in our programme of National Service Frameworks which will lay down models of treatment and care which people will be entitled to expect in every part of the country.

So this National Service Framework for Mental Health spells out national standards for mental health, what they aim to achieve, how they should be developed and delivered and how to measure performance in every part of the country.

These standards are founded on a solid base of evidence, which has been examined and validated by the External Reference Group chaired by Professor **Graham** Thornicroft. I am very grateful to them for their thorough and professional work which should help raise standards, tackle inequalities and meet the special needs of women, men, and different ethnic groups.

This National Service Framework fleshes out the policies announced in our White Paper 'Modernising Mental Health Services'. It will be a guide to investment in mental health services including the extra £700 million which the Government is providing over this year and the next two. It will be backed up, in due course, by changes to bring the law on mental illness up to date to reflect modern treatments and care, following the root and branch review conducted by the independent expert group under Professor Genevra Richardson.

Most people who suffer from mental illnesses are vulnerable and present no threat to anyone but themselves. Many of these patients have not been getting the treatment and care they need partly because the system has found it so difficult to cope with the small minority of mentally ill people who are a nuisance or a danger to both themselves and others.

The Government is committed to do whatever is necessary to deliver a modern and dependable health service, fit for the new century. Mental health services and the professionals who provide them will get the attention and resources they deserve. This National Service Framework will set the standards and these standards will be met.

Rt Hon Frank Dobson MP
Secretary of State for Health

1.0   The National Service Framework for Mental Health

- **developing the National Service Framework for mental health**

- **a new vision for mental health**

- **a Government wide agenda**

Introduction

The new NHS and *Modernising Social Services* were landmarks for the future of health and social services. The two White Papers set out a range of measures to drive up quality and reduce unacceptable variations, with services responsive to individual needs, regardless of age, gender, race, culture, religion, disability, or sexual orientation.

A First Class Service explained how NHS standards would be:

- **set** by the National Institute for Clinical Excellence and National Service Frameworks

- **delivered** by clinical governance, underpinned by professional self-regulation and lifelong learning

- **monitored** by the Commission for Health Improvement, the new National Performance Assessment Framework, and the National Survey of Patients.

Similarly, *A New Approach to Social Services Performance* described a Performance Assessment Framework for social services, outlining plans to strengthen assessment by the Department of Health and detailed proposals for national performance indicators for social services.

The first two National Service Frameworks cover two of the most significant causes of ill health and disability in England - coronary heart disease and mental health - two priorities in *Saving lives: Our Healthier Nation*. The National Service Frameworks have also been identified as priorities in *Modernising Health and Social Services: National Priorities Guidance for 1999/00 - 2001/02*.

This National Service Framework focuses on the **mental health needs of working age adults** up to 65. Mental ill health is so common that at any one time around one in six people of working age have a mental health problem, most often anxiety or depression. One person in 250 will have a psychotic illness such as schizophrenia or bipolar affective disorder (manic depression).

Most people with mental health problems are cared for by their GP and the primary care team. This is what most patients prefer, and is more likely to be effective when specialist services provide support, and where there is local agreement on how to provide integrated care.

Generally, for every one hundred individuals that consult their GP with a mental health problem, nine will be referred to specialist services for assessment and advice, or for treatment.

Some people with severe and enduring mental illness will continue to require care from specialist services working in partnership with the independent sector and agencies which provide housing, training and employment.

Specialist services, including social care, should ensure effective and timely interventions for individuals whose mental health problems cannot be managed in primary care alone, for example, patients with severe depression or psychotic disorders. Specialist services are essential when these problems coexist with substance misuse - co-morbidity or dual diagnosis.

Working partnerships with agencies which provide housing, training, employment and leisure services will be required to address the needs of some people with enduring mental health needs.

Developing the National Service Framework

The National Service Framework has been developed with the advice of an External Reference Group, chaired by Professor Graham Thornicroft from the Institute of Psychiatry, King's College London. The External Reference Group brought together health and social care professionals, service users and carers, health and social service managers, partner agencies, and other advocates.

A full range of views were sought by the External Reference Group, which was assisted by the Department of Health.

Emerging findings from the External Reference Group were incorporated in *Modernising Mental Health Services*. The Group distilled existing research and knowledge, and considered a number of cross cutting issues, such as race and gender. This National Service Framework is founded on their work.

Guiding values and principles

The External Reference Group developed ten guiding values and principles to help shape decisions on service delivery. People with mental health problems can expect that services will:

- involve service users and their carers in planning and delivery of care
- deliver high quality treatment and care which is known to be effective and acceptable
- be well suited to those who use them and non-discriminatory
- be accessible so that help can be obtained when and where it is needed
- promote their safety and that of their carers, staff and the wider public
- offer choices which promote independence
- be well co-ordinated between all staff and agencies
- deliver continuity of care for as long as this is needed
- empower and support their staff
- be properly accountable to the public, service users and carers.

Scope

The National Service Framework for mental health will help drive up quality and remove the wide and unacceptable variations in provision. It:

- sets national standards and defines service models for promoting mental health and treating mental illness

- puts in place underpinning programmes to support local delivery

- establishes milestones and a specific group of high-level performance indicators against which progress within agreed time-scales will be measured.

It concentrates on the mental health needs of working age adults up to 65, and covers health promotion, assessment and diagnosis, treatment, rehabilitation and care, and encompasses primary and specialist care and the roles of partner agencies.

The Framework also touches on the needs of children and young people, highlighting areas where services for children and adults interact, for example the interface between services for 16 - 18 year olds, and the needs of children with a mentally ill parent. A major programme of service development, supported by the Mental Health Grant and Mental Health Modernisation Fund, is addressing the mental health needs of children and adolescents.

The needs of older people with mental health problems are being reviewed as part of the development of a National Service Framework for older people, which should be published in spring 2000.

National standards and service models

Standards will be set in five areas:

Standard one	Mental health promotion
Standards two and three	Primary care and access to services
Standards four and five	Effective services for people with severe mental illness
Standard six	Caring about carers
Standard seven	Preventing suicide

The standards are realistic, challenging and measurable, and are based on the best available evidence. They will help to reduce variations in practice and deliver improvements for patients, service users and their carers, and for local health and social care communities - health authorities, local authorities, NHS trusts, primary care groups and trusts, and the independent sector.

A wide range of evidence has been synthesised in this National Service Framework. Evidence has been graded, according to the system used, for example, by Bandolier **www.jr2.ox.ac.uk/Bandolier** and in the Health Evidence Bulletin for Wales: Mental Health[1] (V).

- **Type I evidence** - at least one good systematic review, including at least one randomised controlled trial

- **Type II evidence** - at least one good randomised controlled trial

- **Type III evidence** - at least one well designed intervention study without randomisation

- **Type IV evidence** - at least one well designed observational study

- **Type V evidence** - expert opinion, including the opinion of service users and carers.

Achieving systematic change

The national standards in this National Service Framework will be achieved only by:

- recognising that change needs to be systematic and sustainable

- measuring change with early milestones and longer term goals

- building a programme which is both ambitious and realistic - ambitious standards and realistic local delivery systems with national underpinning programmes

- applying concerted action - using local mechanisms such as health improvement programmes, joint investment plans, the clinical governance framework, and the new flexibilities between health and local government to secure change in mental health services as a priority.

Delivering the National Service Framework will require new patterns of local partnership, with mental health a cross cutting priority for all NHS and social care organisations and their partners.

The focus for delivery will be with local health and social care communities. Some of the issues are long-standing and complex. This National Service Framework therefore includes five underpinning programmes which will be led nationally and will support local health and social services to achieve essential changes.

Remaining relevant

During the implementation of the National Service Framework, there will be changes such as new treatments, innovations, and different expectations. All National Service Frameworks will have to evolve if they are to stay relevant and credible in a changing environment. To ensure this Framework starts and stays up-to-date a national group, outlined in Section three of the main document, has been set up to oversee both implementation and future development. Milestones will be made more challenging when earlier ones have been reached.

Ensuring successful progress

Some national milestones have been established, and progress will be measured through a small number of high-level performance indicators within the NHS and Social Services Performance Assessment Frameworks, the latter applying the *Best Value* principles to social services. These will be complemented by the programme of systematic service reviews which will be undertaken by the Commission for Health Improvement and the Social Services Inspectorate, working with the Audit Commission.

To help local planning and implementation of this ambitious programme of change, local milestones for each standard have been outlined to measure progress along the way. These will be more challenging for some than for others, and it is not intended that all will reach each milestone at the same time.

In many areas the first priority will continue to be addressing gaps in current services for people with severe and enduring mental illness - 24 hour staffed accommodation, assertive outreach, home treatment or secure beds, for example. This will address issues of equity of access and safety, including public safety. In areas where specialist mental health services are able to meet local needs for severe mental illness, the most cost-effective focus will now be on people with common mental health problems.

Modernising Mental Health Services sets an ambitious agenda. The Government has already committed an extra £700 million over three years to help local health and social care communities reshape mental health services. Together with main allocations, this provides the resources for implementation of this National Service Framework over the next three years. Further studies of cost effectiveness, and rigorous performance management, will ensure that the Framework is implemented, making better use of existing resources. The future speed of implementation of this National Service Framework will be shaped by evidence of increased cost effectiveness in delivering mental health services, available resources, and rigorous performance management.

New investment and reinvestment of existing resources will need to be prioritised, recognising that mental health services are whole systems which work effectively only when the component parts are all in place and in balance.

The National Service Framework's programme of change cannot be implemented in a matter of months. Additional facilities, extra staff and more training will be required in some areas to achieve some of the standards. Recruitment and training of some specialist medical staff may take five to ten years. Implementing the National Service Framework fully across the NHS and social services, and throughout other agencies, could take up to ten years. These challenges can be met if concerted, focused and determined action is applied from the start.

Measuring progress and managing performance
The targets set out in the National Priorities Guidance, alongside the targets set for efficiency and value for money, will make health and social services accountable to the Government and the public for delivering new national standards of mental health and social care.

A First Class Service sets out how the NHS will deliver quality standards and *The NHS Performance Assessment Framework* describes how these will be measured. And *A New Approach to Social Services Performance* explains how best value and performance will be managed in social services. Together, these new systems will help to ensure that services develop in the right direction, additional investment for change is targeted through the Modernisation Fund and the Mental Health Grant and resources are used efficiently according to the principles of *Best Value*.

New vision for mental health

Soon after the Government came into office it started to take action on mental health, setting up an Independent Reference Group to advise Ministers on the closure of the remaining long stay psychiatric hospitals. And additional in-year resources were made available to mental health services in 1997/98.

Ministers announced the establishment of the External Reference Group in July 1998. Its findings were taken into account in *Modernising Mental Health Services*, which emphasised three key aims:

- **safe services** - to protect the public and provide effective care for those with mental illness at the time they need it

- **sound services** - to ensure that patients and service users have access to the full range of services which they need

- **supportive services** - working with patients and service users, their families and carers to build healthier communities.

Modernising Mental Health Services gave mental health care a new direction, away from neglect and deterioration, and on to a process of reform, rebuilding and renewal. It pledged an additional £700 million in this year and the next two years, and a fresh start for modern and dependable mental health services through this National Service Framework. The mental health strategy promised:

- extra investment and new systems to manage resources more effectively

- well integrated care processes, crossing professional and agency boundaries

- legal powers which work with and underpin comprehensive local services.

For the first time mental health was made a shared national priority for health and social services in *Modernising health and social services: National Priorities Guidance for 1999/00 - 2001/02*.

Review of the law

In July 1998, Ministers announced a root and branch review of the Mental Health Act, to ensure that the legislative framework supports modern mental health care.

An independent expert group, chaired by Professor Genevra Richardson of the University of London, published its initial proposals for consultation earlier this year. The group reported to Ministers in July and their report will be published later this year, alongside a Government consultation paper on proposed changes to the law.

Neither mental health nor criminal justice law currently provides a robust way of managing the small number of dangerous people with severe personality disorder. Home Office and Health Ministers are considering a more effective framework for assessment and management which will protect the public whilst ensuring that the requirements of the European Convention on Human Rights are met. A consultation paper was published in the summer.

Mental health care in prison

The recent joint report on prison health care[2] (V) called for closer partnerships between prisons and the NHS at local, regional and national levels. This will have significant implications for some mental health services. Better needs assessment is likely to identify unmet or inappropriately met need, and local services will need to explore opportunities to improve mental health care for prisoners within existing resources. Improved partnership work between the NHS, local authorities and the probation service will also be required for service development and the care of service users, especially individuals with severe mental illness.

The configuration of mental health services

Mental health services represent a continuum from primary care to highly specialised services. For any local health and social care community mental health services will be provided by two or more organisations. No reconfiguration will unify all provision; the interfaces and boundaries must be managed effectively to provide and commission integrated services.

Providing integrated services
The new NHS and *Modernising Mental Health Services* set out the advantages of specialist mental health NHS trusts. Mental health service providers need to demonstrate:

- senior leadership of and commitment to mental health services

- clinical governance, including continuing professional development and lifelong learning

- evidence of a commitment to the underpinning programmes including education and training, recruitment and retention, information services and research and development

- clear lines of accountability for mental health services.

And specific arrangements should be in place to ensure:

- service user and carer involvement

- advocacy arrangements

- integration of care management and the Care Programme Approach (CPA)

- effective partnerships with primary health care, social services, housing and other agencies including, where appropriate, the independent sector.

In the medium term these criteria are most likely to be met in NHS trusts with a critical mass of mental health services. Single speciality mental health NHS trusts are likely to be the preferred option in inner cities and some metropolitan areas. Where populations are more dispersed other options may be better, although these are unlikely to include combined mental health and acute NHS trusts in the longer term.

Over recent years, the advantages of a closer relationship between primary care and specialist mental health services have become clearer. Some primary care trusts might be given responsibility for the provision of local specialist mental health services - community mental health teams, local residential care, day care, domiciliary support and local inpatient care - subject to the following criteria:

- either an established track record:

  - the trust includes managers, mental health professionals, GPs and primary care teams who have developed a good track record by applying, for example:

    - guidelines and protocols for the integrated care of people with mental health problems

    - a systematic approach to diagnosis, treatment and care, and to disease prevention and health promotion

    - rigorous monitoring of health indicators and focused action to tackle ill health and inequalities in health

  - or robust plans in the primary care trust proposal for improvement of mental health services that:

    - meet the requirement in health improvement programmes to improve and develop mental health provision

    - command the broad support of local service users and carers, and are subject to rigorous monitoring

- effective arrangements to manage the interface between local specialist and more specialised mental health services, including secure psychiatric services

- a continuing focus on individuals with severe and enduring mental illness, in line with the standards and service models in this National Service Framework, and a commitment to joint work between health and social services

- board membership includes competent management of specialist mental health services

- proportional representation of mental health professionals on the executive of the primary care trust.

Commissioning mental health services

Commissioning of local mental health services should be consistent with service priorities emphasised in *Modernising Mental Health Services* and the standards set in this National Service Framework.

Commissioning in the new NHS (HSC 1998/198) identified a number of more specialised services, including medium and high secure psychiatric services, services for severe eating disorders, mother and baby units, early dementia, and gender dysphoria. These services will continue to be provided within specialist mental health NHS trusts; high security services will remain within the three high security hospitals.

Local specialist mental health services should be commissioned through a unified local commissioning process. Health authorities, under the aegis of regional specialised services commissioning groups, will retain responsibility within the NHS for commissioning specialised mental health services. Guidance on the arrangements and management of regional commissioning of high and medium security services has been set out in HSC 1999/141.

Local health and social care services will need to agree their arrangements for commissioning with the NHS Executive regional offices and social care regions. It is likely that these arrangements will evolve over time as local health and social care communities make use of the new flexibilities between health and local authorities, which allow budgets to be pooled, integrated provision, and the identification of lead commissioning roles.

Options for commissioning could include:

- a joint commissioning board, including the local authority, health authority and primary care group

- a lead commissioner, which could be either local authority, primary care group or primary care trust or health authority.

Whichever option is selected, long term service agreements, which will replace contracts, should be consistent with the health improvement programme and community care plans.

Where NHS patients are treated under contract in the private and voluntary health care sector, the responsible NHS commissioning body should ensure that its contracts apply the same clinical governance principles, including the use of this National Service Framework.

Links to Government wide policies

Mental health is a priority for health and social services in *Modernising Health and Social Services: National Priorities Guidance for 1999/00 - 2001/02*. *Partnership in Action* proposed new flexibilities between health and local authorities that have been enacted through the 1999 Health Act, flexibilities which will be essential to the successful implementation of this National Service Framework.

The White Paper, *Saving lives: Our Healthier Nation*, includes mental health as one of its four key areas. This Framework sets out the action to be taken by health and social services to deliver their contribution to the achievement of the target for mental health - a reduction in the suicide rate by at least one fifth by 2010.

Moreover, a range of Government policies will also support this National Service Framework. Social exclusion can both cause and come from mental health problems. Initiatives designed to promote social inclusion - for example, Sure Start, Welfare to Work, New Deal for Communities and the work of the Social Exclusion Unit - will all strengthen the promotion of mental health and individual well-being, and reduce discrimination against people with mental health problems.

2.0   National standards and service models

- **national standards**

- **interventions and evidence-base**

- **service models**

- **examples of good practice**

- **measuring progress**

This National Service Framework sets out standards in five areas; each standard is supported by the evidence and knowledge-base, by service models, and by examples of good practice. Local milestones are proposed; time-scales need to be agreed with NHS Executive regional offices and social care regions, and progress will be monitored.

Standard one addresses mental health promotion and combats the discrimination and social exclusion associated with mental health problems.

Standards two and three cover primary care and access to services for any one who may have a mental health problem.

Standards four and five encompass the care of people with severe mental illness.

Standard six relates to individuals who care for people with mental health problems.

Standard seven draws together the action necessary to achieve the target to reduce suicides as set out in *Saving lives: Our Healthier Nation*.

These standards will be challenging for all mental health services. Although some services may already have reached a number of milestones, none can claim to have achieved them all. As progress is made, the national milestones will be rolled forward; NHS Executive regional offices and social care regions will agree further milestones with each health and social care community.

Standard one

Mental health promotion

Aim

To ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems.

Standard one

Health and social services should:

- **promote mental health for all, working with individuals and communities**

- **combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.**

Rationale

Mental health problems can result from the range of adverse factors associated with social exclusion and can also be a cause of social exclusion. For example:

- unemployed people are twice as likely to have depression as people in work

- children in the poorest households are three times more likely to have mental health problems than children in well off households

- half of all women and a quarter of all men will be affected by depression at some period during their lives

- people who have been abused or been victims of domestic violence have higher rates of mental health problems

- between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent

- some black and minority ethnic groups are diagnosed as having higher rates of mental disorder than the general population; refugees are especially vulnerable

- there is a high rate of mental disorder in the prison population

- people with drug and alcohol problems have higher rates of other mental health problems

- people with physical illnesses have higher rates of mental health problems.

The World Health Report 1999[3] (IV) demonstrates that neuropsychiatric conditions are the commonest cause of premature death and years of life lost with a disability - 10% of the burden of disease in low and middle income countries and 23% in high income countries. The World Health Organisation (WHO) Mental Health Unit of the Regional Office for Europe has prioritised action to reduce stigma, counteract depression and suicide, and to audit mental health services.

Besides the immense costs in personal and family suffering, mental illness costs in the region of £32 billion in England each year. This includes almost £12 billion in lost employment and approaching £8 billion in benefits payments[4] (IV).

Interventions and evidence-base

Action across whole populations

Mental health promotion[5] (V) is most effective when interventions build on social networks, intervene at crucial points in people's lives, and use a combination of methods to strengthen:

- individuals to enhance their psychological well-being

- communities in tackling local factors which undermine mental health.

A report by the Mental Health Foundation this year - '*Bright Futures - promoting children and young people's mental health*'[6] (V) - summarised the evidence on mental health promotion for children and young people. It highlighted the significance of supporting parents during pregnancy and after birth with home visits, high quality child care, and helping through schools and community networks.

Exercise, relaxation and stress management have a beneficial effect on mental health. Reducing access to illicit drugs, taking alcohol in moderation, maintaining social contacts, reducing smoking, and talking things over are also helpful measures[7,8] (I). Teaching interpersonal awareness reduces emotional exhaustion and depression[9] (III).

Another report by the Mental Health Foundation underlined the need to consider the physical and spiritual facets of mental health and mental health problems, and to tailor individual programmes to individual circumstances[10] (V).

The Health and Safety Executive 1995, *Survey of Self Reported Work Related Illness,* estimated that almost 300,000 people in Britain believed that they were suffering from work related stress, anxiety or depression.

Programmes for individuals at risk

There is increasing evidence of effective interventions to help to develop better coping mechanisms and reduce the risk of mental health problems in individuals who are at risk because of a life event.

Professional emotional support for pregnant women caring for their existing young children can decrease the rate of postnatal depression [11] (I). Helping new parents to develop child rearing skills is effective [12] (V), and young, single parents can be helped to cope better [13] (I).

High quality pre-school and nursery education have been shown to produce improvements in self-esteem, motivation and social behaviour. Pre-school education may substantially decrease the chances of drug dealing 20 years later [14] (I). Programmes which target children with behavioural problems can reduce the development of difficulties later on [5] (II).

Work can cause both mental and physical ill health. Studies show significant levels of stress within the workforce, including in the NHS [15] (V). A healthy workplace can promote mental health [15] (V). Learning to mobilise support at work and to participate in problem solving and decision making can improve mental health [16] (III).

Mental health problems associated with work include depression and anxiety, alcohol misuse, and sickness absence. Work overload, monotony, and pressure of work are key factors, as are lack of control over work and exclusion from decision making [15] (V).

High quality interventions for individuals who are unemployed can reduce the psychological impact of job loss, and promote re-employment, particularly in those at risk of mental ill health [5,17] (I)(III).

Mental health can deteriorate during long term unemployment. One study [18] (II), enhanced self-confidence, increased motivation and reduced the negative feelings associated with unsuccessful job-seeking. Depressive symptoms were reduced and confidence improved. Long term, the treated group had higher monthly earnings and fewer job changes.

Many local authorities and NHS trusts, often in partnership with independent sector agencies, have set up vocational training and employment support schemes for people with mental illness. These need to be planned and integrated with other statutory employment services to ensure effective use is made of skills, resources and support systems.

People who are vulnerable as a result of either divorce [19] (II) or unemployment [20] (III) [21] (II) can be helped to adjust, and shown how to build coping skills.

Programmes for vulnerable groups

Some groups face a high risk of mental illness, for example, individuals who have suffered severe abuse, black and minority ethnic groups, people who sleep rough, individuals in prison, and people with physical illnesses. Problems with alcohol and drugs can exacerbate mental health problems.

Victims of child abuse

Research on the neurophysiological effects of child abuse [22] (IV) has shown that trauma during childhood can have a devastating affect on all functions of the developing brain - emotional, cognitive, behavioural and psychological including self-harm. Developmental effects of child victimisation include insecure attachments, dissociation, drug abuse, self injury and aggression [23] (IV).

Childhood sexual and other abuse is known to be more frequent in the histories of individuals with both mental illness and personality disorder [24] (IV).

Domestic violence

Violence between adult partners occurs in all social classes, all ethnic groups and cultures, all age groups, in those with disability as well as the able bodied, and in both homosexual and heterosexual relationships [25] (V). Women are usually the most frequent victims. Exposure to violence in the home is linked to juvenile crime and aggression. There is evidence of the effectiveness of community-wide mental health interventions which use parent support, voluntary groups, community parent advisers, and school programmes aimed at reducing bullying and promoting interpersonal skills [26] (I).

Race and mental health

In the African-Caribbean population, especially in young men, the rates of diagnosis of psychotic illness are high, relative to the white population, as is admission to hospital under the Mental Health Act, treatment by physical rather than talking therapies, and admission to secure services. This group is also more likely to be referred to mental health services by the criminal justice system, than by GPs or social care services [27] (II).

