DH Department of Health

The National Service Framework for Mental Health – Five Years On

December 2004

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1. Foreword

The National Service Framework (NSF) for Mental Health was published in 1999, setting out a comprehensive vision for mental health care in England. Earlier this year, you asked me to report on the progress that has been made since the NSF appeared and this document reviews what has been achieved. Officials from the Department of Health and the National Institute for Mental Health in England (NIMHE) have provided me with valuable information but in the end the report represents my personal view.

In reviewing the impact of the NSF, I have been struck most of all by the huge amount of activity that it has generated, the benefits of which are now becoming apparent. An impressive range of policy initiatives has been triggered in an area of health care that was previously neglected. Services have become increasingly responsive to the needs and wishes of the people who use them.

Specialist community mental health teams have been set up across the country, offering home treatment, early intervention or intensive support for people with complex needs. Staff numbers have substantially increased. Modern treatments are in widespread use. Most users of services report that their experience of mental health care has been positive. Suicide rates are at their lowest recorded level. It is a record of progress and achievement that I believe is unprecedented in the history of NHS mental health care.

Yet more is needed and some changes – improvements in the experience of patients from ethnic minorities, for instance – are needed urgently. This is only to be expected – we are after all five years into what was always expected to be a ten-year period of transformation.

We now need to plan for the next five years in a way that re-casts our NSF in line with the direction that the NHS as a whole is taking – towards patient choice, the care of long-term conditions and improved access to services. We need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole.

Not that we have finished the reform of specialist services. Key areas for further action are:

- in-patient care – starting with the allocation of an extra £30 million this year to improve the ward environment;

- services for people with 'dual diagnosis' – mental illness and substance misuse – the most challenging clinical problem that we face.

In the next five years, we also need to tackle:

- social exclusion in people with mental health problems, improving their employment prospects and opposing stigma and discrimination;

- services for ethnic minorities, abolishing inequalities in care and earning the confidence of people from minority communities;

- the care of long-term mental disorders, setting out a new model of mental health care in primary care;

- the availability of psychological therapies.

In addition, underlying these developments will be:

- better information and information systems;

- workforce re-design, with new roles for key staff.

These initiatives will be central to the Department of Health's programme for mental health care reform in the next few years. They will drive the work of NIMHE. They will shape the agenda for research, clinical guidelines and performance assessment.

Two things are crucial to progress in these areas. Firstly, there is the Government's continuing commitment to mental health as one of the priorities of the NHS. Secondly, we depend on the rest of the health and social care system – primary care trusts, strategic health authorities, local authorities and the Healthcare Commission – to respond to the Government's commitment, keeping mental health in the mainstream of reform and investment.

If this can be done, the ten-year period from 1999 will live up to the promise and energy of the first five years.

Yours sincerely,

Louis Appleby
National Director for Mental Health

About this report

In reporting progress on the National Service Framework (NSF) for Mental Health, I have followed the structure of the NSF itself. For each of its seven standards and for each of the 'underpinning strategies', eg finance or workforce, I have set out what has been achieved and highlighted areas for further action. This distinction is not as clear-cut as it sounds – many areas of work fall into both categories and I have then had to decide which makes more sense.

I have also had to judge what is accepted as an achievement. I have not included conferences, networks or statements of intent, however major – even policy documents are included only when they are clearly leading to action and change. Towards the end of the report, I have presented my own commentary on the key changes and challenges of the last five years and the priorities for the next five.

I have been helped enormously by the autumn assessment process, carried out for the National Institute for Mental Health in England, in which changes in services are mapped annually. The autumn assessment data for 2003, covering 2003/04, have been analysed by an independent organisation, Mental Health Strategies, and this analysis is the basis of many of the findings in this report as well as the 'opinion' boxes that are scattered through the text (the 2004 data will not be fully analysed until early 2005). In presenting data on finance, I have pulled together the work of Mental Health Strategies and a separately commissioned analysis of Department of Health financial data carried out by Professor Gyles Glover of the University of Durham – my sincere thanks to both.

Numerous individuals and organisations also gave me their views on progress under the NSF. All views were valuable. The Government's Mental Health Task Force commented that one of the most important points about the NSF was that it existed at all. After decades of neglect, it made clear the importance of mental health services within the NHS. What benefits have followed from this is the subject of this report.

2. Standard 1: Mental Health Promotion

The standard

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.*

Background

This was the NSF's first and most wide-ranging standard. It indicated a policy focus on positive aspects of mental health and well-being, and a move away from an almost exclusive concern with mental illness. It highlighted the link between stigma and social exclusion.

What has been achieved?