Depression is diagnosed relatively less frequently in the Asian population than in the white population, although young Asian women have a relatively high rate of suicide [28] (I).

The stigma attached to mental illness can be compounded by racial discrimination [29] (V), with access to appropriate assessment, treatment and care inhibited [30, 31, 29, 32, 33] (IV,IV,V,IV,IV).

Refugees and asylum seekers are a particularly vulnerable group [34] (V). Post traumatic stress disorder is the most common problem, and the risk of suicide is raised in the long term.

Combined evidence suggests that services are not adequately meeting mental health needs, and that black and minority ethnic communities lack confidence in mental health services. All mental health services must be planned and implemented in partnership with local communities, and involve service users and carers. If services are to match the needs of black and minority ethnic communities and reduce the present inequities, this principle is especially important.

People who sleep rough

Up to half of the 2,000 people who sleep rough on our streets each night have mental health problems but less than a third receive treatment, according to a report last year by the Social Exclusion Unit. One in two have a serious alcohol problem, and one in five misuse drugs. In 1997, it was estimated that one in three rough sleepers have multiple needs, most commonly related to substance misuse combined with mental health problems [35] (V).

Homelessness among young people also brings significant problems. *Off to a Bad Start*, a study of homeless young people in London aged 16-21 years, found that almost two thirds had suffered recently from psychiatric disorders. A third also reported at least one attempted suicide at some point. Only one fifth, however, had been in contact with psychiatric services in the past year [36] (IV).

People in prison

Health and local authorities should also be involved in assessing the mental health needs of prisoners during their time in custody and in preparation for their release, contributing to their through-care and release plans for support in the community. Rates of all types of mental disorder, especially drug and alcohol dependence, are higher in prisons than in the general population [37] (IV) and there is considerable variation in the delivery, quality and effectiveness of prison health care [38] (V). Continuity of care is also essential, providing through-care as prisoners return to their local communities.

People with alcohol and drug problems

For people whose alcohol consumption exceeds recommended guidelines, brief primary care interventions such as assessment of alcohol intake and provision of advice can help to reduce it [39] (I).

Individuals who misuse alcohol or drugs are at a significantly increased risk of suicide [40,41] (IV, V) with suicide rates among drug users, especially young people, continuing to rise [42] (V). *Safer Services* [41] (V) stressed the need for stronger links between drug and alcohol services and community mental health services as part of an overall suicide prevention strategy.

Combating discrimination and social exclusion

Surveys by the Department of Health, MIND and the Health Education Authority (HEA) all report that people feel strongly about mental illness [43-45] (V,V,V). Most people are generally caring and sympathetic, but they are also concerned about the danger which they associate with a very small number of people with severe mental illness. The HEA report *Making Headlines* [45] (V) shows that negative media coverage of mental health is widespread.

Public education is an effective way of reducing stigma [46] (III). The Department of Health, through its *Impact* strategy works in partnership with service users, the Royal College of Psychiatrists, Mental Health Media and the voluntary sector, to provide better information and build understanding among the public. The Government spent more than £2.5 million nationally on public information and mental health promotion over 1997/98 and 1998/99.

Subsequent standards in this National Service Framework address the needs of people with mental health problems. However, it is important to recognise that they may need help to tackle discrimination. Legislation requires organisations to make reasonable adjustments to accommodate the needs of disabled employees. The Disability Discrimination Act 1996 places a duty upon employers to take steps to prevent disabled persons, including those with mental impairment, from being placed at a disadvantage.

Service models and examples of good practice

To achieve Standard one, local services will need to give priority to mental health promotion in their health improvement programme, and take every opportunity within the social inclusion agenda to develop effective strategies to promote mental health and prevent mental illness.

Mental Health Promotion

Mental Health Promotion: A Quality Framework[47] (V) provides a framework for demonstrating the benefits and value of mental health promotion with a focus on measuring success. It provides a practical guide to assist local health and social care services and employers to develop mental health promotion strategies. It is based on three goals to promote:

- emotional resilience - life skills training, parenting classes

- citizenship - mentally healthy workplaces, anti-bullying programmes

- programmes which focus on community improvements - environmental awareness and improvement, anti-stigma campaigns.

Tel: 01235 465565

Anti-stigma programme

In 1998 the Royal College of Psychiatrists launched a national campaign, planned to last for five years. The aim is to reduce the stigma attached to mental health problems via a public and professional educational initiative. The campaign is entitled *Changing Minds - every family in the land*[48] (V).

The College has produced a series of booklets with information on anxiety, depression, schizophrenia, Alzheimer's disease and dementia, anorexia and bulimia, and alcohol and other drug misuse.

The campaign is inclusive and is working in collaboration with a variety of other interest groups: service users, carers, professionals, the media, the general public, and those involved in education. Additionally, the British Medical Association, Royal Colleges of Physicians and General Practitioners, and the Department of Health are part of the project team. Baseline measures of public opinion were recorded to assess the impact of the initiative.

Tel: 0207 235 2351 x 122

Action across whole populations

Local health and social care communities should focus activity through initiatives such as healthy schools, healthy workplaces, healthy neighbourhoods and other settings, using programmes to improve understanding of the factors which affect mental health.

Saving lives: Our Healthier Nation summarises a number of practical actions that individuals can take:

- support others at times of stress

- better their lives through using education, training, and employment opportunities

- use opportunities for relaxation and physical exercise

- drink sensibly and avoid illegal drugs

- increase their understanding of what good mental health is

- contact help quickly when difficulties start

- contribute information to service planners and get involved.

Mental health promotion in schools

Promoting Mental Health in Schools is an education resource pack that contains guidelines, activities, worksheets, a short film and a booklet by Meridian Television. One of its key themes is discovering what concerns young people, such as bullying, examinations, helping to care for an older relative and, loss of, or worry about, a family member. The pack, which is supported by the Department of Health, also contains a useful directory of resources.

Tel: 01703 222555

Mentoring programme for high schools

The scheme provides mentors for 14 to 16 year olds in Manchester schools, from private firms, the public sector, and educational establishments. The aim is to help young people recognise and develop their strengths and skills through talking with adults who bring wider experience and perspectives. It is run by Manchester Education and Business Partnership (EBP), the Training and Enterprise Council (TEC), and has local authority funding.

Outcomes for the students include improved self-esteem, self-confidence and self-worth, raised aspirations, more responsibility for their own learning, greater awareness of the world of work and higher education, opportunities to communicate with adults other than teachers, and a chance to identify and make the most of their abilities.

Tel: 0161 256 0120

Support for young people at risk of school exclusion

The Brandon Centre, a voluntary sector, inner London project offering psychological treatments to young people, has a number of outreach school-based projects. In special and mainstream schools, and in a pupil referral unit, troubled young people are offered a variety of psychological treatment approaches to tackle their mental health problems.

Tel: 0207 267 4792

Managing stress at work

The Health and Safety Commission has issued guidance to help employers manage work-related stress and has commissioned research to answer some of the outstanding questions. A discussion document `Managing Stress at Work' has been issued for consultation.
www.open.gov.uk/hse/condocs.

Tel: 01787 881165

Mental well-being in the workplace

A resource pack for management training and development has been produced by the Health and Safety Executive and identifies a range of actions to promote mental well-being. It looks at human resources policy, focuses on employees, and identifies good management practices and includes case studies[49] (V).

Tel: 01787 881165

Improving the health of the NHS workforce

A partnership of key organisations convened by the Nuffield Trust produced a report that includes evidence-based recommendations on management culture and employment practice. It outlines interventions to enhance the sense of control staff can have over work and recommends how to develop a culture in which staff are valued and supported.

Tel: 0207 631 8450

Managing stress in Healthy Cities

In Birmingham, large scale workshops on stress were used as part of a Healthy Cities programme. The workshops covered the physical, cognitive and behavioural aspects of anxiety and stress, and offered a wide range of options for managing stress.

Tel: 0121 678 3400

Action for individuals who are at risk

Local health and social care communities should ensure that individuals identified as at risk are encouraged to make contact with either formal services, such as the primary care team, or other sources of practical support, including a self-help group.

Saving lives: Our Healthier Nation summarises the effective interventions as:

- teaching parenting skills

- support groups for young isolated mothers to improve their mental health and the emotional and cognitive development of their children

- rapid treatment for depressed mothers to prevent emotional or cognitive harm to their children

- school programmes to help children with learning difficulties including dyslexia

- help at school for children whose parents are divorcing

- programmes to build resilience in vulnerable children

- social support for unemployed people to help them to find work

- practical information for those caring for people with dementia

- self-help groups for those recently widowed.

Home visitors

A Child Development Programme at the University of Dublin using home visitors was effective in reducing depression[50] (III).

262 first time mothers living in a deprived area of Dublin were all seen by the public health nurse, but around half the group were also allocated a 'community mother', one of 30 experienced mothers living in the same community. Children in the group being seen by the community mothers were more likely at the end of the year to have a better diet, had all their immunisations, and to be read to daily.

The scheme demonstrated that non-professionals can deliver a child-focused health promotion programme effectively.

Tel: 00 353 126 93244

Befriending

The Befrienders in Dunstable is a registered charity working in partnership with local health and social services and volunteers with the aim of providing support for people who are isolated and alone, and lack a supportive community. Their main activity centres on a variety of membership clubs and a public café, open five days a week. The organisation has over 200 volunteers and over 50 staff.

Tel: 01582 422040

Initiatives for vulnerable groups

Local health and social care communities should identify particularly vulnerable individuals and groups, and explore the opportunities to promote better mental health, perhaps within wider social inclusion initiatives and programmes. Following the publication of the Joint Report on Prison Healthcare[2] (V) closer partnerships between prisons and the NHS should be established.

Mental health needs of Asian women

Newham Primary Care Group, partnered with the Newham Asian Women's Project, conducted a mental health needs assessment. The aim was to focus on the mental health needs of young Asian women, including self-harm. Women's views were explored through focus groups and in-depth interviews were held with women with a history of self-harm. Recommendations for action to improve access to local services are being considered.

Newham Primary Care Group **Tel:** 0208 552 2632
Newham Asian Women's Project **Tel:** 0208 472 0528

Integrated approach to mental health and homelessness

In Newcastle a multi-agency group aims to identify the needs of homeless people with mental health problems, to break down agency boundaries and forge links with other direct access developments for homeless people across the city. Each agency has committed itself to reviewing policies and procedures that have a direct impact on homeless people with mental health problems, for example, access to housing, admission and discharge policies, and emergency cover out of hours.

Tel: 0191 256 3007

Mental health promotion in prisons

Mental health is a priority for the HM Prison Service's Directorate of Health Care, which is also the World Health Organisation's UK Collaborating Centre for promoting health in prisons. The Directorate has issued detailed guidance on the value of promoting mental health in prisons through, for example, anti-bullying strategies, regular physical exercise and contact with families, friends and the outside community.

Tel: 0207 217 3000

Combating discrimination and social exclusion

The broad approach set out in *Saving lives: Our Healthier Nation* highlights the action which can be taken locally to promote social inclusion. For example:

- improvements in education will help to raise standards, expectations and opportunities for everyone

- better working conditions and reduced unemployment will improve mental health

- tackling discrimination is a prerequisite for more equal access to health and social care.

Health Action Zones

The Lambeth, Southwark and Lewisham Health Action Zone has a particular focus on young people, disability and social exclusion. They aim to improve employment opportunities for young people with mental health problems. Through flexible support schemes, it helps to maintain young people in education or in work.

Tel: 0207 716 7000

Healthy Charters

The Healthy Sandwell Charter focuses on the needs of the whole population, and especially on the needs of those from black and minority ethnic communities. Sandwell is ranked the ninth most deprived district in England.

The charter acknowledges that no one agency can be responsible for mental health promotion and prevention. Empowerment, respect for individuals, fairness and equity, and the encouragement of partnerships are key to making the strategy a success. There are three goals: healthy structures, a healthy environment, and emotional resilience. Specific targets include reductions in alcohol consumption, tranquilliser dependence, and self-harm.

Tel: 0121 500 1500

Performance assessment

Performance will be assessed at a national level by:

- a long term improvement in the psychological health of the population as measured by the National Psychiatric Morbidity Survey

- a reduction in suicide rates

- health improvement programmes demonstrating action within and linkages between organisations to promote good mental health:

  - in schools, workplaces and neighbourhoods

  - for individuals at risk

  - for groups who are most vulnerable

and to combat the discrimination against and social exclusion of people with mental health problems.

Recommended local roles and responsibilities

Lead organisation: health authority

Lead officer: chief executive

Key partners: local authority, NHS trust, independent sector providers, primary care group, including GPs, local employers, educational establishments, and service users and carers.

Standards two and three

Primary care and access to services

Aim

To deliver better primary mental health care, and to ensure consistent advice and help for people with mental health needs, including primary care services for individuals with severe mental illness.

Standard two

Any service user who contacts their primary health care team with a common mental health problem should:

- **have their mental health needs identified and assessed**

- **be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.**

Standard three

Any individual with a common mental health problem should:

- **be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care**

- **be able to use *NHS Direct*, as it develops, for first-level advice and referral on to specialist helplines or to local services.**

Rationale

Mental health problems are common and primary care teams provide most of the help that individuals need. However, there are a number of points of access to mental health services, and local health and social care communities need to ensure that advice and help is consistent. *NHS Direct* will provide a new source of first-level advice, and should in time be able to provide a route to specialist helplines such as the Samaritans, SANEline, National Schizophrenia Fellowship and MIND helplines.

People with mental health problems, including individuals making contact for the first time, approach health and social services in a variety of ways. Many contact their GP, or another member of the primary health care team, including a nurse or community pharmacist.

Out of hours they may:
- telephone a helpline
- go to an Accident and Emergency (A&E) Department
- phone for an ambulance.

And some are referred from the criminal justice system through, for example, court diversion schemes or directly from a police station or from a prison.

Whatever the point of contact, the principles of *The new NHS* should apply. Individuals in need should be able to access services which are responsive, timely and effective. All services should be sensitive to cultural needs, including the needs of people from black and minority ethnic communities.

Interventions and evidence-base

Primary mental health care

One quarter of routine GP consultations are for people with a mental health problem [51] (IV) and around 90% of mental health care is provided solely by primary care [52] (IV).

The most common mental health problems are depression, eating disorders, and anxiety disorders. Many of these disorders can be treated effectively in primary care, but some will need fast referral to specialist services. Effective interventions include medication and psychological therapies, alone or combined.

Reports indicate that only about 30% to 50% of depression in primary care is recognised by GPs [51,53,54] (IV, IV, IV). Other reports suggest that GPs' recognition of severe depression is more accurate [55] (IV). Treatment outcomes may be poor [56,57] (I,IV).

There is scope for GPs and practice nurses to improve their assessment and communication skills [58] (III), and the knowledge, skills and training to give non-drug treatments [59] (III). Training can improve the recognition of mental health problems in primary care [60] (II) which can sometimes be masked by physical symptoms.

Postnatal depression

Between 10% and 15% of women have postnatal depression after childbirth. Severely depressed mothers may resort to suicide, which is the second most common form of maternal death in the year after birth[86] (IV), and may require hospital admission.

Informal social support can reduce the risk of postnatal depression[11] (I). Health visitors, with training, can use their routine contacts with new mothers to identify postnatal depression, and treat its milder forms. Prevention of postnatal depression need not always demand expensive extra services. Maternity and support staff can do much to help[87] (V).

Eating disorders

Severe eating disorders such as anorexia and bulimia can result in long term ill health, and may cause death.

Most mild eating disorders can be managed within primary care. Dietary education and monitoring of food intake are effective components of treatment[77] (V). Antidepressants may be effective in panic and eating disorders[67,88] (II, I).

Individuals with severe disorders should be referred for specialist assessment, including a full medical and psychiatric assessment[77] (V).

While family therapy seems very effective in younger people, adults with anorexia are more likely to respond to individual eclectic psychotherapy, and those with bulimia to group or individual cognitive behavioural therapy[67] (I). Antidepressants can reduce purging and bingeing whether or not the person is also depressed[89] (I). Computer programmes can be used to give individuals accessible, structured information[90] (II).

Anxiety disorders

Panic attacks, phobias, or persistent generalised anxiety can impede a person's ability to work, form relationships, raise children, and participate fully in life. GPs often see anxiety, mixed anxiety and depressive disorders, which may be associated with high levels of disability[91] (IV). People who have anxiety symptoms usually smoke more, and may drink more alcohol too, increasing their risk of physical ill health.

Anxiety can mask an underlying depression, and may have a physical cause, such as alcohol or substance misuse. Benzodiazepine medication reduces severe and disabling anxiety, but should be used for no more than two to four weeks[92] (V).

Panic disorder responds to both cognitive behavioural therapy and antidepressant medication, with a more sustained recovery following psychological treatment. Simple phobias respond best to exposure treatments. Cognitive behavioural therapy is also indicated for social phobia and generalised anxiety disorder[67] (I).

Obsessive-compulsive disorder is effectively treated, at least in the short term, by antidepressant drugs[93] (I), but again recovery may be more sustained if achieved following cognitive behavioural therapy[67] (I).

Co-morbidity or dual diagnosis

Around half of those reporting any substance misuse disorder have experienced other mental health problems. Of individuals seeking help for substance misuse, more than half have had a mental disorder in the previous six months. It is not unusual for around 30% of those seeking help for mental health problems to have current substance misuse problems [94] (V). Assessments of individuals with mental health problems, whether in primary or specialist care, should consider the potential role of substance misuse and know how to access appropriate specialist input. The likelihood that substance misuse will increase suicide risk [41] (IV) must also be considered.

Consistent access to services round the clock

Local services need to establish explicit and consistent arrangements for access to services round the clock [95] (V). Patients will often contact their GP first. Helplines and A&E services are also able to provide first-line help.

Helplines

Local and national helplines have started to form part of the services available to people with mental illness and their carers. They are especially valuable to people who initially prefer not to seek help from the NHS. Young men, for example, may not always find it easy to talk to their GP.

The best known telephone service is that offered by the Samaritans, founded in 1953, receiving 4.5 million calls each year. SANEline was established some seven years ago and is now run from three bases, with around 70,000 calls per year. The National Schizophrenia Fellowship has a large network of local helplines, with the backup of a uniquely expert national service. The CALM helpline was launched in December 1997 in Manchester and is specifically aimed at young men who would be unlikely to contact more mainstream services and who are at greater risk of suicide.

A number of mental health services have developed their own helplines, although the hours of availability may be limited.

The early evidence from the *NHS Direct* pilot sites endorses the value of telephone services. *NHS Direct* will also pilot links to specialist mental health helplines, and will be able to provide interpreter services across the country.

Accident & Emergency (A&E) departments

Although A&E departments do not provide the ideal environment for a mental health assessment, they are likely to continue to provide an entry point for people with mental health problems. The A&E modernisation fund will enable local health and social care communities to improve the safety and privacy of assessment facilities.

Easy access to A&E can lead to individuals with acute mental health problems seeking help directly, making up perhaps 5% of attenders. Three main groups of people with mental health problems are seen in A&E departments [96] (V).

As *NHS Direct* is developed it will provide a further access point, which will complement specialist mental health helplines. When national coverage has been achieved it will be able to provide first-level advice in the first language of the caller.

Depression
Each year, one woman in every 15 and one man in every 30 will be affected by depression, and every GP will see between 60 and 100 people with depression [61,62] (IV, IV). Most of the 4,000 suicides committed each year in England are attributed to depression.

A recent review of the literature [56] (I) concluded that depression can be a major risk factor both for the development of cardiovascular disease and for death after a myocardial infarction. Depression can also be associated with chronic physical illness such as arthritis.

Depression can affect other family members. The emotional and cognitive development of socially deprived children of a depressed mother is especially affected, with boys more vulnerable than girls [63,64] (II, I).

Depression in people from the African-Caribbean, Asian, refugees and asylum seekers communities is frequently overlooked, although the rate has been found to be 60% higher than in the white population, with the difference being twice as great for men [32] (IV). People from black and minority ethnic communities are much less likely to be referred to psychological therapies [65, 66] (IV, V).

Anti-depressant medication is an effective treatment for depression [67-69] (I, I, I). Different groups of anti-depressants (tricyclics, SSRIs etc) have all been shown to be more effective than placebo in treating depression [70] (I). However, people with depression often feel they do not receive adequate information concerning their treatment [71, 72] (V, IV).

Anti-depressant medication is not always prescribed in correct doses [70, 73, 74] (V, IV, I). Anti-depressant medication may also be over-prescribed [75, 76] (III, IV).

A number of second-line treatments such as lithium and electroconvulsive therapy (ECT) provide effective treatment of chronic and severe depression [67,77-79] (I, I, V, I). A survey of ECT use has recently been completed. The raised suicide rates in those with bipolar disorder can be reduced by pharmacotherapy [80] (III).

Depression can also be treated by structured psychological therapies, such as cognitive behaviour therapy; brief, focal psychoanalytic therapy; and interpersonal therapy. However, non-directive counselling is less effective [67,81] (I, V).

Cognitive therapy may also reduce relapse rates [82,83] (I, II). The combination of antidepressants and psychotherapy are currently being reviewed [84] (I).

A number of clinical guidelines and local protocols for the management of depression have been developed. These include the consensus statement by the Royal Colleges of Psychiatrists and General Practitioners published in 1992 [85] (V). Clinical guidelines have been commissioned by the NHS Executive and will be available in late 2000.

Firstly, people with a combination of physical and mental health problems. Notably individuals who have self-harmed, and who may need physical treatment prior to their mental health needs being met. A significant proportion of the mental health workload in A&E departments is related to self-harm, which is one of the top five causes of acute medical admissions for both men and women in the UK.

Secondly, people who sleep rough may also have medical and mental health problems coexisting, as may victims of violent attacks.

Thirdly, people who have a physical illness, but are also very distressed, depressed or anxious.

A&E departments also play a key role in providing mental health services outside standard working hours, especially individuals who are not registered with a GP. One study reported that the majority of emergency psychiatric assessments at night were performed either in A&E departments or on psychiatric wards [97] (IV). Young men may seek help in A&E departments in preference to visiting their GP.

Although there is insufficient evidence to point to any particular clinical intervention as most effective following self-harm, there are a number of promising approaches [98] (I). In Bristol, patients were given crisis cards which allowed access to emergency telephone support, leading to a reduced rate of repetition amongst individuals who had self-harmed for the first time. More complex treatments may be beneficial in some cases. For example, problem solving therapy - a six session treatment aimed at helping people learn to solve personal problems; and dialectical behaviour therapy - a somewhat longer term treatment combining cognitive and supportive approaches.

It is essential that people who have self-harmed receive a specialist psychosocial assessment before discharge, preferably performed by a mental health nurse or other professional who knows local services and can arrange speedy follow-up and appropriate support.

Psychiatric liaison nurses based in A&E departments can perform psychosocial assessments, provide knowledge of local services, and offer training to other A&E staff [96] (V). Social work deployment in some A&E departments has demonstrated similar gains, with links made with local authority services.

Access to specialist services
A duty doctor, Section 12 approved, and an approved social worker must be available around the clock, every day of the year. Services should provide a more comprehensive approach, with better access to the multi-disciplinary mental health team for emergency assessment and care. All local agencies, including the police, need to be able to access specialist mental health services, including secure psychiatric services, for 24 hours a day [95] (V). Court diversion schemes need to be linked into local mental health services.

A person in a public place who appears to be suffering from mental disorder and to be in immediate need of care or control can be taken by the police to a place of safety. Suitable places of safety should be identified through local agreements. As a general rule, a hospital or other appropriate health service facility should be used rather than a police station[99] (V). When there is no GP and no friend or relative to help, the police can seek rapid access to health services for people with psychosis [100] (IV).

A survey commissioned by the Department of Health and the Home Office found that at least 190 mental health assessment schemes for mentally disordered offenders were operating at magistrates' courts and police stations in 1996. These schemes aim to ensure that people who come into contact with the criminal justice system have their mental health needs identified and addressed, as they would if in the community, and that assessments are readily available to help choose the best option for dealing with each case.

Interventions are made on the basis that early access to health and social care will help prevent further deterioration in a person's condition, reduce the likelihood of re-offending and avoid unsuitable use of custody. An assessment scheme in inner London was shown to provide better and more rapid assessment and transfer to NHS care than prison-based assessment [101,102] (IV, IV).

Service models and examples of good practice

To achieve Standards two and three each primary care group will need to work with the support of specialist mental health services to:

- develop the resources within each practice to assess mental health needs

- develop the resources to work with diverse groups in the population

- develop the skills and competencies to manage common mental health problems

- agree the arrangements for referral for assessment, advice or treatment and care

- have the skills and the necessary organisational systems to provide the physical health care and other primary care support needed, as agreed in their care plan, for people with severe mental illness.

And local health and social care communities need to ensure round the clock access to mental health care via GPs, helplines, A&E departments and other agencies, such as drop-in centres often run by voluntary organisations. Services should be accessible to the criminal justice system.

Strengthening primary mental health care

Primary care groups should work with primary care teams and specialist services to agree and implement assessment and management protocols across the primary care group, initially for people with depression, including the assessment of any risk of suicide. Further protocols should be implemented for postnatal depression, eating disorders, anxiety disorders, and for people with schizophrenia. The majority of mental health care will remain within primary care as at present. The protocols will ensure that more complex cases receive ready access to skilled specialist assessment and treatment, including psychological therapies, and continuing care.

A number of protocols have been developed locally. The National Institute for Clinical Excellence will be asked to review these, and, where appropriate, to kitemark examples of good practice, which will be promulgated for local use.

Guidelines on the management of mental disorders have been published by the WHO [103 279]. A UK version of the guide is being developed at the WHO Collaborating Centre, Institute of Psychiatry, supported by the Royal College of Psychiatrists, and other professional, educational and service user groups. It emphasises the information needs of service users and their families, simple social and psychological management strategies, and medication. It is expected to be available at the end of the year. More details are available from the WHO Collaborating Centre: telephone 0207 740 5293 or email: **r.jenkins@iop.kcl.ac.uk**.

The primary care therapy team

The primary care psychological therapy service in Salford provides assessment and focused treatment for depression, anxiety and other adjustment reactions. Maximum impact is achieved through practice-based protocols, standardised assessment tools, and staff resources targeted on the basis of need. Services centre on two primary care groups in Salford and Trafford, maximising access to services for patients and reducing unfair variation.

Tel: 0161 772 3479

One stop shop clinics

Seven GP practices have contributed to a pilot scheme in Newton-le-Willows - the Vista Road Centre. The mental health NHS trust and social services department provide a one stop shop, through a multi-agency team of:

- approved social workers
- community mental health nurses
- clinical psychologists
- psychiatrists
- counsellors
- occupational therapists
- voluntary sector staff.

A variety of treatments are available, ranging from listening and advice, to medication, psychological therapy and counselling. The team operates an open door referral policy.

There is a service user-led drop-in centre in partnership with the local MIND organisation. Bed use has reduced by over 40% since 1994.

Vista Road Centre **Tel:** 01925 291094
Drop-in centre **Tel:** 01925 292190

Similarly, specialist services working with primary care teams should agree protocols for the referral, assessment and treatment of people referred to them

Specialist mental health services should establish liaison arrangements to support the general practices in the primary care group, including continuing professional development to enable all relevant staff to identify, assess and manage mental health problems.

Audit of a psychological therapy service

The Central Manchester Healthcare NHS Trust developed a systematic audit of their psychological therapy service. This consisted of five full time psychiatry trainees, and a large number of sessional staff offering cognitive behavioural treatments and psychodynamic therapy. A standard assessment procedure now ensures that referrals are prioritised and standardised measurement enables outcomes to be systematically assessed.

Tel: 0161 273 3271

Primary care groups should enable patients and their families to understand their mental health problem and their treatment, and to make contact with local self-help groups.

A variety of information is available from, for example, the Royal College of Psychiatrists, and voluntary organisations such as SANE, MIND and Depression Alliance. With the development of information technology, information will increasingly be available through electronic media, and health and social care communities should explore means of enabling service user access.

Support should be provided to help service users contact relevant self-help groups, including CRUSE and RELATE, as well as groups with a specific focus on mental health.

Ensuring consistent access to services round the clock
Each local health and social care community should establish an integrated system to enable people to access consistent advice and help at any time of the day or night, every day of the year. This should be via the GP or primary care team; helplines, both national and local; and A&E departments through mental health liaison services. As it is developed, *NHS Direct* will complement existing national helplines such as the Samaritans and SANEline, and local helplines including CALM.

Each local health and social care community should ensure that there is a gateway to specialist mental health services through effective out of hours services, which should also be accessible to the criminal justice system.

CALM - the Campaign Against Living Miserably

CALM is a pilot helpline in Manchester, funded by the Department of Health, offering a safety net for young men with mental ill health. It aims to tackle the stigma attached to depression and mental illness and encourage take-up of the services available. It is staffed by trained counsellors who offer advice, guidance, and information. The intention is to extend the service to other areas, in partnership with local health and social care communities.

Tel: 0161 237 2764

A local mental health helpline

The freephone helpline service in north west Lancashire provides a confidential service, including listening and access to information, for anyone experiencing mental health problems. The helpline is funded by the health authority.

Tel: 01253 306538

An A&E mental health liaison service

A multi-disciplinary team at The Whittington Hospital has input from psychiatry, nursing and social work. It operates between 9am and 11pm seven days a week to provide a rapid and effective assessment for people in a mental health crisis. Benefits of the service include:

- patients are seen quickly
- all patients are seen regardless of catchment area
- good liaison with GPs and specialist mental health services
- good engagement of patients
- effective assessment and management of risk including a follow-up appointment if required

The A&E team works in partnership with the duty doctor and an approved social worker, and a newly established emergency home treatment team in south Islington.

Tel: 0207 530 3069

Liaison psychiatry - self-harm team

In Newcastle, a team comprising senior mental health nurses trained in psychosocial assessment and a consultant psychiatrist, meets on a daily basis and provides an assessment service to patients admitted to the general hospital following an episode of self-harm. Being based in the mental health unit, the team is able to link patients into continuing mental health care when necessary. The team is also involved in teaching and research.

Tel: 0191 282 4842

Self-harm intervention service

A service in mid-Cheshire provides psychosocial assessment of mental health state, suicidal intent, co-morbidity and social needs of people attending A&E, medical admission wards or the paediatric unit. Assessments may lead to support provided during admission to a medical unit or transfer to a psychiatric bed. Within three days of discharge, the majority of patients are seen at home for follow-up and the GP is informed immediately.

The team also supports mental health awareness programmes, and offers de-briefings to staff across the whole trust who have been involved in traumatic events.

Tel: 01270 612373

Performance assessment

Performance will be assessed at a national level by:

- a long term improvement in the psychological health of the population as measured by the National Psychiatric Morbidity Survey

- a reduction in suicide rates

- *NHS Direct* roll out

- the extent to which the prescribing of antidepressants, antipsychotics and benzodiazepines conforms to clinical guidelines

- access to psychological therapies

- experience of service users and carers, including those from black and minority ethnic communities.

In addition, progress will be monitored through local milestones, for example:

Milestones	Data
• Timely access to specialist assessment and treatment; and action implemented to tackle delays	Waiting list monitoring using CPA database records from single point of entry and CPA reviews
• Information available for people with mental health problems, including access to local self-help groups and support services such as housing and employment	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans
• Protocols on emergency access agreed and implemented across local health and social care communities within health improvement programmes	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans
• A&E departments have liaison arrangements - specialist nurse or other evidence-based approach	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans
• Duty doctor, Section 12 approved, and approved social worker always available for mental health emergencies	Common information core
• *NHS Direct* contacts reported directly to corresponding CPA information system	Mental Health Minimum Data Set (from CPA information systems)

Recommended local roles and responsibilities

Lead organisation: primary care group

Lead officer: chief executive

Key partners: GP and the primary care team, NHS trust, independent sector providers, police and criminal justice system, local authority, and service users and carers.

Standards four and five

Effective services for people with severe mental illness

Aim

To ensure that each person with severe mental illness receives the range of mental health services they need; that crises are anticipated or prevented where possible; to ensure prompt and effective help if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible.

Standard four

All mental health service users on CPA should:

- **receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk**

- **have a copy of a written care plan which:**

    - **includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator**

    - **advises their GP how they should respond if the service user needs additional help**

    - **is regularly reviewed by their care co-ordinator**

    - **be able to access services 24 hours a day, 365 days a year.**

Standard five

Each service user who is assessed as requiring a period of care away from their home should have:

- **timely access to an appropriate hospital bed or alternative bed or place, which is:**

    - **in the least restrictive environment consistent with the need to protect them and the public**

    - **as close to home as possible**

- **a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.**

Rationale

People with severe mental illness form a small proportion of those with mental health problems but have very high rates of psychological and physical morbidity. The WHO[104] (IV) has found that mental illness, including drug and alcohol misuse, accounted for almost 11% of the global burden of disease in 1990. This is expected to rise to 15% by 2020.

Worldwide, mental illness accounts for about 1.4% of all deaths and 28% of years lived with disability. In 1990, [104] (IV) five of the ten leading causes of disability were psychiatric conditions: unipolar depression, alcohol misuse, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder. People with severe mental illness are also socially excluded, finding it difficult to sustain social and family networks, access education systems and obtain and sustain employment.

In a pooled analysis of 20 studies of 36,000 people, mortality among people with schizophrenia was found to be 1.6 times that of the general population; the risk of suicide nine times higher; and the risk of death from other violent incidents over twice as high [105] (IV).

Crises should be anticipated or prevented, with rapid intervention if necessary. Hospital admission, including secure mental health care, or the provision of a supported place may be required during the course of the illness.

Interventions and evidence-base

Individuals with short term severe mental illness, such as severe depression, anxiety or panic disorder, generally respond well to treatment with drugs and psychological therapies, which can be provided in primary care (Standard two) with support from specialised services.

People with recurrent or severe and enduring mental illness, for example schizophrenia, bipolar affective disorder or organic mental disorder, severe anxiety disorders or severe eating disorders, have complex needs which may require the continuing care of specialist mental health services working effectively with other agencies. Most people manage well with this care and benefit from living in the community, posing no risk to themselves or others [106] (IV).

Many people with severe mental illness continue to live with their families, and are treated in the community with the support of primary care staff. A range of services is needed in addition to primary care - specialist mental health services, employment, education and training, housing and social support. Needs will fluctuate over time, and services must be able to anticipate and respond to crisis.

Some people with severe and enduring mental illness find it difficult to engage with and maintain contact with services, posing a risk to themselves or to others.

Assessment

Assessment should cover psychiatric, psychological and social functioning, risk to the individual and others, including previous violence and criminal record, any needs arising from co-morbidity, and personal circumstances including family or other carers, housing, financial and occupational status.

The prevalence of co-morbidity was indicated in a recent study carried out at the Maudsley Hospital [107] (IV). Drug and alcohol problems were assessed in individuals with severe mental illness such as schizophrenia and depression. Over the course of a year, 36% of patients had some form of substance misuse problem, 32% for alcohol and 16% for drug problems.

Assessment should also cover physical health needs. The National Psychiatric Morbidity Survey showed high levels of physical ill health and higher rates of death amongst those with mental health problems compared to the rest of the population [105, 108] (IV, IV).

Evidence suggests that the quality of the initial assessments is enhanced when it is multi-disciplinary and undertaken in partnership between health and social care staff [109] (III). All staff involved in performing assessments should receive training in risk assessment and risk management, updated regularly [41] (V). A locally agreed pro-forma should be used, with all decisions recorded and communicated to colleagues on a need to know basis [110] (V).

When service users are involved in agreeing and reviewing the plan, the quality of care improves [72] (V), and their satisfaction with services increases. They want to be involved, but commonly feel excluded [111-114] (V, V, V, V). The quality of the relationship between patient and professional in psychological therapies can make as much as a 25% difference in outcome [67,115,116] (I, III, II).

Carers' views are important too [117-119] (IV, V, V), not least to avoid wrong assumptions about their ability and willingness to care [120] (V). Care plans should be explicit about the responsibilities of all who have a role in providing care [121] (V). However, in most cases the service user should always be consulted if information is to be passed to their carer [120] (V).

Service users from black and minority ethnic communities commonly report that mental health assessments are undertaken from a perspective which may not always be sympathetic to ethnicity [65,122-124] (V, V, V, V).

The Department of Health and the Royal College of Psychiatrists have recently collaborated in developing a register of all those psychiatrists in the United Kingdom with an interest or special expertise in transcultural psychiatry[125](V). The register has been distributed to the chairs of college divisions and all college tutors as well as voluntary agencies, service user groups, NHS Executive regional offices, health authorities, and the Home Office Mental Health Unit. The register indicates special experience, region and site of work of psychiatrists as well as languages spoken, research interests and their readiness to be contacted.

Mental health services need to develop and demonstrate cultural competence, with staff having the knowledge and the skills to work effectively with diverse communities. An interpreter, or in the last resort a family member, will be necessary when language is a barrier between service user and practitioner. But recruitment of staff from, and representative of, local communities is the most effective longer term strategy to build cultural competence.

Prompt assessment is essential for young people with the first signs of a psychotic illness, where there is growing evidence that early assessment and treatment can reduce levels of morbidity [126] (V). Clinical responsibility for the mental health care of older adolescents can sometimes lead to disagreements between child and adolescent mental health services and adult services if working arrangements between the two services have not been addressed. Variations exist for the 'cut-off' point for referral to adolescent services, for example, 16, 18, 21 years or school leaving. Local arrangements should be agreed to avoid confusion and possible delays.

There is also evidence that delaying treatment with antipsychotic medication leads to poorer long term outcome for individuals with schizophrenic illness [127] (IV). Better public and professional understanding, together with integrated mental health systems across primary and specialist services, will promote earlier intervention.

Prisoners in England and Wales have very high rates of mental illness, substance misuse and personality disorder [37] (IV). A pilot remand and assessment service with dedicated NHS secure beds speeded up assessment and transfer of mentally disordered offenders [128] (IV). Specialist mental health services should increasingly provide in-reach services.

Care planning and review

Care planning and the delivery and regular review of a comprehensive package of services for people with severe mental illness is a multi-agency endeavour [109] (V).

Different systems of assessment, care planning, delivery and review have developed. In social services, care management provides the framework for needs assessment and the organisation of a package of care. In the NHS, the CPA has established a similar framework for assessment, care planning and review by a designated care co-ordinator.

Following two Social Services Inspectorate reports [129] [130] (V,V), a recent review [131] (V) recommends that care management and CPA should be fully integrated.

Both the individual and those trying to help them can be put at risk by a failure to communicate with others who are also involved [132] (V). Services should have policies which enable the sharing of information on a confidential and secure need to know basis, including with the criminal justice system [133] (V).

Professionals in adult mental health services should be familiar with local child protection procedures and know how to obtain specific advice quickly. The welfare and safety of children living with a severely mentally ill parent must be considered with social services if there is a risk that the child could be subjected to sexual, physical or emotional abuse, or neglect. Behaviour which indicates a risk to other children outside the family home must also be taken into account.

When the mental health care of a young person needs to transfer to services for working age adults, a joint review of the young person's needs must be undertaken to ensure that effective hand-over of care takes place. This should be incorporated into a care plan under the CPA arrangements for adult services.

Antipsychotic medication benefits the treatment of individuals with schizophrenic and similar illnesses with a proven reduction in rate of relapse [134] (I). The development of new and atypical antipsychotic drugs, with a different range of side-effects, may offer scope for improving the effectiveness of treatment and reducing the impact of side-effects [135-137] (I, I, I). Clozapine may be effective in those who have not responded to the older drugs [138] (I).

Some side-effects of antipsychotic medication may lead people to discontinue their treatment. As relapse is five times as common if the service user does not take their prescribed medication [139] (III), non-compliance is likely to be a contributory factor in many cases of relapsing psychotic illness [140] (III). It is therefore essential to adhere to prescribing guidelines.

The incidence of adverse reactions tends to increase with dosage [141] (II), and there is no evidence that the standard dose of antipsychotic medication is less effective than a higher dose in preventing relapse [142] (I).

Simple measures, such as written information, may help people to continue their medication[143] (IV). Compliance therapy[144] (II) involves a combination of information, education and attention to the factors which may lead to someone stopping medication.

For schizophrenia there is growing evidence of effectiveness for psychological therapies, including some cognitive approaches and anxiety management techniques[67,145-147] (II, II, II, I). Psychological therapies with the families of those with schizophrenia, combined with medication, can prevent relapse, and reduce admission to hospital[148] (I).

Enduring personality disorders may substantially complicate the treatment of most mental health problems[67] (I). Specific cognitive behavioural, dialectical behaviour therapy, and psychodynamic treatments for personality disorders have now been tested[149-151] (II, II, I) and show promising evidence of effectiveness. Their use within secure psychiatric services is now being researched.

For people with severe and enduring mental illness, the care package may need to include help with social skills and social networks to address the social isolation of individuals with severe mental illness. It is reported that one in four service users have no contact with their families, and one in three have no contact with friends[152] (IV). The National Psychiatric Morbidity Survey confirmed that adults with a psychotic disorder living in the community had significantly smaller social networks than was the case for the total sample[153] (IV).

An appreciable number of service users may also need help to access employment, education and training[154] (V) and some at least will be able to obtain and sustain work[155,156] (IV, IV).

Service users themselves believe that adequate housing and income, and assistance with the social and occupational aspects of daily living are among the most important aspects of care[157-159] (V, V, IV) and reduce disability.

People with co-morbidity pose a major challenge for services. Their problems and needs are the responsibility of a range of services such as primary care, specialist services, drug and alcohol services, probation or housing associations. However, none of these has the statutory responsibility or the expertise to deal with the full range of difficulties presented by these people. Their behavioural problems and reluctance to engage with services adds to the challenge. Consequently, this group tends to be stigmatised and responsibility passed across agencies. The needs of people with a dual diagnosis should be met within existing mental health and drugs and alcohol services.

Engaging service users
Some of the 15,000 people in England with severe and enduring mental illness, between 14 and 200 per 100,000, are difficult to engage. They are a diverse group[160] (V), more likely to live in inner city areas, to be homeless, and to be over-represented in suicide, violence and homicide[161] (V).

Substance misuse is a growing concern; it may increase the risk that an individual poses and can make treatment of the coexisting mental illness more difficult. Specific measures may be needed to engage people with co-morbidity.

In the past, around half those with severe and enduring mental illness lost contact with specialist mental health services, leaving their GP to provide continuing care [162] (IV). Up to a third of the individuals with severe mental illness may move out of their locality within a year [163] (IV). Their peripatetic lifestyles can make it difficult for services to stay in touch.

If personal and public safety and well-being are to be assured, it is essential that mental health services stay in contact with people with severe and enduring mental illness, especially individuals who are assessed as at risk of harm themselves or of posing a risk to others. Services should provide flexible help and outreach support in response to fluctuating need and risk. Should a crisis develop, the service user and their carer and their GP must know what to do - information should be included in the care plan.

Community mental health teams provide the core of local specialist mental health services. Service users are more likely to stay in contact with community rather than hospital-based services and are more likely to accept treatment. Studies suggest that these service, help to reduce suicide rates [126,127,164,165] (III, IV, I, I).

Community mental health teams may provide the whole range of community-based services themselves, or be complemented by one or more teams providing specific functions. This latter model is most common in inner city and urban areas. Whichever model is used, the mental health system will need to provide the range of interventions and integration across all specialist services.

Community mental health teams may work with other specialist teams covering early intervention; assertive outreach; home treatment; the needs of those with co-morbidity; black and minority ethnic communities; homeless people; or mentally disordered offenders. Rehabilitation teams focus specifically on the housing, income, occupational and social needs of people with serious disabilities resulting from their mental illness.

Assertive outreach or assertive community treatment is a form of intensive case management [160] (V) that provides a clinically effective approach to managing the care of severely mentally ill people in the community [166] (I). Staff providing comprehensive assertive outreach care for clients will visit them at home, act as an advocate, and liaise with other services such as the GP or social services. Help is usually needed to find housing, secure an adequate income, and sustain basic daily living - shopping, cooking, and washing, for example. Opinion varies about the optimum staff-client ratio for assertive outreach. In some settings the ratio is a low as 1:12.

Assertive outreach can establish a more stable community base, and reduce time spent in hospital. Of 23 controlled studies, 61% reported significant reductions in hospital admissions [167] (I). It is particularly useful for individuals with whom it is hard to sustain contact [168] (1).

Response to crisis

Crises and emergencies require early intervention for the safety of both the public and the patient [160,169] (V, V). Yet in 1997, two in three health authorities reported that they did not yet provide access to the community mental health team throughout the 24 hour period; 50% reported they had no local helpline; and 50% that they were unable to provide immediate home support. So far, few authorities have specifically designated crisis resolution teams.

Timely access to services reducing delays in assessment, treatment and care can also reduce the risk of relapse and potential harm to the service user and others [170,171] (IV, IV).

For people on enhanced CPA, A&E will sometimes be the right place for them to go, especially if they have harmed themselves. However, alternative places should be available. Some health and local authorities with a high prevalence of mental ill health provide a 24 hour walk-in clinic, staffed by psychiatrists, nurses and social workers, and supported by the community mental health team in the daytime. Such clinics together with local authority, charitable and voluntary drop-in centres provide access to information, advice and treatment. Established links to statutory services will ensure that onward referral can be arranged when necessary.

Service users and carers themselves indicate that in a crisis they require a rapid response; continuity of care; and alternatives to hospital-based assessment and admission, such as crisis houses and service user-run sanctuaries in the community [172] (V).

Access to hospital

At present it can be difficult to find any type of mental health bed for an urgent admission. There is a need for more intensive care beds in some inner city areas, particularly in London [169] (IV), where bed occupancy can exceed 100% [169,173,174] (IV, IV, IV). Some parts of London, however, do not experience the severe problems reported by others [175] (V).

Hospital bed use varies very widely: one recent survey has revealed a threefold difference in the number of residential places per unit of population [176] (IV). In 1992, one in seven people with schizophrenia needed admission, accounting for half the total expenditure on schizophrenia care [177] (IV). They form the group most likely to need access to a hospital bed or other supported place during their illness.

However, this variation in bed use may be due to population characteristics. The rates of mental illness are higher in urban than in semi-rural or rural areas [91] (IV). This is partly because severely mentally ill people move into cities, and partly because being born in a city is also associated with a higher risk of developing schizophrenia [178] (IV).

People in inner cities are also more likely to live alone and to move more frequently [179] (IV). Morbidity can be hidden in rural areas [180] (V), as people may be reluctant to seek help in small communities if they feel their anonymity may be compromised.

Access to services depends on a number of factors which include ethnic group, gender, social class, level of education and where people live [181] (I).

There are a high number of compulsory admissions, and admissions to secure beds, from the African-Caribbean population [182] (III). A one day census in London and the south east of all psychiatric inpatients in acute and low secure psychiatric units, and seven private psychiatric units, [33] (IV) showed that 16% of inpatients came from black and minority ethnic communities, when this group only represented 3.7% of the local population. In forensic services the most deprived one fifth of the population have a fourfold higher admission rate compared to the remaining four fifths [183] (IV).

But the variation in hospital bed use may also be a sign that not all mental health services are operating a whole systems approach. A report from the Centre for Health Economics at York [184] (I) indicates that the demand for hospital beds can be reduced by care provided in alternative locations.

It has been shown that admission is more likely if an emergency assessment takes place either on a hospital ward or in an A&E department [187] (IV). Patients admitted through A&E have shorter lengths of stay, indicating that at least some of the admissions might have been preventable [186] (IV).

There is some evidence that implementing a policy of short stays for those needing admission to hospital may improve both care and outcomes [187] (I). There is also evidence that good quality care and rapid follow-up can be improved when the same team works in both residential and home settings, helping to minimise the length of inpatient stay [188] (III). It should also reduce the high risk of suicide in the weeks and months after discharge [41] (V).

Surveys of acute psychiatric wards also indicate that up to one third of inpatients would be better placed elsewhere [189,190] (IV, IV). This is likely to reflect a tendency for patients to stay longer than they need to, with discharges delayed by inadequate rehabilitation services, and shortages of 'move on' accommodation, especially 24 hour staffed accommodation, or supported independent accommodation arranged by the local authority.

Similar surveys in secure units also indicate patients placed inappropriately in levels of security which are higher than needed. There are gaps in medium secure provision, especially long stay medium secure provision, in local intensive care provision, in long stay low secure accommodation and in the number of supported community places, including day care [191,192] (II, III). These shortfalls result in delayed discharge and transfer, put extra pressure on local inpatient services, and hinder the effective use of resources.

The National Beds Inquiry, set in train by the Secretary of State in the autumn of 1998, is drawing together existing evidence and comparative data on bed requirements across the National Health Service. It is taking account of future trends and best practice inpatient care. The Inquiry Team will report to the Secretary of State later this year, and its findings will be published.

Mental health service beds have been considered within this inquiry. It is acknowledged that both needs and current provision vary widely across the country. A range of services is required for a local population: from secure beds through acute services and including

community support of various kinds. A shortage of provision at one point along this range causes pressure on other services. Consequently, a lack of available local inpatient beds is likely to be closely related to the shortage of secure accommodation, hostel provision or supported accommodation in a particular area. Audits of bed usage will provide data for local planners.

Concerns about the quality of inpatient care have been documented. Whilst it may be effective in reducing acute symptoms, a review in 1996 reported that the needs for home-based support, rehabilitation and suitable accommodation were not always met, and contact with both ward staff and community care staff was minimal [193] (IV).

Inpatient wards may also present risks for staff, with high bed occupancy rates, a high proportion of patients who are disturbed and detained under the Mental Health Act [169] (IV), and the growing problem of substance misuse associated with severe mental illness [194] (IV).

In 1996, the Mental Health Act Commission visited 47% of acute adult psychiatric inpatient units in England and Wales [174] (IV). In over a quarter of wards there were no nurses interacting with patients as the Commissioners arrived, although inpatient settings should offer therapeutic, educational, and recreational activities to meet the needs of service users [195] (V).

Some service users do not feel safe in hospital. This is especially true for women, and for individuals with a history of abuse, and young people [196] (V). Reports of sexual assaults and harassment are increasing; self-harm and suicide can occur [41,197] (IV, IV,).

Providing safe care for the small number of women in mixed sex accommodation is a priority. The Government's commitment to working towards the elimination of mixed sex accommodation is outlined in HSC(97) 1 which laid down three national objectives:

- ensuring that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients

- achieving fully the Patient's Charter standard for segregated sleeping, washing and toilet facilities across the NHS

- providing safe facilities for patients in hospital who are mentally ill which safeguard their privacy and dignity.

While accommodation for social and therapeutic activities will usually be mixed, the Government wants to ensure that single sex day space is always provided. Further guidance will be issued for mental health services.

Guidance is also available from NHS Estates concerning the physical environment in residential units for those with mental ill health and there will also be advice on secure mental health services [198] (V).

Home treatment and alternatives to hospital

Community-based assessment and treatment may be effective alternatives to hospital admission[199] (V), with crisis resolution and sustained home care for people with serious mental illnesses[200] (I). This can be delivered either by members of the community mental health team, or a specialised home treatment or crisis resolution team. It may involve intensive work with a single service user over a period of several days. Staff should be skilled in risk assessment and management, and will need supervision and support. Staff-service user ratios for effective working in crisis teams may need to be as low as 1:8.

There is evidence that, for black people, who tend to be more critical of mental health services[201, 202] (V, IV), home treatment is more acceptable than a hospital admission, and there is better continuing engagement with services[160] (V). Involving service users in the service planning process can help to develop more acceptable and culturally sensitive services[203] (V).

Crisis houses can be an alternative to hospital admission under the Mental Health Act, especially where the home environment has contributed to levels of distress. A crisis house may consist of a small number of beds, often for a group with specific needs, for example, women, people from black and minority ethnic communities, or young people with a first episode of psychosis. Close liaison with the community mental health team is essential for good quality care, and access to the full range of services.

Twenty four hour staffed places provide accommodation and support for some of the most disabled and disturbed service users who would otherwise require long term hospital care[204] (IV). On average around 25 people per 250,000 fall into this group, but in inner city areas (especially inner London) the levels of need are up to five times higher.

Despite evidence of their value, there are shortfalls of 24 hour staffed places and supported accommodation in some parts of the country, including those where needs are highest. Further development of this element of the mental health system of care is a high priority through partnership between statutory and non-statutory services.

Family placement of people with mental health problems who can benefit from care provided in a domestic environment is also being developed in some local authorities with support from the voluntary sector[130] (IV).

Ordinary housing supported through the local authority also has an important place in providing more or less independent living. Much of this type of accommodation is provided by housing associations, and managed by specialist independent organisations.

Housing and support schemes commissioned by local authorities working in partnership with health authorities also provide more or less independent living. Much of this type of accommodation is provided by housing associations, and managed by specialist independent organisations. A guide for organisations responsible for commissioning such provision has been developed[205] (IV).

Service models and examples of good practice

To achieve Standards four and five requires local health and social care communities to prioritise the needs of those with severe mental illness in local mental health strategies. Systems need to be developed to ensure integrated systems for assessment and care planning; care delivery and review; engaging service users; responding to crisis; and ensuring timely access to either home treatment, hospital care or an alternative place for those who need it.

Assessment and care planning

Care management and CPA should be fully integrated with two levels of CPA and used consistently [131] (IV)

- standard CPA for individuals who require the support or intervention of one agency or discipline, who pose no danger to themselves or to others, and who will not be at high risk if they lose contact with services

- enhanced CPA for individuals with multiple needs, and who need to be in contact with more than one professional or agency (including criminal justice agencies). This group needs more intensive help from a range of services, and may have more than one clinical condition, or a condition which is made worse by alcohol or drug misuse. They will include those who are hard to engage, and with whom it is difficult to maintain contact. Some individuals would pose a risk if they lost contact with services.

The principles of assessment, care planning, care delivery and review by a named care co-ordinator are paramount.

The written care plan for individuals on an enhanced CPA should include:

- arrangements for mental health care including medication

- an assessment of the nature of any risk posed; and the arrangements for the management of this risk to the service user and to others carers and the wider public, including the circumstances in which defined contingency action should be taken

- arrangements for physical health care: how and what will be provided - usually by the GP, but also by social services when help with meals and personal hygiene may be offered

- action needed to secure accommodation, appropriate to the service user's needs

- arrangements to provide domestic support

- action needed for employment, education or training or another occupation

- arrangements needed for an adequate income

- action to provide for cultural and faith needs

- arrangements to promote independence and sustain social contact, including therapeutic leisure activity

- date of next planned review.

The written care plan should be drawn up by the named care co-ordinator, with the involvement of the service user, and where appropriate their carer. It should include explicit contingency arrangements so that the service user or their carer can contact specialist services if they need to. A copy should be given to the service user and his or her GP.

Care management within the CPA

An effective joint working project between health and social services has operated in Dewsbury since the early 1990s. It is situated within the north Kirklees area which has a population of 160,000.

A CPA care manager, employed by social services, was established in 1995 to, develop the CPA process, and monitor and manage it in line with social services care management systems. The manager is responsible for all care purchasing monies including drug and alcohol placements, and all CPA.

CPA is targeted to include people on priority levels who have the greatest need and the highest risk.

The integration of CPA and care management has benefited service users, carers and staff by:

- avoiding administrative problems with the application of systems
- facilitating the early allocation of a worker to undertake community care assessments
- allowing funding for enhanced care plans to be committed immediately
- providing a central point for communication, well used by other agencies.

A Beacon Service and winner of the Nye Bevan Awards, announced by the Prime Minister in July 1999.

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Integrated health and social care management

The three community mental health teams in north Kensington, a deprived inner city area, are fully integrated across health and social care boundaries. They have common supervisory and disciplinary procedures; and health care staff are trained in care management assessment, and have access to social care budgets.

Tel: 0208 962 4300

CPA with an integrated information system

Tameside and Glossop Community and Priority Services NHS Trust has established a framework for CPA which includes a pilot of the Mental Health Minimum Data Set. This enables the service, which is jointly managed with Tameside social services, to collect and analyse data across all mental health provision; to integrate information across health and social care, including care management; to link an analysis of current service provision to identify service gaps; and to inform service development. The system enables effective clinical audit.

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Local health and social care communities need to ensure that primary care and specialist services have agreed and implemented protocols which ensure the effective and safe care of people with severe mental illness. The primary care team will usually take responsibility for physical health care, but may take on a more extended role in agreement with the care co-ordinator.

A number of protocols have been developed locally. The National Institute for Clinical Excellence will be asked to review these, and, where appropriate, to kitemark examples of good practice, which will be promulgated for local use.

A general practice register for people with severe and enduring mental illness

The St Hilary Brow practice, in Wallasey, is a Primary Care Act pilot. The practice developed a practice-based register for patients with severe and enduring mental illness in 1992. Information about each contact with specialist services has helped the practice ensure that patients are reviewed regularly, and that primary care services are fully integrated with specialist services.

Tel: 0151 638 2216

Better primary care for people with enduring mental illness

The team in Scarborough aims to promote effective psychiatric provision within a primary care setting for individuals with a stable, enduring mental illness. The project will provide early intervention for schizophrenia, early management of the onset of psychotic symptoms in young people, and depression and management, and will minimise risk in mental health care.

Aims of the three stage intervention process include:
- training GPs to care for patients with stable, enduring mental illness
- signposting referrals to the most appropriate agency via practice-based mental health workers, and
- producing a register of patients with enduring mental health illness to ensure regular mental, physical and social reviews are carried out.

The three year project is jointly funded by North Yorkshire Health Authority, Tees and North East Yorkshire NHS Trust, and the Sainsbury Centre for Mental Health.

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Early interventions

The Imparting Research and Information to Students on Schizophrenia project (IRISS) is a joint venture between the National Schizophrenia Fellowship and the National Union of Students in the West Midlands. It was developed in response to the growing concern about the incidence of mental health problems amongst the student population; the high number of students committing suicide, and the increasing number of students leaving college before completing their studies.

The project aims to achieve:
- an increase in mental health awareness among the student population, dispelling the stigma commonly associated with mental illness
- the development of support for students who experience mental health problems.

The project has:
- produced a National Awareness leaflet
- trained over 200 welfare officers and welfare staff and some Open University tutor counsellors
- achieved national press and TV promotion of mental health awareness
- worked with the student media on mental health information articles
- piloted student support initiatives
- advised and supported the creation of local mental health projects
- networked with student community action groups
- raised awareness through Rag and other student fundraising events.

Tel: 0207 330 9100/9101

Health information and education for people with schizophrenia

Healthy Living with Schizophrenia is a practical guide produced in 1998 by the Health Education Authority for people with a diagnosis of schizophrenia to help them acquire and maintain good health. It covers all aspects of living with schizophrenia, and is intended specifically for service users themselves and their carers.

Tel: 01235 465565

Risk assessment and management

This project, a collaboration between the Surrey Hampshire Borders NHS Trust and the University of Surrey, uses a robust, multi-agency, evidence-based and pragmatic risk assessment screening tool for clinicians working in all mental health service inpatient and community settings. The focus is on assessing risk to the individual, as well as risk to others. Evidence-based guidelines supported by an educational programme are being developed.

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Agreements between primary care and specialist mental health services

This model, which has been developed in Nottingham, has criteria agreed to target care management resources on people with severe mental illness. This has been undertaken through the local primary care liaison group with the mental health NHS trust and social services department.

Similar agreements have been developed in Bath, Berkshire, Brent, Lambeth, Norfolk, north Birmingham, north Derbyshire and south Derbyshire.

Tel: 0115 924 9924 x44745

Access to employment and accommodation

A partnership between Walsall Health and local authorities and the National Schizophrenia Fellowship, the aims of this service are to improve access to employment opportunities and accommodation for people with mental health problems.

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An effective work programme

A well established and cost-effective work programme in Avon and West Wiltshire to provide work opportunities for people with severe mental illness, with support from the Centre for Mental Health Services Development and effective service user involvement.

This is a vocational work programme for people with a mental illness seeking routes back into mainstream employment. The vocational assessment process leads to realistic goal planning through an occupational action plan.

The scheme involves work development teams liaising with the Employment Service, local New Deal Initiatives, voluntary organisations and further education colleges to improve and develop vocational services.

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Review framework when people are involved with the criminal justice system

The Revolving Doors Agency has developed a review framework, funded by the Home Office, to examine multi-agency arrangements in the community for people with mental health problems who are in contact with the criminal justice system. This has been piloted in four areas, and has proved a practical tool, which provides a kick-start for a local multi-agency action plan. It is being circulated to all health authorities [206] (V).

Tel: 0207 242 9222

Engaging service users

Local mental health services must identify each service user with severe and enduring mental illness. Where there is a risk that they may lose contact and discontinue treatment, the care plan should clearly state the arrangements necessary to safeguard the individual, their carers and the public.

Assertive outreach team within statutory services

The North Birmingham Assertive outreach team offers intensive support to people with severe mental illness living across the locality who have shown that they are difficult to engage, or likely to lose contact. All the clients are under the care of one psychiatrist and all team members are fully qualified staff. The aim is to develop a therapeutic alliance with service users, facilitating the delivery of effective treatment. The team operates outside office hours and at weekends.

Tel: 0121 6235528

Assertive outreach team within the independent sector

The Tulip Outreach Team offers a similar service in Haringey. Tulip is an independent, non-profit making organisation funded by health and social services. It offers an outreach service to people who are falling between the gaps in conventional services. The clients are mostly black or Asian, and may be homeless or at risk of becoming homeless.

Tel: 0207 889 6921

Assertive outreach service within the community mental health team

In south west London the assertive outreach team is integrated within community mental health teams, ensuring continuity of care and full integration of services for people with severe mental illness with complex needs. Effective prioritisation of work in small caseloads of around 12 service users enables routine daily supervision and early intervention in a crisis.

A Beacon Service
Tel: 01730 266544   **e mail:** status@statusmeetings.co.uk

Culturally sensitive support

A voluntary-led African-Caribbean initiative, developed in partnership with local health and social services, providing culturally appropriate support for black and ethnic minority service users. The Wolverhampton African-Caribbean Community Initiative, funded through social services, provides day care, outreach services and supported housing for African-Caribbeans with mental illness. Its partnership working includes the close involvement of service users.

The initiative often acts as a link between mainstream services and the African-Caribbean section of Wolverhampton's diverse community. Project workers and volunteers maintain contact with some seriously mentally ill people who otherwise might lose contact with services.

A Beacon Service
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Service user support

Northumberland User Voice supports and equips service users to influence mental health services in Northumberland. Northumberland Mental Health Services NHS Trust consulted with service users to discover what measures would most help them to have their say in the decision making process. Now two full-time workers facilitate service user involvement.

Core funding for the project is provided by Northumberland Health Authority and additional trust monies have enabled the service to offer training for service users and professionals. User Voice is also exploring further ways of developing service user involvement such as project placements, college training and localised service user training.

A Beacon Service
Tel: 01730 266544 **e mail:** status@statusmeetings.co.uk

Responding to crisis

Individual care plans should always include a contact point in case problems arise. Each local health and social care community should agree a protocol for sharing information about any individual on enhanced CPA, with the necessary confidentiality and security safeguards, on a need to know basis. Access should include the primary care team, local specialist mental health services, and those working in the criminal justice system.

24 hour crisis resolution

The crisis resolution team operating in north Birmingham offers support to people in their own homes through counselling, practical help, monitoring, and liaison with other services. The team is available 24 hours a day. Service user satisfaction with the service is high. People particularly value access round the clock, the quick response, and the practical help and support they receive.

Tel: 0121 623 5528

Crisis places

The Drayton Park project in Islington is an alternative to hospital admission for women in mental health crisis. It can accommodate up to 12 women and 4 children accompanying their mothers. The aim is to divert women from hospital inpatient care, and provide a service which is acceptable, safe and appropriate for their needs. Drayton Park offers 24 hour support, assessment, a short term residential stay, and a range of treatment and service options.

A Beacon Service.
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Weekend access to services

The North East Essex Mental Health Trust Safe for the Weekend aims to ensure continuity of care for people with severe mental health problems over the weekend when other services are not available, by offering intensive home support and day care.

A Beacon Service.
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Access to hospital

Each local health and social care community will need to establish a balance of supported places, hospital beds, and home treatment taking into account the forthcoming conclusions of the National Beds Inquiry. Services should encompass:

- supported living options including individual tenancies and shared housing. The level of support should be flexible, so that more support can be provided at times of crisis

- supervised short or medium term hostel accommodation with residential staff support

- 24 hour staffed accommodation in the community for people with severe mental illness who have a high-level of disability

- inpatient hospital beds including intensive care beds for people needing a short period of intensive intervention and observation. Where length of stay in intensive care starts to become prolonged, transfer to alternative long stay secure accommodation may need to be considered

- alternatives to acute inpatient admission such as crisis houses, day hospital or centre, home treatment or respite admission

- a range of secure provision, including local intensive care or high dependency units, medium secure and high secure places. There needs to be specific consideration for people who need long term care and for specific groups, such as women, and individuals who misuse substances.

Local health and social care communities should map existing services - inpatient beds and mental health places, together with the other services, such as home treatment or additional 24 hour staffed places, which can either reduce the need for admission or enable earlier discharge. The housing strategies of local authorities should estimate the gaps in the service and the needs for accommodation and support for people with a mental illness.

Key service gaps should be identified, together with the pressures that can result from unbalanced provision. Shared management arrangements for beds, places and other community services will help to ensure that the system operates as a whole, rather than as functionally separate parts.

It is vital that planning and development of a continuum of accommodation is undertaken in partnership between the range of agencies, including criminal justice agencies. Health and local authorities will have clear responsibilities in this area through joint investment plans. The service mapping audit undertaken by local authorities, with social care regions in 1998, will provide a useful baseline for such work.

Analysis of the National Beds Inquiry will help local health and social care communities to assess the range of provision that they will need. Regional Specialist Commissioning Groups will identify the needs for and commission the range of secure services to ensure a good match between service need and service use.

Local inpatient care should be provided as close as possible to home so that family and community links can be sustained. It can be helpful if access to these beds is managed through the crisis resolution team.

The needs of minority groups should be carefully considered, including women, young people, people from black and minority ethnic communities, people with substance misuse problems as well as mental illness, personality disorder, or with a combination of learning disability and mental illness.

If a bed in an adolescent unit cannot be located for a young person, but admission is essential for the safety and welfare of the service user or others, then care may be provided on an adult ward for a short period. As a contingency measure, NHS trusts should identify wards or settings that would be better suited to meet the needs of young people. A protocol must be agreed between the child and adolescent mental health services, and adult services. Protocols should set out procedures that safeguard the patient's safety and dignity.

Bed management

A five module bed management learning set was developed[207] (IV)in London. The programme shows that inpatient beds must be seen as part of a system of care. Improvements in bed management may be needed at a variety of levels:

- early discharge planning

- a 'gate-keeper' to agree all acute admissions

- a dedicated bed manager

- a flexible and rapid response to indications of relapse

- rapid follow-up provided after discharge, preferably by someone known to the patient, with particular attention given to those who have self-discharged or live alone

- integrated hospital and community services

- in-reach by community mental health staff

- greater service user involvement in multi-disciplinary care planning

- identification of revolving door patients and case management priority given to this group

- effective CPA with assertive key working

- improved medication management (input from specialist pharmacists, compliance aids, increased frequency of contact with care co-ordinator)

- increase alternatives to acute admission (extend day hospital and centre opening hours, assertive outreach and home treatment, crisis houses, family placement scheme, respite care, crisis plans for all on CPA)

- improved clinical leadership

- wider range of skills within community and other mental health teams, including inpatient

- evidence-based practice developed

- effective links with A&E departments, such as community psychiatric nurse liaison

- effective links with criminal justice system including liaison with police and courts

- system to alert practitioners to non-attendance of patients at appointments so that alternative means of contact pursued.

Tel: 0207 403 8790

Home treatment and alternatives to hospital

Local health and social care communities should be able to offer home treatment as an effective and practicable alternative to hospital admission, focussing initially on those groups for whom hospital admission is most problematic - for example, black service users and women.

Home treatment

The Psychiatric Emergency Team in north Birmingham manages people with affective disorders and psychosis who have been referred because they present a risk to themselves or to others. A package of treatment and care (drug treatments and psychological therapies) is delivered. Staff work intensively with their clients, spending up to several days at a time at the client's home. The majority of staff are black, levels of engagement are relatively high, and rates of drop out relatively low.

Tel: 0121 623 5528

Home treatment

The Stamford Resource Home Treatment Service has successfully reduced dependence on hospital services. It is provided in a rural area and is designed to provide prompt and effective home treatment for people with a mental health crisis. It comprises a 24 hour crisis team, day hospital, inpatient facility, community mental health team and 24 hour helpline - combining to provide treatment at home wherever possible to, prevent unnecessary admissions and to reduce periods of hospitalisation.

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Home treatment service

The Bradford Home Treatment service was established in 1996 by Bradford Community Health NHS Trust, in conjunction with Bradford social services, to provide intensive support for people suffering acute mental health crises. A team made up of psychiatric nurses, social workers, support staff and medical input operates on a 24 hour, seven day a week basis. It is able to offer early interventions in times of crisis across a range of clinical problems and has developed its assessment and risk management skills.

Tel: 0274 414007

Assessing progress in specialised services

The Inner Cities Initiative Group has developed a method of benchmarking services to achieve visible service improvement.

Trusts are:

- actively working together
- developing joint training resources
- sharing best practice.

Key performance indicators in each of the six areas of the NHS Performance Assessment Framework have been developed.

Tel: 01423 770556

Reviewing services and learning lessons

All ten agencies in Camden and Islington with a statutory responsibility for mental health services are working together to resolve operational problems which might occur in services for people with severe mental illness. The Camden and Islington Area Mental Health Committee co-ordinates the scheme, identifies good practice, ensures that lessons from inquiries are learned, reviews other cases, and implements change in local service delivery.

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Performance assessment

Performance will be assessed at a national level by:

- a long term improvement in the psychological health of the population as measured by the National Psychiatric Morbidity Survey
- a reduction in suicide rates
- the integration of CPA and care management
- access to single sex accommodation in hospital
- a reduction in the psychiatric emergency readmission rate
- prescribing antipsychotics
- access to psychological therapies
- access to rehabilitation services
- experience of service users and carers, including those from black and minority ethnic communities
- a reduction in the numbers of prisoners awaiting transfer to hospital.

In addition, progress will be monitored through local milestones, for example:

Milestones	Data
• Protocols agreed and implemented for the management of people with severe mental illness between primary care and specialist services	NHS Executive regional offices and social care regions monitoring of health improvement programmes, local implementation plans and primary care trust development plans
• Arrangements in place for assessment and access to services for those coming into contact with the criminal justice system	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans
• Waiting times monitored for referral for psychological therapies and action implemented to tackle delays	Waiting list monitoring using CPA database records from single point of entry and CPA reviews
• Using clinical guidelines, all service users should be assessed for and receive new antipsychotics where indicated	Mental Health Minimum Data Set. CPA reviews
• All service users assessed as requiring rehabilitation receive access to education, training, occupational and social care support, including supported accommodation	CPA review returns, data integrated into Mental Health Minimum Data Set
• Following an assessment of local need, the range of specialist functions to anticipate and prevent a crisis are available, including early intervention, assertive outreach and rehabilitation	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans

Milestones	Data

• Using the framework of the National Bed Inquiry, local communities have reviewed the shortfalls and pressures across local beds and places, including the independent sector:
  - use of high secure beds
  - use of medium secure beds
  - availability of intensive care places
  - local acute beds
  - crisis and refuge places
  - 24 hour staffed places
  - hostel places and other supported residential places
and prioritised investment to overcome service shortfalls
	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans

• Local health and social care communities achieving more effective use of mental health beds and places, including reducing bed occupancy rates where these exceed 95%	Annual audit of all service users in hospital bed. Hospital Episode Statistics data integrated into Mental Health Minimum Data Set
• Steady reduction of inappropriate out of area treatments	Hospital Episode Statistics data

Recommended local roles and responsibilities

Lead organisation: NHS trust

Lead officer: chief executive

Key partners: health authority, local authority, primary care group, including GPs, criminal justice agencies, independent sector providers, and service users and carers.

Standard six

Caring about carers

Aim

To ensure health and social services assess the needs of carers who provide regular and substantial care for those with severe mental illness, and provide care to meet their needs.

Standard six

All individuals who provide regular and substantial care for a person on CPA should:

- **have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis**

- **have their own written care plan which is given to them and implemented in discussion with them.**

Rationale

Carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental illness. Providing help, advice and services to carers can be one of the best ways of helping people with mental health problems. While caring can be rewarding, the strains and responsibilities of caring can also have an impact on carers' own mental and physical health, and these needs must also be addressed by health and social services.

The Government has shown the importance it attaches to ensuring that all carers get the services and support they need in its national strategy for carers, *Caring about Carers*, published earlier this year[120] (V). The new approach is built around three critical elements - information, support and care - representing a new substantial policy package for carers. Extra funding of £140 million has been provided between 1999/00 and 2001/02 to help local authorities provide a wider range of services to allow carers to take a break from their caring responsibilities.

Interventions and evidence-base

About half of those with severe mental illness live with family or friends, and many others receive considerable support from them. Carers of service users, including young carers, should be involved in their own assessment and care planning process, which takes account of the state of their own mental and physical health needs, and ability to continue to care[120] (V).

Women are more likely to be carers than men - 58% of carers in Britain are women - and are also more likely to carry the main responsibility for caring, where there is more than one person with some responsibility [120] (V).

The families of individuals with severe mental illness may have to contend with demanding behaviour, extra financial burdens, restrictions upon their social and family life, and occasionally a risk to their own safety[208] (IV). The needs of those caring for people with severe mental illness or dementia are especially high [120] (V).

Assessing carers' needs

The Carers (Recognition and Services) Act 1995 gives people who provide "substantial care on a regular basis" the right to request an assessment from social services. But the implementation of this Act is patchy. Assessments are not always carried out. Some carers are offered very sensitive, practical and emotional support. But others receive little, or no help.

Variations in assessment of carers' needs occur between individual social workers and care managers, between teams, between areas within authorities, and between authorities. When assessments are undertaken, carers report satisfaction both with the process and with the results. Carers should be entitled to expect at least an annual discussion of the care they provide; the help they receive; what they feel they need; and what is available[120] (V).

There is evidence that carers of people with severe mental illness are not getting the services they need to support them, or to ensure that their own health is maintained. Young carers are a particularly vulnerable group[209] (V). Few authorities had implemented the Carers (Recognition and Services) Act 1995 within their mental health services when inspected recently by the Social Services Inspectorate[130] (V).

In another Social Services Inspectorate report the carers of people with mental health problems were especially critical of how little they were consulted about care plans for service users, how their own needs were not assessed, and how little support they received[210] (IV).

Findings in *Safer Services*[41] (V) from a range of local inquiries and research show that extreme crimes of violence, manslaughter and murder are much more likely to be committed against family members or carers than against a stranger. Carers need to know what to do in a crisis, and to be assured that prompt action will be taken.

Participants report that they find family and relative support useful [211,212] (III, IV), and it can reduce relapse rates [148] (I).

Service models and examples of good practice

To achieve Standard six local services need to pay greater attention to the needs of carers, and to the specific needs of those who care from someone with a mental health problem. This should include the assessment of each carer's needs when requested, the agreement of a care plan which is reviewed at least annually, and the development of local networks to support carers. Carers should be made of aware of their right to request an assessment.

Needs assessment and carer's plan

Local health and social care communities should ensure that each carer receives an initial assessment of their caring, physical and mental health needs. Some people with mental illness will have care needs that vary over time. This does not mean that the needs do not present a regular and substantial burden for their carer, and should not be a reason for exclusion from the assessment and care planning process.

Service providers must ensure that carers are provided with information on the help available to meet their particular needs.

Checklist for GPs and primary care teams to help carers

- Have you identified those of your patients who are carers, and patients who have a carer?

- Do you check carers' physical and emotional health whenever a suitable opportunity arises, and at least once a year?

- Do you routinely tell carers that they can ask social services for an assessment of their own needs?

- Do you always ask patients who have carers whether they are happy for health information about them to be told to their carer?

- Do you know whether there is a carers' support group or carers' centre in your area, and do you tell carers about them?

110

Social services should record each carer's needs, draw up a care plan and agree it with the carer. The views, circumstances and needs of service users and carers may be distinct, and can sometimes conflict. Local arrangements should be made to ensure that the user's and carer's plans are considered together. The carer's health needs should also be taken into account.

The CPA care co-ordinator should inform users and carers of the carer's right to request an assessment and ensure co-ordination of users' and carers' assessment plans. Local authority care managers have an equal part to play in co-ordination, making links, for example, with primary care services to ensure the carer's emotional, mental and physical needs are kept in mind as part of the carer's assessment.

The carer's plan should include:

- information about the mental health needs of the person for whom they are caring, including information about medication and any side-effects which can be predicted, and services available to support them

- action to meet defined contingencies

- information on what to do and who to contact in a crisis

- what will be provided to meet their own mental and physical health needs, and how it will be provided

- action needed to secure advice on income, housing, educational and employment matters

- arrangements for short term breaks

- arrangements for social support, including access to carers' support groups

- information about appeals or complaints procedures.

The plan should be reviewed at least annually. More frequent reviews may be necessary if either the service user's or carer's health or circumstances change significantly.

The carer's plan should be confirmed in writing, or in another format that is accessible to the carer. And the assessment should be communicated to the GP and primary care team. Primary care staff, especially GPs and community nurses, are in a key position to detect signs of stress, difficulty or deteriorating health in carers. They should know who to contact to ensure that the carer's assessment is carried out, and regularly reviewed, and ensure that this happens.

Where the person with mental illness is a parent, health and local authorities should not assume that the child or children can undertake the necessary caring responsibilities. The parent should be supported in their parenting role and services provided so that the young carer is able to benefit from the same life chances as all other children, and have the opportunity for a full education, and leisure and social activities. The young carer's plan should take account of the adverse impact which mental health problems in a parent can have on the child.

National Schizophrenia Fellowship Education and Support Programme (CESP)

The National Schizophrenia Fellowship and Sainsbury Centre for Mental Health Development have developed, evaluated and will shortly be licensing an education and support programme. The eleven week programme is co-led by trained carers and professionals, is evidence-based, and incorporates psychosocial intervention.

Its objectives are to provide carers of people with serious mental health problems with the knowledge, skills and confidence to deal more effectively with their role. Outcomes will be to improve the health of the carers themselves, and that of the family member for whom they are caring.

National Schizophrenia Fellowship: 0208 547 3937

Support for families and carers

A project in Avon and West Wiltshire focuses on how family interventions for people with schizophrenia can be extremely effective in preventing relapses.

Inter-agency working, sharing ideas and ensuring services complement each other and communicate well to avoid duplication, is a key part of the success of this scheme.

With an emphasis on early intervention and assessment of each case to provide an individually tailored programme, the results show that the drop-out and non-engagement rate is far below those found in other services.

A Beacon Service.
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Local health and social care communities, when planning and providing services, should ensure that carers from black and minority ethnic communities have access to the information which they need; are able to use culturally appropriate services; and can contribute to service planning and development.

Prioritising carers

As part of their Positive Mental Health Strategy, Sandwell mental health services are promoting positive mental health for carers of people with mental health problems. To help target resources, the following priority groups have been identified: children; young people; black and minority ethnic people; women; people who find services difficult to engage with; young men aged 16-35 years; homeless people; single parents and unemployed people.

Tel: 0121 500 1500

Local health and social care communities should provide support for carers' groups and carers' centres, and work with them to develop local networks of support for carers. This support is particularly valuable for carers of people with mental illness, as there is a sense that only carers in a similar position can understand the difficulties. Carers' groups should be involved in the planning and development and support for carers.

Where service users are resident in secure mental health services, carers may need support, especially if they have been victims of the family member, or if the family member is located at a distance from the home. Contact with the carer will continue to be of great value to service users. Secure mental health services need to have skilled staff who can facilitate continuing links.

Performance assessment

Performance will be assessed at a national level by:

- a long term improvement in the psychological health of the population as measured by the National Psychiatric Morbidity Survey
- a reduction in suicide rates
- implementation of each local authority's Caring about Carers action plan
- a reduction in the psychiatric emergency readmission rate
- experience of service users and carers, including those from black and minority ethnic communities.

In addition, progress will be monitored through local milestones, for example:

Milestones	Data

• Carers of people with severe mental illness who provide substantial care on a regular basis should:
 	
  - be identified by health and social services
 	
  - have an assessment of their caring, physical and mental health needs
 	
  - have a care plan agreed and implemented to meet their own needs
	CPA review returns, data will be integrated into Mental Health Minimum Data Set

• Carers of people with severe mental illness who provide substantial care on a regular basis:
 	
  - have seen and had explained to them the care plan of the person for whom they provide care*
 	
  - understand the nature of their illness
 	
  - know how to contact services if they need to
	CPA review returns, data will be integrated into Mental Health Minimum Data Set

• Carers express increasing satisfaction with services:
 	
  - for those they care for
 	
  - for themselves
	CPA review returns, data will be integrated into Mental Health Minimum Data Set Local survey

• Carers involved in service review and development	NHS Executive regional offices and social care regions monitoring of health improvement programmes

Recommended local roles and responsibilities

Lead organisation: local authority

Lead officer: director of social services

Key partners: health authority, primary care group, including GPs, NHS trust, independent sector providers, and service users and carers.

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* The service user's consent should always be explicitly sought before information is passed on to their carer. If the service user is incapacitated, information may be passed to the carer if it is in the service user's best interests

Standard seven

Preventing suicide

Aim

To ensure that health and social services play their full part in the achievement of the target in *Saving lives: Our Healthier Nation* to reduce the suicide rate by at least one fifth by 2010.

Standard seven

Local health and social care communities should prevent suicides by:

- **promoting mental health for all, working with individuals and communities (Standard one)**

- **delivering high quality primary mental health care (Standard two)**

- **ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an A&E department (Standard three)**

- **ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard four)**

- **providing safe hospital accommodation for individuals who need it (Standard five)**

- **enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard six).**

and in addition:

- **support local prison staff in preventing suicides among prisoners**

- **ensure that staff are competent to assess the risk of suicide among individuals at greatest risk**

- **develop local systems for suicide audit to learn lessons and take any necessary action.**

Rationale

Mental health is one of the four target areas in *Saving lives: Our Healthier Nation* with a specific target to reduce suicide by one fifth by 2010. The likelihood of a person committing suicide depends on several factors[213] (V) including both mental and physical illness; stressful life events such as bereavement, separation and divorce, or unemployment; and access to the means of suicide.

Although the overall rate of suicide is falling - by more than 12 per cent since 1982 [214, 215] (IV, IV) - there are still over 4,000 deaths from suicide in England each year.

Despite this overall trend, some people remain at a relatively higher risk of death by suicide:

- men are three times more likely than women to commit suicide. Young men are at particularly high risk. Suicide is the leading cause of death among men aged 15-24 years and the second most common cause of death among people aged under 35 years

- men in unskilled occupations are four times more likely to commit suicide than are those in professional work

- among women living in England, those born in India and East Africa have a 40 per cent higher suicide rate than those born in England and Wales

- certain occupational groups such as doctors, nurses, pharmacists, vets and farmers are at higher risk, partly because of ease of access to the means of suicide

- more than one in ten people with severe mental illness kill themselves

- the risk is also raised for individuals with depression, and those who have suffered a major loss

- people who have previously harmed themselves, or individuals who misuse drugs or alcohol are at relatively high risk of suicide

- suicide rates in prison are high.

Interventions and evidence-base

Suicide accounts for 400,000 years of life lost before the age of 75 years. It is associated with poverty and adverse social circumstances [215] (IV), and numerous studies have demonstrated the correlation between poor housing, low income and mental ill health [62] (IV).

Mortality amongst those unemployed or seeking work was shown to be raised after both the 1971 and the 1981 censuses [216] (IV). Unemployment may impair physical and mental health and is associated with increases in suicide and self-harm [217] (V). Individuals in prison are at especially high risk of suicide [218] (IV).

Adults who are separated, divorced, or who have experienced a major loss such as the death of a loved one are also at increased risk of suicide. Individual counselling can improve psychological adjustment for individuals whose risk is due to depression, financial strain or low assertiveness [19] (III).

At least one per cent of patients seen in hospital after harming themselves go on to commit suicide during the next 12 months and up to five per cent do so over the following decade [219] (IV).

Safer Services[41] (V) reported that one in four people who subsequently took their own lives, around 1,000 people each year, were found to have been in contact with specialist mental health services in the year before death. Of these 16 per cent (one in 25 overall) were inpatients at the time of their death, and 24 per cent, one in 16 overall, had been discharged from hospital within the previous three months. Many were not fully compliant with treatment when discharged, and in most cases staff perceived the immediate risk of suicide to be low. *Safer Services* also recorded that around half of the suicides were committed by people with a history of self-harm and either substance misuse or previous admission to hospital.

Although suicide is a relatively rare event, an average primary care group with a population of 100,000 people would expect 10 suicides each year, amongst whom two or three would have been in contact with mental health services during the previous year.

Evidence indicates that access to firearms or poison increases the risk that a person may use them to commit suicide. Although in absolute terms the number of deaths is small, the excess risk for certain groups is significant. Farmers and vets have the highest proportional mortality ratio. A recent agreement with the pharmaceutical industry has reduced the pack size of paracetamol in order to prevent the likelihood of paracetamol overdoses being used in suicide attempts.

Service models and examples of good practice

Promoting mental health and well-being
As set out in Standard one, local health and social care communities need to work with the whole population; with individuals at risk; and with vulnerable groups; and work to combat discrimination and social exclusion.

Preventing suicide among individuals in contact with health and social services

As set out in Standards two and three, local health and social care communities should:

- ensure that primary care staff are able to assess and manage depression, including the risk of suicide

- establish a network of specialist mental health helplines and other services, in time linked to *NHS Direct*, to provide round the clock advice and help for those in mental distress

- develop and implement protocols to ensure that people who have self-harmed receive a specialised psychological assessment prior to discharge from A&E

- ensure access to a duty doctor, Section 12 approved, and an approved social worker, round the clock.

Preventing suicide among people with severe mental illness

As set out in Standards four and five, local health and social care communities need to ensure that:

- care management and CPA are integrated and implemented systematically for all individuals in contact with specialist health and social care services

- care plans are reviewed at a frequency which reflects assessments made of the risks identified for individuals

- training for staff in specialist mental health services in risk assessment and management is a priority, and is updated at least every three years

- assertive outreach is in place for all individuals who may fail to take their prescribed medication and would then be at risk of depression, severe mental illness or suicide; for those who have a tendency to drop out of contact with services; and for those who are not well engaged with services

- safety on wards is improved to reduce access to the means to commit suicide. Inpatient suicides are twice as frequent as suicides in prison, and this suggests that access to means and the lack of supportive observation for people at risk in hospital is a factor in their death

- follow-up for people recently discharged from hospital is a priority and steps are taken to improve the continuity of care and the transfer of information between hospital and community staff.

Learning materials on mental health risk assessment and risk management

A learning guide developed by the University of Manchester on mental health risk assessment and risk management, including suicide risk, includes information about best practice, groups with special needs, the legislative framework and ethical issues, and the perspectives of service user and carer.

Tel: 0161 275 5221

In addition, progress will be monitored through local milestones, for example:

Milestones	Data
• Local health and social care communities prioritise mental health promotion in their health improvement programmes, including a focus on groups where the risk of suicide is high, including prisons	NHS Executive regional offices and social care regions monitoring of health improvement programmes and joint investment plans
• Maternity services working with health visitors develop and implement protocols for assessment and management of mental health during pregnancy and after delivery	NHS Executive regional offices monitoring of health improvement programmes and local implementation plans
• A&E Departments develop and implement protocols for those who present with self-harm	NHS Executive regional offices monitoring of health improvement programmes and local implementation plans
• Local health and social care communities, working with their consortia, meet the training and educational needs for risk assessment and management in relevant staff groups including primary care, A&E and midwives, as well as the mental health teams	NHS Executive regional offices and social care regions monitoring of health improvement programmes and consortia plans
• Care plans for those with severe mental illness include an urgent follow-up within one week of discharge from hospital	CPA review returns, data integrated into Mental Health Minimum Data Set
• Care plans to provide point of access for carers in a crisis	CPA review returns, data integrated into Mental Health Minimum Data Set
• Inpatient units and other residential settings review physical environment to reduce access to means of suicide	NHS Executive regional offices monitoring of health improvement programmes and Mental Health Act Commission reports
• Local health community to hold multi-disciplinary review after each local suicide to examine potential contributory factors; implement any recommendations; and report outcome to the regional office annually	NHS Executive regional offices and social care regions monitoring of health improvement programmes

Recommended local roles and responsibilities

Lead organisation: health authority

Lead officer: chief executive

Key partners: NHS trust, local authority, primary care group, including GPs, independent sector providers, police, criminal justice agencies, and service users and carers.

Specific measures to prevent suicide

- local health and social care communities should develop local partnerships with prisons to prevent suicides among prisoners

- local health and social care communities should ensure that staff are competent to assess the risk of suicide among individuals who are most vulnerable.

Assertive outreach linked to court diversion

People who self-harm commonly have multiple problems, including a history of contact with the criminal justice system. The assertive outreach team within the Bedfordshire and Luton Community NHS Trust, linked with a court diversion scheme and with input from probation services, offers a proactive service which reduces risk, builds good relationships, and helps to secure effective treatment and care.

A Beacon Service.
Tel: 01730 266544   **e mail:** status@statusmeetings.co.uk

Local health and social care communities should:

- ensure that there is quick access to an effective place of safety, such as an acute bed or alternative supported residential place, if care away from home is needed when a crisis occurs

- when a suicide occurs, audit the treatment and care provided, so that any lessons learned can be quickly incorporated, and practice changed [220] (V). Useful information about events surrounding suicides can be obtained from a variety of local sources, including case records, written reports from staff, transcripts of the inquest, summaries of management inquiries, and through discussion with relatives and carers.

Performance assessment

Performance will be assessed at a national level by:

- a reduction in suicide rates.

3.0   Local implementation

- **ownership of standards**

- **performance assessment**

- **national and regional support for local implementation**

Introduction

Local health and social care communities must translate the national standards and service models into local delivery plans. This will be supported by the national action, which is set out in Section five.

This Section concentrates on local delivery by the NHS and social services. It will require systematic and sustained system changes, harnessing the skills and capabilities that already exist in mental health services, and sharing learning across and between organisations.

All staff should be engaged in shaping services and in planning and delivering change, with incentives to alter both attitudes and practice. Implementing the National Service Framework will be challenging. Strong leadership, with the clear commitment of managers, clinicians and other practitioners, a determination to target resources and a readiness to promote learning from other organisations will be essential to secure and sustain change.

Staff can expect to have the reasons for change and benefits for service users clearly demonstrated and explained, drawing on the evidence-base of the National Service Framework. It will be essential for local authority elected members and non-executives of local NHS organisations to be engaged too, so that they can champion local change.

A new opportunity for change

This Framework has a number of distinctive features which together separate it from earlier attempts to implement change in mental health, including:

- **a clear statement of what has to be done**
- **flexibility, a mix of national and local milestones, and firm performance management**
- **dedicated national and regional support, including:**
    - **the Mental Health Modernisation Fund and Mental Health Grant**
    - **five complementary national programmes**
    - **a national Mental Health Implementation Group and Team**

A clear statement

All too often the development of mental health services has depended on local advocates for change, rather than a planned and systematic approach to achieve a shared vision. The evidence-base for treatment approaches and service models has sometimes been regarded as equivocal.

In contrast, the National Service Framework provides local health and social care communities with a sound evidence base for action, together with service models and examples of good practice in action. It provides a common vocabulary for treatments, and service models to be used across the country.

Flexibility, milestones, and performance management

Local health and social care communities are ultimately responsible for ensuring the implementation of the national standards and service models set out in the National Service Framework. Their strategies for implementation must be reflected in health improvement programmes, joint investment plans, service and financial frameworks and long term service agreements from 2000/01.

The starting points for health and social care communities will vary greatly. While local strategies to achieve full implementation of the National Service Framework will need to vary to reflect different starting points and local priorities, the National Service Framework must nonetheless be fully implemented over a planned time-scale through the health improvement programme.

Locally agreed milestones must be set so that local health and social care communities can be held to account by NHS Executive regional offices and social care regions, ensuring delivery of a national framework of high quality mental health services. It may not be possible for all local health improvement programmes to reflect a detailed mental health strategy including funding in 1999, but the likely requirements for mainstream funding from 2001/02 should be considered when entering into other service commitments.

Shared vision and partnership

Successful implementation at local level will require a common vision and strategy supported by a wide local constituency. The 1999 Health Act places a new Duty of Partnership on health and local authorities and provides for new flexibilities through pooled budgets, integrated provision and lead commissioning.

Local health and social care communities will need to assess the current interfaces between all health organisations and local government departments, and determine how best to fulfil the Duty of Partnership, deploying the new flexibilities to achieve the national standards, and to demonstrate progress against local milestones.

Agreement must be achieved on the total resource available for mental health, including the Mental Health Grant, Modernisation Fund and mainstream local authority and health authority funding. If the total resource is to be used to maximum effect, there must be local agreement and confidence in the mechanisms employed to delegate budgets and responsibilities while retaining adequate accountability in all sectors.

Local elected members and non-executives of NHS trusts, primary care groups, primary care teams and health authorities should aim to facilitate close partnerships, which could be fostered through cross membership of local authorities and NHS boards.

Developing local capacity

Variations in local services stem from different local capacities, capabilities and the potential of both organisations and individuals to deliver the new Framework. For this reason, the Government has set aside funding to support organisational and professional development.

NHS Executive regional offices in partnership with their respective social care regions and their constituent local health and social care communities have developed plans to utilise funding in various ways. Generally there will be a mix of development investment at local community level and at region-wide, or sub-regional level.

Some local health and social care communities may opt for joint appointments to manage the preparation for local implementation, others will rely on regional level support, while some will use a combination of approaches. This national resource, designed to support local development, will be monitored through the national Mental Health Implementation Group, described later in this Section.

National programmes

Local health and social care communities face a large agenda of change. National strategies and measures are being put in place to achieve that change locally in mental health. The Duty of Partnership placed on health and local authorities will support implementation of the Framework, as will the requirement for jointly produced health improvement programmes and joint investment plans, underwritten by long term service agreements that focus on quality improvement.

Within NHS organisations, the new Duty of Quality will drive the quality agenda, underpinned by clinical governance, the National Institute of Clinical Excellence and the Commission for Health Improvement. Social services are already beginning to implement *Best Value*.

- **a national Mental Health Implementation Group** which will be led by the head of mental health policy in the Department of Health, an assistant chief inspector from a social care region, and a director from a regional office of the NHS Executive. There will be representatives from each NHS and social care region working with members of the national mental health policy team, collaborating with colleagues across the Department of Health. It will:

  - monitor the high-level performance indicators

  - synthesise monitoring of milestones by the NHS Executive regional offices and social care regions

  - ensure progress on each of the underpinning programmes

  - manage national communications on the National Service Framework

  - commission further work on the National Service Framework

  - take the lead in keeping the National Service Framework up to date

  - work with the Commission for Health Improvement and the Social Services Inspectorate as they review implementation

- **a national Mental Health Implementation Team** led by an experienced mental health services chief executive will support the role of the Implementation Group. The national Team will:

  - develop a detailed understanding of the state of readiness and action planning across England

  - provide support to regions through an external challenge to action and implementation plans

  - facilitate and promote sharing of good practice in delivery to support local health and social care communities

  - inform the Mental Health Implementation Group about progress and any concerns about implementation.

Sharing good practice

The National Service Framework will require organisations to learn from the experiences of others. All local services have relative strengths and weaknesses. Rapid improvement will come from organisations sharing the strengths and being prepared to consider how others have dealt successfully with specific weaknesses.

The new Learning Zone will contain a national database of Service Delivery and Practice: **www.learningzone.nhsweb.nhs.uk**. It will include examples of how NHS staff have tackled issues in service delivery. NHS staff will be able to enter details and search for information, including learning opportunities. And a sister publication to Bandolier, ImpAct, will be published bi-monthly, and be available on the internet: **www.jr2.oxac.uk/Bandolier**

The National Institute for Social Work's range of library and information services provides a comprehensive international knowledge-base for social care practice to social care employers and practitioners. The Department of Health has recently provided extra funding to extend this service to make available on-line the best evidence of what works in social care in all practice areas. This is supplemented by on-line access to research evidence, journals, research publications and up to date information on good practice.

Learning centres will be supported within the NHS providing a peer group focus for sharing learning and practice and problem solving in a number of areas, including the delivery of National Service Frameworks.

Social Services Inspectorate and Joint Review Inspection Teams will continue to identify and publicise good practice initiatives.

During May 1999 NHS **Beacon Services** were chosen in six areas of service delivery, including mental health. A Beacon is a service within the NHS, which has been selected as a particularly good example. Beacons will have financial support to enable them to disseminate learning to other NHS organisations, including through the Learning Zone and Service Delivery and Practice database. To achieve Beacon status, services were able to demonstrate a high-level of joint working across the health and social care interface. The Government is therefore looking at the possibility of increasing links between the Beacons initiatives for the health service and local government. For more information about the mental health Beacon Services, contact Status, who are running the programme of visits, on 01730 266544 or by e-mail at **status@statusmeetings.co.uk**.

A **mental health learning network** is planned to give a specific and early focus on the NHS Learning Network and mental health services. The national infrastructure provided by the Learning Network provides an excellent opportunity, at an early stage in the implementation process, for mental health services to share experiences in the management of change, service development and quality improvement. The focus will be upon motivating and supporting clinicians and managers to take maximum advantage of this infrastructure for learning. Mental Health Minimum Data Set learning sites will also offer an opportunity for mental health service development.

A comprehensive implementation plan

A comprehensive and successful strategy for implementation will be characterised by:

- **an integrated approach to service, organisational and professional development**, which recognises the need to match up and resource organisational development and professional development needs, alongside service development priorities

- **robust and sustainable mechanisms for implementing the National Service Framework** - including local implementation teams with clear accountability to chief officers. The National Service Framework's ambitious agenda of change has been designed to deliver sustainable improvements. It must therefore be fully engaged and addressed by the underpinning national strategies, effectively structured and managed

Professional development and good practice

The National Service Framework has considerable implications for workforce planning, education and training, and recruitment in mental health services. In addition to national strategies, NHS Executive regional offices will be developing a range of regional mental health development centres to provide support at local level for clinical, managerial and organisational development.

The evolving NHS Learning Network will provide opportunities for local mental health services, encouraged by mental health demonstration projects, to promote ongoing professional and organisational development.

Dedicated support

Regional offices in partnership

The National Service Framework is designed to provide a national pattern of services sensitively implemented at local level. To meet the manifest local challenges, local implementation will be supported and monitored by the NHS Executive regional offices and social care regions.

Each region now has a Regional Mental Health Development Plan developed by its Regional Implementation Team, setting out essential action the region will take to implement the Framework. Regions, with the agreement of constituent health and social care organisations, will develop a range of support responses to facilitate local implementation, including enhancement of local capacity to manage change, the establishment of regional development centres, and employment of key support managers, for example in primary care.

NHS Executive regional offices and social care regions will jointly determine their arrangements for programme management, involving all local health and social care communities. And a programme of development will be agreed with each local health and social care community. These will be drawn together in eight regional mental health development programmes and will demonstrate linkage with other key strands of the modernisation agenda.

National support

In acknowledging the challenge of implementation, national support will be provided through:

- **the NHS Mental Health Modernisation Fund**, which has provided £40 million to promote new health service developments this year. This includes £5 million for development teams to support implementation of this Framework across the NHS and social care, providing help for organisational and professional development at a local level

- **the Mental Health Grant**, which has provided £38 million for adult social services this year

- **five national programmes**, set out in Section five, to underpin implementation: finance, workforce planning, education & training, R&D, clinical decision making support systems and NHS Information strategy

- **clear delivery outcomes and value for money**. The Modernisation Fund supports mainstream investment in mental health services. It does not replace it. New investment must produce improved outcomes for patients and service users

- **action orientation** - early action to address serious shortfalls as well as a firm costed strategy taken forward in health improvement programmes and joint investment plans. Early action has already been achieved through national targeting of the Modernisation Fund, particularly in relation to secure beds

- **support and understanding by all stakeholders**, service users and patients, carers, social care staff, clinicians, managers, trust non-executives and local authority elected representatives

- **engagement of primary care**, fully involving primary care groups and primary care teams, ensuring an integrated service with an efficient balance of provision between primary and secondary care and a clear understanding of the impact of the National Service Framework on primary care services

- **promotion and support of leadership and management development**, achieving safe, sound and supportive mental health services needs strong leadership and positive management

- **delivery through partnerships**. The successful delivery of mental health services by social services, primary care and NHS trusts will result from full joint working between them and with service users, patients and carers

- **effective service networks**. A scarcity of special skills and training opportunities means that ways must be found to share them

- **secure services at every level**. Knowledge and experience of commissioning and managing secure services and networks is limited. So that the clinical and financial risks are managed effectively, all local health communities need to ensure that adequate skills are available locally.

Preparing for implementation

The Government's strategy for mental health, *Modernising Mental Health Services*, gave a clear indication of the national priorities for mental service development and, combined with the results of the national stocktake exercise in the autumn of 1998, will have given local health and social care communities a clearer idea of the way ahead. The National Service Framework confirms what is expected of a local strategy: each local health and social care community will need to undertake further detailed preparation for delivery between now and April 2000 within the context of developing their health improvement programme and joint investment plans.

As a guide to the action which will need to be taken, preparation for implementation can be divided into six phases:

1 Laying the organisational groundwork for the development of an implementation strategy

Some of this groundwork will have been undertaken prior to publication of the National Service Framework and it will include:

- identifying and involving key local partners

- implementing a communication plan quickly and appropriately to inform local partners of the value, principles and broad standards of the National Service Framework

- agreeing an accountability structure for the production of a local National Service Framework implementation plan

- agreeing an outline process to develop a local implementation plan by April 2000.

2 Establishing a multi-agency National Service Framework local implementation team

To function adequately this local implementation team must:

- enjoy the recognition and trust of all local mental health partners

- have a named operational lead, with a clear remit and explicit accountability arrangements

- be adequately resourced to be able to deliver the implementation plan in a timely way

- have access to adequate information on which to begin to develop a local strategy.

3 Identifying priorities for service development to meet the National Service Framework standards along with any organisational and personal development required to underpin effective and efficient delivery

A local service development plan should be based upon a methodology agreed between all the partners for ordering priorities and contain:

- a service map of all mental health services provided to the local population

- a statement of priorities, which reflect the national milestones and are reflected in the ordering of local milestones

- a single financial statement for each health authority and social services, setting out for a specific period all combined sources of available and anticipated funding

- a comprehensive, costed plan for service developments with milestones submitted for consideration in the local health improvement programme and joint investment plan.

4 Ensuring organisational fitness to deliver the National Service Framework through a whole system approach

To do this, the local implementation team will need to:

- audit mental health services on a range of elements including: service user and carer involvement, partnership working, including with criminal justice agencies, the development of clinical governance, arrangements for Best Value, workforce policies, information systems, monitoring and evaluation and communications

- review the arrangements for managing the commissioning process, specifically in relation to primary care groups and primary care teams, and joint provision of services; recommending change where indicated

- produce a strategy to address the organisational and system changes envisaged, containing milestones which match the emerging milestones for the service development and professional development needs of the National Service Framework and other national strategies

- introduce systems to monitor progress of the strategy based on new Performance Assessment Frameworks, the continuing work of the Social Services Inspectorate, the work of the Commission for Health Improvement, the Mental Health Minimum Data Set, the Audit Commission, and the National Survey of Patients.

5 Producing a professional development strategy

It is likely that in any health and social care community there will be a shortage of some skills and that the balance of existing skills will need to be adjusted. There are likely to be resource implications related both to training and workforce.

The professional development strategy will need to address:

- the requirements of clinical governance, which will ensure continuing professional development, lifelong learning and a service-led programme of post qualifying training

- costed workforce and recruitment requirements for the strategic period to meet capacity and capability deficits

- short term needs for professional, clinical and management development, in-house, regional or national training provision

- education and training commissions: local education and training consortia, which bring together all local employers to plan and commission education and training, and sustained workforce development opportunities

- leadership programmes

- milestones for achievement which match the emerging milestones for the service development needs of the National Service Framework and other national strategies.

6 Producing the final strategic plan by April 2000

A comprehensive strategy for implementation of the National Service Framework should set out:

- local service gaps, as identified against the National Service Framework standards

- immediate short term action required

- milestones which fully reflect service gaps and National Service Framework priorities for development, in the context of other NHS and local authority strategic priorities

- financial cycles and sources including the Modernisation Fund for Mental Health and the Mental Health Grant

- planning processes including health improvement programmes and joint investment plans

- joint performance assessment of the plan.

Clinical governance and improving practice

Local implementation teams will need to harness the increasing body of evidence that shows how to improve quality of care through changing professional practice and service delivery. Clinical governance provides the framework for this in the NHS.

The evidence on changing clinical practice demonstrates that:

- the quality of care depends on the interaction between the clinician, the patient and the organisation within which care takes place. Greatest change comes from using multiple, co-ordinated methods for influencing behaviour

- attempts to change practice are more likely to succeed if there has been a systematic attempt to diagnose the barriers to change, and this is used to guide the change strategy

- successful change needs a planned approach to the dissemination of information

- there are a range of proven approaches to influencing clinical practice which should be fully exploited by clinical managers and educators planning strategies for change.

Clinical Governance: Quality in the new NHS sets out the Government's programme of modernisation and achievement for the NHS and outlines the key steps that should be undertaken.

Key local delivery dates

September 1999	Social services departments submit Mental Health Grant spending plans to Department of Health, with summary details of local mental health strategy updates. Common information core data returns made.
November 1999 to February 2000	Social care regions and social services performance assessment process - including a key focus on mental health.
November 1999 to January 2000	NHS Service and Financial Framework process. Local authorities and health authorities put forward bids to Department of Health for 1999 Health Act flexibilities, to start from April 2000.
December 1999	Common information core data returns made.
March 2000	Joint investment plans mental health services for working age adults submitted to Department of Health by health authorities and social services. Health improvement programmes submitted to NHS Executive regional offices, incorporating mental health as a priority. Community care plan updates produced. Common information core data returns made. Long term service agreements for mental health agreed by 1 April. National Service Framework local delivery plans submitted to NHS Executive regional offices and social care regions. Regional mental health development plans agreed.
March 2001	Regional mental health development plans updated.

4.0 Ensuring progress

- **assessing performance**

- **national milestones**

Introduction

The *Performance Assessment Framework for the NHS*, published in April 1999, covers six domains of performance:

- improving people's health

- fair access to services

- delivering effective health care

- efficiency

- the experience of patients and their carers

- health outcomes.

Each health authority will make an annual performance agreement with its regional office, covering all the key objectives of the health authority for the year, and incorporating the plans set out in the Service and Financial Framework. Annual accountability agreements between each health authority and its primary care groups will contain key targets, objectives and standards for service delivery, consistent with national priorities and the local health improvement programme, embodied in long term service agreements.

The Commission for Health Improvement, an arm's length body, will take forward a programme of systematic reviews of local services, in partnership with the Social Services Inspectorate and the Audit Commission. These reviews will specifically cover the implementation of each National Service Framework. The Commission, with the Social Services Inspectorate, will oversee arrangements for investigating serious incidents in mental health services.

The Performance Assessment Framework for personal social services is organised in the five *Best Value* performance domains:

- national priorities and strategic objectives

- cost and efficiency

- effectiveness of service delivery and outcomes

- quality of services for service users and carers

- fair access.

The final performance indicators for 1999/00 were confirmed in July 1999. The data for 1998/99 will be published in November.

The duty of *Best Value* will be introduced for all local government services from 1 April 2000. Each local authority will draw up and publish a programme of *Best Value* performance reviews which will cover all services over a five year period. These will:

- challenge why and how a service is provided

- compare the authority's performance with that of others across a range of national indicators

- consult with service users, their carers and local taxpayers and businesses

- embrace fair competition as a means of securing efficient and effective services.

All local authorities will develop *Best Value* performance plans covering all their services and publish these by 31 March each year. The plans will identify objectives, performance indicators and targets which are consistent with those which have been nationally specified and local priorities.

The Social Services Inspectorate (SSI) and the Audit Commission will review each local authority's social services functions once every five years, combining in joint reviews the practice and service expertise of the Inspectorate with the value for money expertise of the Audit Commission. Each review looks at the performance of an authority across the whole of its social services responsibilities, and produces a published report. The SSI's inspection division also conducts three focused inspections in each authority every five years, one of which will encompass adult services. One in two of adult services inspections look at mental health services. SSI inspections consider and sign-off local authority reviews. Inspections may also lead to the use of new powers of intervention if services are found to be failing.

SSI regional offices will also carry out bi-annual monitoring to inform annual reviews of progress against national priorities, working with the District Auditor to consider and agree the social services elements of *Best Value* performance plans.

Where concerns are raised about services, the Secretary of State can order targeted inspections of local authorities.

Joint performance assessment
Three interface indicators have been included in the Performance Assessment Frameworks for both health and social services, and will be monitored jointly by the NHS Executive regional offices and social care regions. One of these relates to mental health - the emergency psychiatric readmission rate.

Performance indicators

Performance indicators measure:

- input, such as the allocation of specific resources

- process, such as the establishment of new and better services

- outcome, such as health improvement, social functioning, service users' and carers' experience of services, and health outcomes.

The use of a balanced range of indicators improves the reliability of the overall assessment, and reduces the risk of perverse incentives. At the same time services must not be overburdened with too many targets and indicators.

In the past, measurement has focused on input and process rather more than on outcome. Better outcome measures are required. A set of 20 outcome indicators for severe mental illness, shown in Annex A, are recommended by the Working Group convened under the auspices of the National Centre for Health Outcomes Development. None is currently available nationally, although some could be developed with improved information systems - either nationally or locally.

Where resources or processes are known from research to result in better outputs and outcomes, they can provide very useful measures of short and medium term progress, and act as surrogate measures of output and outcome.

Service performance should be assessed to ensure that services are inclusive, equitable and non-discriminatory. Most services already collect and analyse information by age and gender. However, ethnicity monitoring is not satisfactory throughout the NHS, and will be given greater priority, especially across mental health services where race remains a key issue.

Local authorities are also expected to collect information and demonstrate that services are equitable and inclusive. Efforts are being made to measure the fairness of access to all social services through the inclusion of a number of ethnicity indicators in the Social Services Performance Assessment Framework. Local authorities will be expected to compare the indicators with those of other authorities and work to improve them. An indicator will soon be developed to ensure that individuals who speak English as a second language are able to access services as well as the rest of the general population.

The following criteria for high-level performance indicators have been informed by the consultation undertaken to develop the performance frameworks for health and social care services, and the report of the External Reference Group.

Indicators should:

- be specific, measurable and fit for purpose

- be attributable - that is, relate to the target activity for which the standard is set

- be evidence-based

- be accessible for professionals, service users and carers

- be consistent with the performance frameworks set out by the Government for health and social care services

- cover a range of input, process and outcome measures

- avoid perverse incentives

- be useable and timely

- be supported by existing and future data sets.

National assessment of performance

A small number of high-level performance indicators will be collected, analysed, interpreted and published nationally. In addition, local health and social care communities will wish to assess performance using a wider range of indicators. Section two proposes local milestones for each of the standards and service models. Most of these relate to inputs and processes, where health and social care communities and their regions will need to assure early progress, and where data can be analysed at a local level. The outcome measures currently available can be measured only nationally. The numbers are too small to show significant trends over time at local level.

These high-level performance indicators will need to cover inputs, process and outcomes. Where possible they will make use of existing data. In some cases new data will be required, and new indicators will have to be developed. The work to establish a set of high-level performance indicators will be taken forward within the context of NHS and Social Services Performance Assessment Frameworks.

The following are proposed for further development:

Performance indicators	Rationale	Availability of data
Measures of the psychological health of the general population	Best measure of population health outcome	Data available through National Psychiatric Morbidity Survey. Monitored six yearly - first survey in 1994
Suicide rates - overall suicide rate, plus rates by age, gender and race, and specifically for prisoners	National target within *Saving lives: Our Healthier Nation*	Data available through Office of National Statistics (published mortality data) and the National Confidential Inquiry into Suicides and Homicides
NHS Direct: - includes advice on mental health problems - networked to specialist mental health lines - able to provide mental health advice in first language of caller	Government commitment	Data collected through *NHS Direct*
Percentage of those admitted for whom single sex inpatient accommodation is available	Government commitment	Data collected through *NHS Charter*
Prescribing of antidepressants, antipsychotics and benzodiazepines monitored	Critical indicators of the quality of care across the whole mental health system	Will be monitored through the Mental Health Minimum Data Set
Arrangements in place to monitor access to psychological therapies	Critical indicator of care across the whole mental health system	Data will be collected through regional office monitoring
Percentage of all inpatients deemed to be in a hospital bed when they need not be, or deemed to be placed at an inappropriate level of security	Prerequisite for the efficient use of resources, and for improving access to the appropriate level of mental health support	Data not currently available Will need to develop national method of collating local reviews
Adjusted unit cost of local specialist mental health services	Critical indicator of service efficiency	Data already collected with NHS high-level performance indicators

Performance indicators	Rationale	Availability of data
Psychiatric emergency readmission rate	Indicates the effectiveness of care planning; and the capacity of alternatives to hospital care	Data already collected within Performance Assessment Framework Will be in the Mental Health Minimum Data Set
Measures of the experience of service users and their carers, including those from black and Asian communities. This should include: - evidence of the appropriate care of African-Caribbean service users - evidence of adequate access to ensure better assessment of mental health problems in the Asian community	Critical indicator of service delivery Particular concerns about cultural competence need to be addressed	Data not currently available An early priority for the National Survey of Patients Local surveys may also be required
Carers' needs assessed, services provided, and plans regularly reviewed	Prerequisite for safe, sound and supportive mental health services, and to meet carers' needs	Data not currently available New arrangements will be required
Protocols agreed and implemented for the management of depression and postnatal depression, of anxiety disorders, of schizophrenia, and of those who need referral to psychological therapies	Critical indicator of the quality of primary mental health care, and of the whole mental health system	Data not currently available Will be collected through regional office monitoring
Care management and care programme approach fully integrated for assessment, care planning, and review	Prerequisite for safe, sound and supportive mental health services, and for the efficient use of resources	Data not currently available Will be collected through regional office monitoring

Three of these performance indicators, the psychiatric emergency readmission rate, the suicide rate and the adjusted unit cost of specialist mental health services are currently included in the NHS High-Level Performance Indicators Set. More information can be found on the Department of Health website: **www.doh.gov.uk/indicat/nhshlpi.pdf**.

The arrangements to encompass new high-level performance indicators for the National Service Frameworks need to be consistent with the overall development of the Performance Assessment Frameworks for health and social services. The first set of high-level performance indicators for mental health will be published in 2000, for local action from April 2001.

As part of the development programme, these indicators will be improved as better data become available.

Local health and social care communities will use the information contained in the indicator sets to:
- review the performance of local services
- compare local performance with that of similar areas and identify areas for improvement
- strengthen the emphasis on quality and outcomes in local health improvement programmes and local service and accountability agreements
- involve the service users of local services by incorporating the indicators into existing arrangements for public accountability, providing information about the performance of local services for patients, service users and carers, and the public
- share information about achieving good results with other organisations
- secure improvements in the quality and accuracy of data collected routinely within the NHS and social services.

National Milestones

Several commitments have been made already:
- *Saving lives: Our Healthier Nation* sets the target of a reduction in the suicide rate by at least one fifth by 2010
- *NHS Direct* will be rolled out to cover 60% of the country by the end of 1999 and the whole of England by the end of 2000
- the Government is committed to removing mixed sex accommodation in hospitals and no new mixed sex wards will be approved. By the year 2002, 95% of health authorities should have removed mixed sex accommodation
- the Public Sector Agreement between the Department of Health and the Treasury requires a reduction of two percentage points in the rate of psychiatric emergency readmissions by April 2002, from 14.3% to 12.3%.

In addition to these commitments, the following national milestones should be achieved:

National milestone	Target	Data

• Health improvement programmes should demonstrate linkages between NHS organisations and partners to promote mental health
  - in schools, workplaces, and neighbourhoods
  - for individuals at risk
  - for groups who are most vulnerable
 	
and to combat discrimination and social exclusion of people with mental health problems
	All health authorities by April 2000	NHS Executive regional offices and social care regions monitoring of health improvement programmes

• Clinical governance report	All health authorities by the end of 2000	NHS Executive regional offices monitoring of health authorities

• Protocols agreed and implemented between primary care and specialist services for the management of
  - depression and postnatal depression
  - anxiety disorders
  - schizophrenia
  - those requiring psychological therapies
  - drug and alcohol dependence
	All health authorities by April 2001	NHS Executive regional offices monitoring of health improvement programmes

• Prescribing rates of antidepressants, antipsychotics and benzodiazepines monitored and reviewed within the local clinical audit programme	All health authorities by 2001	NHS Executive regional offices monitoring of health improvement programmes
• Service users with severe mental illness have an integrated assessment, care plan, with a care co-ordinator responsible for implementing, reviewing and explaining the care plan	All health authorities by April 2000	CPA review returns, which will be integrated into Mental Health Minimum Data Set
• Service users on enhanced CPA have a written care plan which explains to them, their carer and their GP, how to contact specialist mental health services round the clock	All health authorities by April 2001	CPA review returns, which will be integrated into Mental Health Minimum Data Set
• Assertive outreach in place for service users on enhanced CPA and at risk of losing contact with services	All health authorities by April 2002	NHS Executive regional offices and social care regions monitoring of health improvement programmes

National milestone	Target	Data
• Planned increase in medium secure beds	300 extra beds by April 2002	Common Information Core
• Increase in percentage of community mental health teams, which integrate health and social services staff within a single management structure	Increase of 50% over 1999/00 baseline by April 2002	Data not currently available. Will be collected through NHS Executive regional offices and social care regions monitoring

In addition, local health and social care communities need to demonstrate progress on workforce and information.

National milestone	Target	Data
Local workforce strategies, within a national framework, which ensure:		
• A review of local workforce issues to identify pressures and priorities, including the action needed to match workforce to local community	All health authorities and local authorities by April 2000	Data not currently available. Will be collected through NHS Executive regional offices and social care regions monitoring
• An education and training plan which encompasses recruitment to training grades, continuing professional development, clinical skill acquisition, lifelong learning and team development	All health authorities and local authorities by April 2001	Data not currently available. Will be collected through NHS Executive regional offices and social care regions monitoring
• A retention strategy including measures to tackle stress and to improve working conditions, and provide proper supervision and appraisal	All mental health organisations* by April 2000	Data not currently available. Will be collected through NHS Executive regional offices and social care regions monitoring

*   Health and social care commissioners and providers of specialist mental health care, including independent sector providers.

National milestone	Target	Data
Local information strategies, within a national framework, which ensure:		
• An action plan is completed to implement information systems to support those managing the care of all on CPA, including access on a need to know basis across organisational boundaries; and implementation of the Mental Health Minimum Data Set by March 2003	All mental health information systems by April 2001	Data not currently available. Will be collected through NHS Executive regional offices monitoring
• An annual review is conducted of the appropriateness of bed use and recommendations are implemented	All mental health organisations by April 2000	Data not currently available. Will be collected through NHS Executive regional offices monitoring

Together with local milestones, these high-level performance indicators and national milestones will ensure the initial progress towards achieving the improvements in quality signalled in this National Service Framework. Milestones will be kept under careful review, and will be rolled forward over time.

5.0 National support for local action

- **key underpinning programmes**

Introduction

To achieve the National Service Framework's standards, some underlying issues will need to be tackled. Mental health services require an accessible knowledge-base and need to build key information systems. It will also be vital to deploy resources effectively and efficiently.

Much of the action to implement this Framework must be taken locally. But nationally co-ordinated underpinning programmes will also be needed to support local health and social care communities and to tackle some of the more intractable problems of workforce and information.

National action to underpin the Framework will be vital in five key areas:

- finance: revenue, capital and estates.
- workforce planning and education and training
- research and development
- clinical decision support systems
- information

This section outlines aims, sets out the present position, and summarises the national action that will be taken.

Finance: revenue, capital and estates

Aim

To ensure health authorities, primary care groups and local authorities make the best use of resources from mainstream allocations, the Mental Health Modernisation Fund, and Mental Health Grant in delivering comprehensive local mental health services to the standards set out in this Framework.

Present position

The National Service Framework sets standards and defines service models for the promotion and treatment of mental health. Carrying through the programmes required to support local delivery of standards and models will need commitment and investment at national and local level. Vital core functions that must be in place to provide comprehensive services are:

- agreed protocols between primary care and specialist mental health services to ensure speedy access to primary care and specialist services

- agreed protocols to guide referrals for specialised services, such as medium secure care or eating disorder units

- a range of services to respond effectively to a crisis, including access to a place away from home if necessary

- multi-professional teams to assess, plan and offer effective interventions through individual care packages, including home-based treatments, and assertive outreach

- early, effective interventions for people with severe mental illness

- adequate local treatment and care facilities, including local inpatient beds, 24 hour staffed accommodation, day and residential care.

The Government is investing an extra £700 million over this year and the next two years to deliver the vision for modern mental health services as safe, sound and supportive. A joint circular issued in February on the NHS Mental Health Modernisation Fund and the Mental Health Grant 1999/00 (HSC 1999/038: LAC99(8)) set out some key steps which local and health authorities are now taking to ensure that this year's funding is directed more effectively towards services which will meet the needs of mentally ill people and their carers.

This year, the NHS Mental Health Modernisation Fund has provided almost £40 million to promote new health service developments for adults of working age:

- £9.3 million for 24 hour staffed beds

- £4.8 million for assertive outreach

- £2.4 million for antipsychotic medication

- £2.4 million for better access to services, 24 hours a day

- £14.6 million for secure beds

- £4.7 million for regional development plans

- £1.2 million for NHS Beacons to encourage innovation in mental health.

The Government has also provided £106 million this year for social care services for adults with mental illness. Three programmes are being financed by the Mental Health Grant in 1999/00:

- £13.3 million for Target Fund projects to expand and improve provision for mentally ill adults in areas of especially poor provision

- £1.5 million for the Homeless Mentally Ill Initiative (HMII) outside London. Services for homeless mentally ill people in London now come under the London Rough Sleepers Unit

- £7.1 million for selected local authorities from the Mental Health Social Care Partnership Fund.

The remaining £84 million is being made available to support the continuation of existing core grant services.

Detailed funding arrangements for 2000/01 and 2001/02 will be announced later this year.

Most of the large psychiatric hospitals are now closed, or set to close in the next few years. However, reprovision schemes which were completed in the 1980s may now need further reprovision to promote the development of new service models and to meet the Government's commitment to eliminate mixed sex accommodation.

As part of the local delivery plan, a detailed assessment of the quality and appropriateness of current accommodation should be undertaken, and developments prioritised. Local partners need to develop effective joint investment plans. When evaluating the need for estate, health authorities and local authorities should work closely with the voluntary sector to avoid duplication; use long term service agreements to provide greater funding certainty for providers in both statutory and independent sectors; be explicit on the quality improvements sought as a consequence of any investment; and utilise the opportunities provided by the Private Finance Initiative.

Local health and social care communities need to prioritise investment and reinvestment. In some areas the first priority must be to address gaps in current services for people with severe and enduring mental illness - 24 hour staffed accommodation, assertive outreach, home treatment or secure beds, for example. This will address issues of equity and safety, including public safety. In other areas, where specialist mental health services are adequate to meet local needs, the most cost-effective focus will be on people with common mental health problems.

National action

There are substantial variations in the spend per head of population by statutory agencies, which can be explained partly by historical patterns of expenditure, for example, the presence or absence of a large psychiatric hospital. However, these variations in funding can contribute to unacceptable variations in the quality and quantity of services provided.

Resources should be allocated in line with the different needs of local populations with the aim of driving up quality and reducing unacceptable variations in service delivery across the country. A review of resource allocations to health authorities and primary care groups was announced in November 1998; the existing formula has been fixed until 2001/02. The allocation formula for the Mental Health Grant is also being reviewed.

As a first step to inform local investment decisions, the NHS Executive has produced an adjusted unit cost of local specialist mental health services. The Department of Health has also commissioned two pieces of work:

- a review of the evidence of cost-effectiveness of the main interventions and changes proposed in the National Service Framework

- a toolkit to assist with the development of local prioritised plans based on assessing local mental health needs, mapping service strengths and weaknesses. The toolkit would be supported by resources such as the review of evidence on cost-effectiveness, and by comparative performance indicators on mental health services, as benchmark data sets are developed. A key element in these benchmark data sets should be comparable information on how mental health budgets are spent at the local level. This would move local decision makers towards the approach known as programme budgeting and marginal analysis. The results of this work will be made available by the summer of 2000.

Workforce planning, education and training

Aim

The aim is to enable mental health services to ensure that their workforce is sufficient and skilled, well led and supported, to deliver high quality mental health care, including secure mental health care.

Present position

Mental health services face a number of critical challenges:

Recruiting across the range of mental health disciplines

Reports point to difficulties with recruiting NHS mental health staff - psychiatrists, mental health nurses, clinical psychologists and therapists. Some social services departments have similar problems with the recruitment of numbers of approved social workers. The mental health skills of the primary care workforce also need to be strengthened if we are to deliver essential improvements in primary mental health care.

Building a workforce which represents the community it serves

In mental health services, perhaps more than any other, there are serious concerns of discrimination and harassment, against service users and against staff. Recruitment initiatives should attract individuals from all parts of the local community, aiming to build a workforce that reflects the diversity of the local population. Furthermore, education and training should be used to promote cultural competence in the workforce.

Staff retention

Many mental health organisations find it difficult to retain staff. High turnover rates are reported in inner city areas and parts of the service where staff encounter significant levels of stress.

Enabling staff to develop modern mental health skills and competencies

Not all mental health service staff, even those trained relatively recently, have the skills and competencies to deliver modern mental health services. For example, psychological interventions, such as cognitive behaviour therapy, and complex medication management.

Leadership

Mental health services need effective leadership within each organisation and across organisations. Mental health leaders need both to manage their organisations and work with networks in partnership, often operating across organisational boundaries. They should be able to build organisations which work with service users and carers, and which have the confidence of local communities. Staff need to be inspired, motivated and supported.

If these issues are to be addressed, we must apply the following principles and aims:

Agree clear inter-agency workforce plans

Health and social services should agree robust local inter-agency workforce plans within the local health improvement programme to achieve a sufficient skill mix and tackle present shortages and future needs across mental health services, including links with criminal justice agencies.

Create workforces that represent the communities they serve

It is crucial that the workforce should represent the community which it serves. Services need to be culturally competent, and there should be equality of opportunity for all staff.

Ensure that education and training emphasise team, inter-disciplinary and inter-agency working

All education and training should be evidence-based, and should stress the value of team, inter-disciplinary and inter-agency working. Service users and carers should be involved in planning, providing and evaluating education and training.

Provide professional development for staff

Every member of staff should be helped to identify their development needs, and have these incorporated into a personal development plan, with supervision and support, to promote quality services and foster their personal and career development.

Enable strong leadership

Senior managers should establish an organisational culture which enables leadership within mental health services to flourish, inspiring and promoting innovation with a leadership style which reflects the complexity of mental health care.

National action

Mental health providers face a number of challenges as they try to recruit and retain adequate numbers of competent and committed staff. Sustained local action is going to be essential within the local health improvement programme, using local mechanisms for workforce planning, and for education and training, including continuing professional development and lifelong learning.

The national standards and service models will require additional staff, properly trained and supported, to provide modern mental health care. More staff across all groups, including care support workers, will be needed. Skill mix issues must be addressed. Staff need improved working conditions, modernised education and training programmes, and a systematic programme of continuing professional development if we are to enable and support them to deliver mental health services. We also need a systematic approach to ensuring that the workforce is confident in teamwork, and in working with the range of partner organisations.

On social care, Ministers have asked the National Training Organisation to produce a national training strategy for the whole workforce by the autumn. The strategy will be a comprehensive workforce analysis, linking qualifications to roles and identifying any skill gaps, and will be an important part of improving the calibre of the mental health workforce.

The Government is now considering the outcome of a detailed review of professional social work training. The review has raised fundamental issues about the academic level and length of social work training, the need for inter-professional training and widening access to professional training.

As local health and social services strive to tackle their complex workforce problems, a nationally co-ordinated programme of support will be essential. The Department of Health, working with local employers, education consortia and their higher education partners, and the national training organisations, has commissioned an action plan that will clarify and endorse:

- key principles for the creation of a sufficient, skilled and supported mental health workforce

- key skills and competencies required throughout mental health services to ensure services are non-discriminatory, and sensitive to the needs of all service users and carers regardless of age, gender, race, culture, religion, disability, or sexual orientation.

The action plan will include:

Workforce planning

- to establish the current staffing position for:

    - psychiatry specialties

    - mental health nursing

    - clinical psychology

    - professions allied to medicine (therapies)

    - social work

    - linkworkers and advocates

    - care and support staff

- to establish the staffing profile in relation to the level of services needed by the population, service users and carers

- to commission work on skill mix to inform future workforce planning. This should include an advisory group on the delivery of psychological therapies through the range of health and social care staff

- to establish future workforce requirements for 2002 and 2005, and the planning assumptions to meet them

- to verify the availability of suitably qualified staff and the time-scales required to provide the necessary training.

In the meantime, the Government will issue guidance for 2000/01, which will be refined over the next 12 months.

Education and training:

- to work with statutory bodies and professional organisations, education providers, national training bodies, such as the new Partners Council, and employers to ensure that basic training programmes reflect the priorities in this Framework, and to develop lifelong learning and reflective practice

- to disseminate learning and spread good practice from the innovative projects managed by North West Regional Office, the Sainsbury Centre for Mental Health, and workshops held by the High Security Psychiatric Services Commissioning Team and NHS Executive regional offices

- to fast-track a national programme of focused education and training to address critical skill gaps, including competencies for working in a non-discriminatory and culturally sensitive way; risk assessment and management; and psychosocial interventions.

Recruitment and retention:

- to make mental health services a priority in the wider programme of work on recruitment and retention, including the need to attract and retain staff from black and minority ethnic communities

- to disseminate learning from the University of Bath project on best practice in recruitment and retention

- to ensure that employers prioritise the implementation of flexible working, such as supportive, family friendly policies, which will be kitemarked, and other approaches to improve working conditions for staff

- to tackle discrimination and harassment in the workplace, making targeted reductions in workplace accidents and violence against staff

- to identify priorities for action to support staff in managing stress and ensure that local and, if appropriate, national action is taken including mentorship, coaching and appropriate clinical supervision.

Developing and supporting leadership:

- to launch a national leadership programme to address the specific needs of mental health service leaders alongside generic management programmes

- to encourage staff to pursue and continue to develop their careers in mental health services, for example, by issuing key information with a leadership pack, including advice from current leaders at all levels of mental health services and a directory of further sources of advice and information

- to issue a training workbook for managers of mental health services in local authorities, commissioned from the Centre for Mental Health Services Development.

A Performance Management Framework will be developed to assure progress.

A coherent and systematic programme of work, refined over time, is essential. It will need strong national leadership to confront enduring problems and achieve much needed progress. It will underpin but not take the place of action only local mental health services can deliver. The Regional Mental Health Development Programmes will ensure there is a strong link between local and national action.

An action team, chaired by an experienced mental health services chief executive, has been established, to provide national leadership in developing and taking forward the workforce action plan. Following consultation, the team will undertake an assessment of the workforce implications of the National Service Framework and will provide an interim report by March 2000

Research and development

Aim

To develop the knowledge-base for mental health services, making the knowledge accessible to clinicians, practitioners, managers, service users and carers, and others making decisions about mental health services.

Present position

The Department of Health has sponsored mental health research and development through:

- the Policy Research Programme
- the NHS R&D Programme
- the Forensic Mental Health Research Programme
- R&D Support for NHS Providers.

There is also an increasing focus on dissemination, to ensure that new and significant evidence is used by those responsible for mental health services.

Policy Research Programme

Recent studies have included the mental health aspects of primary and secondary care; suicide; social care; legislation; the criminal justice system; ethnicity and mental health; the development of community services; and interagency working. Information on current research programmes and initiatives can be found on the Department of Health website: **www.doh.gov.uk**.

NHS R&D Programme: new structure

Key priorities for mental health were identified as part of the NHS R&D Mental Health Programme, which was the first national priority. These included prevention, needs assessment, community care, residential care and training of health care professionals. Thirty three projects costing £5 million have been commissioned, and thirty one are now complete.

The NHS R&D Programme is now being grouped around three main areas of work:

Health Technology Assessment (HTA): to deliver high quality research information on the costs, effectiveness and broader impact of health technologies for those who manage, work in and use the NHS. It defines technologies broadly to include methods to promote health, prevent and treat disease and improve rehabilitation and long term care.

Service Delivery and Organisation: to produce and promote the use of research evidence about how the organisation and delivery of services can be improved to increase the quality of care, ensure better outcomes, and contribute to improved population health.

New and emerging applications of technology: to promote the use of new or emerging technologies to develop healthcare products and interventions to enhance the quality, efficiency and effectiveness of health and social care.

These three main programme blocks are supported by a fourth programme of work on methodology, addressing the most important methodological challenges to developing work of relevance to NHS policy and practice.

Finally, a fifth programme of work, looking at the ways in which service users can influence the research agenda, also supports the three main programme blocks. Consumer representatives are included on all HTA priority setting groups, and it is intended that learning from this is generalised within other programmes of work.

Forensic Mental Health Research Programme

Forensic mental health was brought into the NHS R&D Programme in April 1999, building on the work of the High Security Psychiatric Services Commissioning Board.

The programme's broad scope covers needs assessment for mentally disordered offenders in a range of settings from primary care to prisons; community-based management; evaluation of therapeutic communities; and the evaluation of other settings with varying degrees of security.

R&D support for NHS providers

Since 1998, allocations have been made for R&D support for NHS providers from an R&D levy, supporting a number of non-teaching and community NHS trusts and general practices, as well as teaching hospitals.

A wide range of mental health research is pursued in the NHS, and held in the National Research Register, which now has over 1,000 mental health projects on record. This research has informed the development of the National Service Framework.

A review led by the Central Research and Development Committee of the NHS has been established to ensure that the NHS R&D levy is consistent with the principles set out in *The new NHS*. This review is supported by a series of Topic Working Groups. Dr Peter Kennedy, former chief executive of York Health Services NHS Trust, chairs the group which is reviewing mental health R&D, and there has been a close working relationship with the developmental work on the Mental Health National Service Framework.

Dissemination

Information on findings from all Department of Health research will be made available through the research and development outputs database announced in *The new NHS*, and in the National electronic Library for Health, announced in *Information for Health*.

Links to other research funders

A National Forum, chaired by the Director of Research and Development, brings together all major health R&D funders to promote coherence, and good relationships with the NHS. The Department also conducts bilateral discussions with the main funders.

The Department has published a *Statement of Partnership* on non-commercial R&D in the NHS [221] (V), funded by charities and universities. It requires the funder to take account of the priorities and needs of the NHS, and to encourage researchers to do so.

Closing the loop

The Government's quality agenda described in *A First Class Service* aims to ensure that research outputs are taken fully into account by those developing services. Sound and accessible research evidence will be readily available from the National electronic Library for Health. Development of the NHS Learning Network will also help and will feature in the implementation of the mental health strategy and the National Service Framework. The Commission for Health Improvement will monitor quality and identify gaps in research evidence, helping to update R&D programmes.

National action

Commissioned papers on mental health research

A series of expert thematic reviews of Department of Health funded mental health research are underway. These will be published in the autumn and made available in both paper and electronic format.

Recommendations of the Mental Health Topic Working Group

In future, Department of Health investment in mental health R&D will focus on the knowledge-base required to implement the National Service Framework. The Mental Health Topic Working Group will complete its review this autumn.

Research priorities are likely to include:

- on service delivery and organisation:

    - evaluating the individual and collective performance of the component parts of the National Service Framework

    - investigating variations in the use of inpatient beds, and their implications

    - investigating ways to enhance staff morale, retention, recruitment and performance, and thereby improve service user engagement and outcomes

- on clinical and practice interventions:

  - evaluating the effectiveness and cost-effectiveness under usual service conditions of psychological and psychosocial interventions

  - comparing the outcomes for self-harm between different types of services

  - assessing relative cost-effectiveness, service user satisfaction and concordance rates of
    - atypical antipsychotic drugs
    - newer antidepressants
    - complementary therapies

    compared to standard management

  - evaluating the better management of antisocial attitudes and behaviours, which attract the definition of severe personality disorder

- on service user involvement:

  - developing and evaluating a range of occupational activities to maximise social participation, enhance self-esteem and improve clinical outcomes

  - developing research tools with service users to assess their view on how services can best meet their needs.

Information on the outcome of further discussions and an action plan for mental health R&D will be issued to mental health services.

Clinical decision support systems

Aim

To help clinicians and practitioners to use the available knowledge to support clinical and practice decisions about individual patients and service users.

Present position

In 1997, the NHS Executive issued *Promoting Clinical Effectiveness: a framework for action in and through the NHS*. It describes how strategies should inform decision taking, to change practice and monitor the outcomes.

Sources of information supported by the Department of Health include:

The Cochrane collaboration

The Cochrane collaboration, which prepares, maintains and disseminates systematic reviews of research on healthcare, has contributed significantly to knowledge in mental health. An extensive database is incorporated in the Cochrane library, containing over 150,000 controlled trials, 126 complete reviews and 74 protocols with information on mental health. The Cochrane library also published a Database of Abstracts of Reviews of Effectiveness (DARE), which includes 39 references to mental health. Four main Cochrane groups are working on:

- dementia and cognitive impairment

- depression, anxiety and neurosis

- developmental, psychosocial and learning problems

- schizophrenia.

Work in progress includes a review of therapeutic communities in psychiatric and other secure settings, commissioned by the Department of Health and conducted by the Universities of Nottingham and Manchester; and a review of neuroleptics in schizophrenia, commissioned as part of the Health Technology Assessment Programme for the NHS Research and Development Programme.

The NHS Centre for Reviews and Dissemination

The NHS Centre for Reviews and Dissemination at the University of York provides information through systematic reviews, principally in the areas of effectiveness and cost-effectiveness. The Centre has published three *Effective Health Care Bulletins* of relevance to mental health: depression in primary care (1993); mental health promotion in high risk groups (1997); self-harm (1998); and one on schizophrenia is due later this year. It has carried out a number of systematic reviews relating to mentally disordered offenders, which will soon be published.

PRODIGY

Prescribing RatiOnally with Decision support In General practice studY (PRODIGY) is a computerised prescribing decision support system for general practitioners. It provides information for patients, supports the regular review of clinical management, and presents prescribing recommendations as well as advice on non-drug treatments for a range of conditions.

PRODIGY is now being rolled out to all general practitioners, and will provide on-screen information for the medical practitioner on effective interventions.

Clinical evidence

This is a very recent initiative designed to provide an evidence equivalent of the national formulary. Clinical guidelines will be updated every six months, and at present covers about 70 common conditions, including mental health problems.

Health Needs Assessment

The Health Needs Assessment on mental illness is being revised and will be available later this year. A Health Needs Assessment on prison health care will be available shortly.

Clinical guidelines and clinical audit

These programmes of work, including the *Effective Health Care Bulletins*, are now the responsibility of the National Institute for Clinical Excellence (NICE), together with their function to appraise new and existing technologies.

Clinical guidelines have been published on the management of violence in clinical settings (1998); and on antidepressant prescribing in primary care (1998). Clinical guidelines on psychological therapies and counselling in primary care, and on the management of schizophrenia are both due later this year. One on depression will be available by late 2000.

Work has also been commissioned from the Sainsbury Centre for Mental Health to develop the knowledge-base for the change management required to improve mental health services.

Clinical audit has been funded by resources directly to the NHS in baseline allocations, and through support to the range of professional bodies and the National Centre for Clinical Audit, which developed a comprehensive database which can be accessed via the internet.

Examples of clinical audit projects directly funded by the Department of Health include the administration of electroconvulsive therapy, Royal College of Psychiatrists; the management of violence in clinical settings, Royal College of Psychiatrists; and service users' satisfaction with CPA and risk management, British Psychological Society.

Services for people with depression are currently being reviewed by the Clinical Standards Advisory Group. Its report will be published later this year with a Government response.

The Standing Nursing and Midwifery Advisory Committee has examined nursing services in acute mental health inpatient settings, and its forthcoming report[222] (IV) will be accompanied by two sets of practice guidance[223] (V).

National action

All existing Department of Health commissioned clinical guidelines and protocols, and those currently in preparation, will be reviewed and quality assured, and then promulgated by the NHS Executive for early local use. Links will be established with the Electronic Library for Social Care (ELSC) at the National Institute for Social Work.

The future mental health priorities for both NICE and ELSC should reflect the needs of clinicians and practitioners as they begin to implement this National Service Framework.

Information strategy

Aim

To ensure that clinicians, practitioners, and all decision makers have the information which they need to enable them to meet the standards in this National Service Framework and to make best use of finite resources.

Present position

There are a number of current concerns:

- firstly, clinical information management in mental health services is poorly developed with information systems very variable. There has been little investment in information technology; and where electronic systems have been developed, this has often been led by local champions in the absence of any standardised models

- secondly, information systems in social services are also underdeveloped, especially systems which share information. Only about 40% of local authorities have adequate systems for sharing information. Progress has been hampered by delayed agreements on protocols, legal issues, and inadequate computer systems. Much of social care is now delivered in the independent sector where routine access to and use of latest evidence of best practice may be less developed than in local authorities

- thirdly, a number of independent inquiries into mental health services have rightly criticised poor communication - within and between organisations, including health, social care and criminal justice agencies.

Information for Health sets the strategic direction for information services in the NHS. For social care, the Social Services Inspectorate uses published standards to measure how local authorities collect and use information, from developing a strategy, through supporting staff operationally, to informing management decisions

Two key areas need urgent development:

- the clinical and practice evidence base needs to be more easily available to busy frontline staff. Although the knowledge-base is growing rapidly, it is rarely accessible for staff to use it as the routine basis for clinical and practice decisions.

- staff responsible for planning and monitoring services do not have some of the basic information they need. For example, there is no systematic information collected on the implementation of care planning and delivery, yet this is the central pillar that supports care management of individuals with severe mental illness, protecting the public and delivering safe, sound and supportive services. Service providers and commissioners do not have systematic information about the appropriateness with which different types of mental health beds and places are used.

These two areas need to be early priorities in the mental health information strategy. Better ways of sharing information about individuals, with safeguards to protect confidentiality and security, also need to be developed.

National action

A mental health information strategy

A mental health information strategy will build on successful local and national developments, including the Health of the Nation Outcome Scale (HoNOS); the Mental Health Minimum Data Set (MHMD), which is being piloted and will be in use by March 2003, and the development of its social care dimension; mapping of mental health social care service provision; the joint health and social care needs-based planning development programme; work on clinical terms and casemix; and expertise in communications.

The strategy will encompass initiatives such as the National Survey of Patients, where mental health will be an early priority. And a second National Psychiatric Morbidity Survey is planned for 2000, looking at people aged 16 to 74 years. In addition to a general population sample, which will be analysed by ethnicity and other individual characteristics, stratified samples will be taken to look in detail at specific settings. It will include people in supported accommodation and individuals who are homeless. The survey will encompass severe mental illness, personality disorder and self-harm, with data comparable to that collected in 1994, and it will provide early trend data.

A draft mental health information strategy, which will include forensic mental health, will be published in Spring 2000. It will focus on three streams:

- information on the knowledge-base for service delivery - the information required to stock the National electronic Library for Health (NeLH), and the access arrangements for this. The information will include clinical guidelines and protocols, and the evidence on specific interventions, all of which will need to be available and easily accessible to professionals, service users and carers and managers. The Electronic Library for Social Care (ELSC) will be co-operating with and connected to NeLH. ELSC will be funded for a further set of developments in the next year aimed at giving practitioners rapid access on-line to some of the key research findings in specific practice areas like mental health

- The Department of Psychiatry at the University of Oxford will take a lead in the development of the mental health section of the NeLH. The library will be developed as a virtual branch library focusing on information relevant for mental health professionals and others. Its short term aims are on the web at: **www.psychiatry.ox.ac.uk/cebm/nelmh**

- information about individual patient care - through the development of electronic patient record (EPR). This will include data that constitute the minimum clinical record - the MHMD will be delivered from this data source. Data in the EPR will be encoded and structured to limit access to those defined as having a need to know; electronic messages will be defined to ensure accurate transmission and receipt.

The wider issues of confidentiality and security involved in communicating with other professionals will be addressed. Quality of life measures, to complement professionally derived measures of health and well-being, should be included.

- information to support management decision making - analysis and interpretation of the data collected through the EPR. In the medium term it is likely that these analytical processes will use information derived from the platform developed by the MHMD, clinical terms and casemix groupings. Together these will support a healthcare framework to measure needs, resources and outcomes, and high-level performance indicators, reference costs and the Performance Assessment Framework.

In the shorter term, priority will be given to better measures of local service performance, focusing on care management and the use of mental health beds and places.

Early progress on benchmarking
It is important that local services are able to work with comparative benchmarking information. Mental Health Strategies have developed an approach to NHS benchmarking, funded by the Inner Cities Mental Health Group; regional offices will ensure that all NHS mental health providers will be participating in a benchmarking group by December 2000.

For social care, the Department of Health and the social care regions have developed a methodology for local authorities to use as a self-audit tool or for joint monitoring, with health authorities or other agencies. It also contributes to information gathered at a national level.

An information strategy for mentally disordered offenders
Work is underway to develop agreed access and discharge criteria for secure mental health care, and for needs assessment to underpin the development of an information strategy for mentally disordered offenders. This work is being carried out by Dr Nigel Eastman, St George's Hospital Medical School, and Professor Graham Thornicroft, Institute of Psychiatry.

Conclusion

The National Service Framework represents an ambitious agenda for change for health and social services in England, driving up quality and tackling variations and inconsistencies in present services.

It encompasses all aspects of mental health - from mental health promotion through to continuing care. The External Reference Group established an inclusive process, engaging a wide range of organisations that have a role in improving mental health and mental health services.

The National Service Framework's standards are clear. Its service models and examples of good practice indicate how the standards can best be achieved. Action on mental health must be integrated into all local delivery systems - health improvement programmes, the development of clinical governance, joint investment plans, and the establishment of long term service agreements, for example.

Performance will be assessed through a small number of national milestones and high-level performance indicators. And local health and social care communities will also agree local milestones with their NHS Executive regional offices and social care regions.

Finally, the National Service Framework recognises the learning and development agenda - organisational, professional and personal - and the need to build capacity and capability, and to share good practice. Regional support and national underpinning programmes will support local implementation, as mental health services tackle a demanding but exciting agenda of change.

Annex A

Outcome indicators for severe mental illness

Using a variety of check lists including a health outcome model, the National Centre for Health Outcomes Development identified outcome indicators for severe mental illness which were fully specified in a standard format. Outcome indicators were grouped under nine headings relating to the aim of the intervention.

Recommendations for implementation were made for each indicator using the following categories:

A   To be implemented generally by periodic survey.

B   To be implemented where local circumstances allow by periodic survey.

C   To be implemented following IT development on a routine basis.

D   To be further developed either because link with effectiveness is not clear or the indicator specification is incomplete.

For some indicators recommendations have been given initially and in the longer term. The categories shown below are the initial recommendations but the indicators marked * should in the long term become category C and those marked ** category A.

	Category

Indicator related to reduction or avoidance or risk of severe mental illness

1   Prevalence of severe mental illness   *A

Indicator related to detection of severe mental illness early

2   Inpatient admission on detection of severe mental illness.   D

Indicators related to maintenance of function and reduction of need for hospital admission

3   HoNOS scores for a service provider population of people with severe mental illness.   *B

4   Proportion of people with severe mental illness lost to follow-up by specialist services.   C

5   Proportion of people with severe mental illness discharged from follow-up by specialist services.   *B

6   Proportion of people with severe mental illness spending more than 90 days in a given year in inpatient psychiatric care.   C

Category

Indicators related to restoration of function and reduction of relapse following hospital admission

7   Longitudinal indicators of change in item, subscale and total HoNOS scores among people with severe mental illness admitted to inpatient psychiatric care. C

8   Hospital readmission frequencies for a resident population of people with severe mental illness. C

Indicators related to promotion of independent living and well-being

9   Service user-assessed health-related quality of life for a service-provider population of people with severe mental illness. B

10   Prevalence of side-effects associated with maintenance neuroleptics within a service provider population of people with SMI. A

11   Paid employment status of people with severe mental illness. B

12   Financial status of people with severe mental illness. B

13   Accommodation status of people with severe mental illness. B

Indicators related to sustaining a collaborative approach

14   Summary of a measure of service user satisfaction with respect to a specific mental health service, among people with severe mental illness. **D

15   Percentage of CPA care plans for people with severe mental illness signed by the service users. D

Indicator related to supporting carers

16   Assessment of impact of severe mental illness on carers. **D

Indicators related to ensuring protection and good physical health of service users

17   Mortality among people with severe mental illness. *A

18   Use of non-psychiatric health care services by people with severe mental illness. D

Indicators related to ensuring protection of carers, service providers and the public

19   Number of homicides by people with severe mental illness. A

20   Incidence of serious physical injury resulting from assaults on staff and service users by people with severe mental illness. B

Footnote

Severe mental illness was defined by the working group as follows:

- there must be a mental disorder as designated by a mental health professional (psychiatrist, mental health nurse, clinical psychologist, occupational therapist or mental health social worker) **and either**

- there must have been a score of 4 (very severe problem) on at least one, or a score of 3 (moderately severe problem) on at least two, of the HoNOS items 1-10 (excluding item 5 'physical illness or disability problems') during the previous six months **or**

- there must have been a significant level of service usage over the past five years as shown by:

  • a total of six months in a psychiatric ward or day hospital, or

  • three admissions to hospital or day hospital, or

  • six months of psychiatric community care involving more than one worker or the perceived need for such care if unavailable or refused.

Membership of the External Reference Group

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Ms Marian Beeforth	Survivors Speak Out
Ms Jenny Bernard	Central Council for Education and Training in Social Work
Mr Don Brand	National Institute for Social Work
Mr Martin Brown**	NHS Executive, Department of Health
Ms Kay Beaumont	British Association of Social Work
Ms Judi Clements	MIND
Ms Bernadette Collins	West London Healthcare NHS Trust
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Dr Sarah Davenport	Salford Mental Health
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Mr Chris Heginbotham	East & North Herts Health Authority
Mr Michael Howlett	Zito Trust
Mr David Joannides	Dorset County Council
Dr Robert Kendell	Royal College of Psychiatrists
Mr Jim Kennedy**	Social Care Group, Department of Health
Ms Ethna Kilduff	UK Advocacy Network
Mr Bill Kilgallon OBE	St Anne's Shelter & Housing Association
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Mr Cliff Prior	National Schizophrenia Fellowship
Mr Tony Russell	Breakthrough
Mr Tom Sandford	Royal College of Nursing
Prof Geoff Shepherd	Health Advisory Service 2000
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Ms Geraldine White	African-Caribbean Mental Health Project
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Glossary

Key terms

Affective or mood disorders

These reflect a disturbance in mood, resulting generally in either depression or elation, which is often chronic or recurrent in nature. There are usually also associated alterations in activity, sleep and appetite. Affective disorders vary greatly in severity and include bipolar mood disorder or manic depressive illness. It may also be often associated with symptoms of anxiety.

Annual Accountability Agreements

An annual agreement, between a health authority and its local primary care groups, which will contain key targets, objectives and standards for the provision or commissioning of services. These agreements will be consistent with national priorities and local health improvement programmes. Progress should be assessed in the context of the NHS Performance Assessment Framework, using locally available information where, for example, high-level performance indicators are not suitable for use at primary care group level.

Annual Performance Agreement

An annual agreement will be made between each health authority and its regional office to cover all the key objectives of the health authority for the year. The agreement should incorporate plans set out in the service and financial frameworks, along with specific objectives concerned with the development of the health authority and primary care groups. These agreements should include an assessment of the expected influence on performance against local plans across each of the six areas of the Performance Assessment Framework.

Antidepressants

Drugs used to treat depression, and other disorders. Two main subgroups: **1** Tricyclic antidepressants: these have been used for many years, and are inexpensive but can be more dangerous in overdose. **2** Selective serotonin reuptake inhibitors (SSRIs): newer and more expensive but generally have fewer side-effects and are safer in overdose.

Antipsychotic drugs

Drugs used to treat psychosis, including schizophrenia and mania. They also have tranquillising effects, reducing agitation.

Anxiety

A mood state in which feelings of fear predominate and where the fear is out of proportion to any threat. Frequently associated with physical symptoms which include fast pulse rate, palpitations, sweating, shaking, 'pins and needles'. Anxiety disorders can include simple phobias, fear of a specific object or situation, generalised anxiety disorder, panic disorder, agoraphobia, obsessive-compulsive disorder, or post traumatic stress disorder.

Approved Social Worker (ASWs)

Approved social workers are social workers specifically approved and appointed under Section 114 of the Mental Health Act 1983 by a local social services authority 'for the purpose of discharging the functions conferred upon them by this Act'. Among these, one of the most important is to carry out assessments under the Act and to function as applicant in cases where compulsory admission is deemed necessary. Before being appointed, social workers must undertake post qualifying training approved by the Central Council for Education and Training in Social Work (CCETSW).

Assertive outreach (assertive community treatment, intensive case management)

An active form of treatment delivery: the service can be taken to the service users rather than expecting them to attend for treatment. Care and support may be offered in the service user's home or some other community setting, at times suited to the service user rather than focused on service providers' convenience. Workers would be likely to be involved in direct delivery of practical support, care co-ordination and advocacy as well as more traditional therapeutic input. Closer, more trusting relationships may be developed with the aim of maintaining service users in contact with the service and complying with effective treatments.

Atypical (novel) antipsychotic drugs

Newer and more expensive antipsychotic drugs which have a different range of side-effects from the standard antipsychotics, and particularly do not produce the neuromuscular (Parkinsonian) side-effects.

Care co-ordinator (or key worker)

A worker (team member) with responsibility for co-ordinating CPA reviews for mental health service users with complex needs and for communicating with others involved in the service user's care. Care co-ordinators usually have the most contact with the service user.

Care management

A system of organising care to vulnerable adults by local authority social services departments. It involves assessing needs, care planning, the organisation of care packages within available resources, monitoring and review and close involvement with service users and carers. For mental health service users it should be integrated with the Care Programme Approach.

Care Programme Approach (CPA)

The CPA provides a framework for care co-ordination of service users under specialist mental health services. The main elements are a care co-ordinator, a written care plan, and at higher levels, regular reviews by the multi-disciplinary health team and integration with the social services care management system. Updated and simplified guidelines, with two levels of CPA, standard and enhanced, will be published by the Department of Health in association with the National Service Framework.

Carers

Relatives or friends who voluntarily look after individuals who are sick, disabled, vulnerable or frail.

Clinical governance

A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will improve.

Cognitive behaviour therapy

A form of psychological treatment based on learning theory principles used mostly in depression but increasingly shown to be a useful component of treatment in schizophrenia.

Commission for Health Improvement

A national body responsible for overseeing and supporting the implementation of clinical governance and the quality of clinical services.

Community mental health nurse

Mental health nurse with specific expertise in working with patients in the community, in functioning in a multi-disciplinary team and in working across the inpatient/ community interface.

Community mental health team

A multi-disciplinary team offering specialist assessment, treatment and care to people in their own homes and the community. The team should involve nursing, psychiatric, social work, clinical psychology and occupational therapy membership, with ready access to other therapies and expertise, for example specialist psychotherapy, art therapy, and pharmacy. Adequate administrative and IT support is vital.

Co-morbidity

The simultaneous presence of two or more disorders, often refers to combinations of severe mental illness, substance misuse, learning difficulties and personality disorder. The term dual diagnosis or complex needs may also be used.

Compliance therapy

The frequent finding of poor compliance with prescribed treatments in individuals with severe mental ill health has led to the development of a cognitive-educational treatment package. The aim is to improve a patient's understanding of their illness and to identify and tackle reasons for lack of adherence to suggested treatments.

Depression

A negative mood state which involves a feeling of sadness. A severe depression can reach the criteria for an affective disorder (q.v.) and require treatment. Depression can frequently coexist with and complicate other physical illnesses. The most frequent disorder found in the National Morbidity Survey was a mixed anxiety-depression.

Dialectical behaviour therapy

A specific type of cognitive behaviour therapy, which includes skills training and exposure to emotional cues, found to be particularly effective in treating those with self-harm behaviour. It is delivered according to a manual to ensure adherence to effective interventions.

Disengagement

Loss of contact with services by the service user.

Dual diagnosis

Dual diagnosis and complex needs are used to describe people with a combination of drug and alcohol misuse and mental illness, a combination of medical needs, including diagnosis, treatment and rehabilitation; and social needs, including housing, social care and independent living. Some of those in this group may also have a history of offending and involvement in the criminal justice system. They are all amongst the most socially excluded.

Eating disorders

These disorders include anorexia nervosa and bulimia nervosa. They are disorders that tend to have an early onset in childhood or adolescence and are less frequently seen in males. Anorexia nervosa involves a distortion of body image in which the person believes they are much fatter than they actually are. They very carefully restrict their intake of calories, exercise to excess, are markedly underweight and may be very secretive. Bulimia nervosa involves episodic binges of over-eating, and self-induced vomiting and laxative abuse in some cases. They may maintain a more normal body weight but can have severe physical complications.

First-level advice from *NHS Direct*

First-level advice is to provide comprehensive information about services and treatments that are available locally. If necessary, *NHS Direct* will aim to ensure callers are directed to the right service, providing referral on to specialist helplines or mental health services.

Gender dysphoria (gender identity disorder)

A conviction that one is 'trapped' in a body of the wrong gender. Tends to have been present from childhood. The individual wishes to live in the opposite gender role from their biological one and often pursues the goal of achieving surgical gender reassignment.

Health Action Zones (HAZs)

HAZs are designated by the Government and help bring together local health services and local authorities, community groups, the voluntary sector and local businesses to establish and foster strategies for improving the health of local people. Twenty-six areas with a history of some deprivation and poor health amongst local residents have now been assigned as Health Action Zones.

Health and social care community

Local health authority, local authority, NHS trusts, primary care groups and trusts, and the independent sector.

Health improvement programmes

Health improvement programmes are the local strategies for improving health and healthcare. Led by the health authority, a health improvement programme will bring together the local NHS with local authorities and others, including the voluntary sector, to set the strategic framework for improving health, tackling inequalities, and developing faster, more convenient services of a consistently high standard to meet the needs of local people.

Home treatment

Treatment may be offered in a patient's home rather than in clinical settings, either by a separate team or by a community mental health team. Frequent home visits by various members of the multi-disciplinary team can lead to an avoidance of some hospital admissions and provide support to informal carers. Such services should be available at weekends and in evenings as well as during office hours.

Independent sector

Voluntary, charitable and private care providers.

Joint investment plans

Joint investment plans established through Executive Letter (97)62, are mechanisms for local and health authorities, with key partner agencies, to set out their investment intent together. They will promote transparency between statutory services and ensure more coherent investment across sectors. Joint investment plans for adult mental health are due to be produced for April 2000.

Long Term Service Agreements

Long term service agreements are between health authorities, and increasingly, primary care groups and NHS trusts on the service that should be provided for a local population. All commissioning in the new NHS now take places through long term service agreements, which replaced annual contracts in April 1999. They run for a minimum of three years and are expected to deliver improvements in health and health care. They need to reflect the development of long term relationships between primary care groups and NHS trusts, based on a shared view of the outcomes of care that are needed, and covering 'pathways of care' that cross traditional organisational boundaries. Further details can be found in *Commissioning in the new NHS (HSC 1998/198)*.

Mental disorder

Mental disorder is defined in the 1983 Mental Health Act as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'. The Act does not define mental illness, which is a matter for clinical judgement.

Mental health

An individual's ability to manage and cope with the stresses and challenges of life.

Mental Health Act (1983)

The Act concerns 'the reception, care and treatment of mentally disordered patients, the management of their property and other related matters'.

Mental Health Grant

Formerly the Mental Illness Specific Grant. Central Government funding by the Department of Health to supplement spending by local authorities on social care for mentally ill people living in the community. Its objective is to enable local authority social services departments improve the social care of people with a mental illness who need psychiatric care.

Mental Health Minimum Data Set (MHMDS)

A new Mental Health Minimum Data Set has been developed to supplement the information on mental health services currently available from the Hospital Episode Statistics (HES), the Common Information Core (CIC) and the Korner aggregated returns. The data set has been developed initially for use within the specialist mental health services, but is flexible enough for use in other settings such as primary care. The data set is person-centred and records the package of care received by an individual.

Mental health organisations

Health and social care commissioners and providers of specialist mental health care, including independent sector providers.

Mental health services

Specialist provision of mental health and social care provision integrated across organisational boundaries.

Mental illness

Range of diagnosable mental disorders that excludes learning disability and personality disorder.

National Institute of Clinical Excellence (NICE)

Established in April 1999, the Institute is responsible for promoting clinical excellence and cost-effectiveness, producing and issuing clinical guidelines.

NHS Mental Health Modernisation Fund

New investment to underpin the mental health service reforms as set out in *Modernising Mental Health Services.*

Performance Assessment Frameworks

Performance Assessment Frameworks are designed to give a general picture of NHS or social care performance. Six areas are covered for the NHS: health improvement; fair access to services; effective delivery of healthcare; efficiency; service users and carer experience; and the health outcomes of NHS care. Five areas are covered for social care: national priorities and strategic objectives; cost and efficiency; effectiveness of service delivery and outcomes; quality of services for service users and carers; and fair access.

Personality disorder

This covers a variety of clinically significant conditions and behaviour patterns, which tend to be persistent and to arise in childhood or adolescence. They are not secondary to other mental disorders but may coexist with them. The disorder will generally involve problematic relationships and may be associated with personal distress. A very small subgroup of those with personality disorder may be antisocial and dangerous.

Primary care groups

Groups of family doctors and community nurses with resources for commissioning healthcare. Their budget is based on their local population's share of available resources for hospital and community health services, the general medical services cash-limited budget, and prescribing.

Psychological therapies

Talking therapies, including psychotherapy, counselling, family therapy, and cognitive-behaviour therapy.

Psychotropic drugs

Medication used in the treatment of mental disorder.

Regional Secure Units (RSU)

Medium secure units for individuals who are thought to pose special risks, particularly of violence to others. (See **Security - medium**).

Schizophrenia

Schizophrenia is a severe psychotic mental illness in which there may be distorted perceptions and thinking, as well as inappropriate or blunted mood. Individuals with this disorder may hold beliefs that seem impossible to others.

Security

- Low: some local hospitals have wards with locked doors and above average staff ratios. Also known as intensive care or high dependency units

- Medium: units, including Regional Secure Units (q.v.), which care for patients whose behaviour is too difficult or dangerous for local hospitals but who do not require the higher levels of security available in special hospitals

- High: provided by the three special hospitals in England - Ashworth, Broadmoor, and Rampton. Their patients are often very dangerous and violent and require intensive care, supervision and observation within the most secure surroundings.

Service and Financial Frameworks (SaFFs)

Service and Financial Frameworks are annual agreements drawn up by each health authority and partners, such as primary care groups, primary care trusts, NHS trusts, social service authorities, and other local agencies, of the resources and activity needed to deliver the objectives agreed in the local health improvement programme for the year ahead. SaFFs encompass primary care, mental health, community and secondary care. They set out the planned local contribution to key national targets, including priorities in the National Priorities Guidance, and targets associated with the modernisation programme. They are examined each year, and refined in consultation with regional offices of the NHS Executive to ensure they are robust.

Service user/s

People who need health and social care for their mental health problems. They may be individuals who live in their own homes, are staying in care, or are being cared for in hospital.

Social care

Personal care for vulnerable people, including individuals with special needs which stem from their age or physical or mental disability, and children who need care and protection. Examples of social care services are residential care homes, home helps and home care services. Local authorities have statutory responsibilities for providing social care.

Substance misuse

Includes illicit drug use, such as heroin and other opiates, amphetamines, ecstasy, cocaine and crack cocaine, hallucinogens, cannabis, and prescribed drugs such as benzodiazepines, as well as substances such as alcohol. Substance misuse can cause psychological, physical, social and legal problems.

Supervised discharge

Under the 1995 Mental Health (Patients in the Community) Act consultant psychiatrists may apply for powers of supervision of patients following discharge from hospital. A supervisor, typically a community psychiatric nurse acting as care co-ordinator, has the power to 'take and convey' the patient to a place of treatment, but not to treat them.

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