Prevalence of mental disorders

In 2000, a survey was carried out by the Office for National Statistics (ONS) on behalf of the Department of Health to estimate the rate of mental disorders amongst adults aged 16 to 74 living in private households.[1]

Overall, 16% of people were found to have a neurotic disorder in the week before interview. The most common of these disorders, experienced by 9% of people, was mixed anxiety and depressive disorder. 4% of people had generalised anxiety disorder, and 3% reported a depressive episode. Phobias, obsessive-compulsive disorder and panic disorders each occurred in less than 2%. Women had a higher overall rate than men (19% compared to 14%).

Of those interviewed, 26% were assessed as having a hazardous pattern of drinking during the previous year (38% of men and 15% of women), while 13% of men and 8% of women reported using illicit drugs in the year prior to interview.

A similar survey had been carried out in 1993 among adults aged 16–64[2] and the findings for this age group in the 2000 survey have been compared with the earlier one. This showed that there had been no change in the overall rate of neurotic disorder in the population. The prevalence of psychotic disorder had remained unchanged at 4 per 1,000 adults aged 16 to 64. The prevalence of illicit drug dependence had approximately doubled over the seven-year period between the two surveys.

An 18 month follow-up study[3] of people interviewed in the 2000 survey showed the extent to which individual people's mental health status had changed:

• 8% had a disorder at both interviews;

• 5%, who had no disorder in 2000, had experienced the onset of an episode;

• 8% had a disorder in 2000 but had recovered at follow-up 18 months later.

Overall, therefore, there was a reduction in the prevalence of neurotic disorder in this group, from 16% to 13%, though it is not possible to extrapolate this change to the population as a whole.

Programmes to counter stigma and discrimination

The 'Mindout for Mental Health' campaign[4] ran from March 2001 to March 2004. The work consisted of a national communications campaign of information, events and materials to highlight the stigma and discrimination that surrounds mental illness. It was aimed particularly at young people, the media and employers. The events, such as '1 in 4', an exhibition of photographs and the personal stories of people with mental health problems, achieved a high press profile. However, there was no evaluation of the impact of the campaign on public attitudes.

In June 2004, the National Institute for Mental Health (England) (NIMHE) launched a five-year plan to tackle stigma and discrimination on grounds of mental health, entitled *From Here to Equality*.[5] The programme of work is aimed primarily at young people, public services including the NHS itself and the media. Practical measures include:

• a speakers' bureau that will train and support people affected by mental health problems to take part in training initiatives and talk to the media;

• a media alert system for people to give positive and negative feedback to journalists and their regulatory bodies;

• joint work with Ofcom to monitor complaints about the portrayal of people with mental health problems.

The need for the NHS to be a model employer and to set its own house in order on stigma and discrimination is particularly important. An inquiry into the death of a doctor in London[6] made clear the need to make it easier for staff with mental illness to find the care they need. It specifically called for measures to reduce stigma within the NHS. A working group has been established on how to improve the care of mentally ill doctors and other health professionals. Guidance to the NHS on the employment of people with mental health problems has been published.[7]

Local mental health promotion strategies

91% of Local Implementation Teams (LITS) – established to drive local progress on the NSF – report that they have implemented a mental health promotion strategy, with 41% reporting good local systems for measuring its impact.

Social inclusion

In June 2004, the Social Exclusion Unit (SEU) published its report[8] on mental health, following consultation with service users and carers and a review of research and good practice. The report sets out a 27-point action plan for the development of better access to employment and social, educational and community activity. For example, it aims to:

- improve the availability of vocational advisers to people under mental health care;

- reduce the number of people receiving incapacity benefit on grounds of mental ill-health;

- make it easier for people with mental health problems to act as school governors or jurors.

Progress will be measured in a number of ways, including:

- positive shifts in attitudes towards people with mental health problems;

- year on year increase in the numbers and proportion of people with mental health problems in paid work;

- income growth amongst people with mental problems on the lowest incomes;

- increase in numbers of people with mental health problems achieving NVQ Level 2 equivalent qualification.

Services intended to promote the social inclusion of people with serious mental illnesses are increasing in number. Table 1 compares figures for 2002 and 2004.

Table 1: Services to promote social inclusion

	Number of services in autumn 2002	Number of services in March 2004
Employment and training	451	482
Day centres offering employment and training	309	326
Advice and information	337	365
Advocacy	238	263
Befriending and volunteering	141	150
Self help	341	331
Service user group	313	326
Staff facilitated service user group	155	163

Initiatives for women

A women's mental health strategy[9] has been developed, recognising that the needs of women service users were not being adequately addressed. This was followed by guidance[10] for organisations responsible for planning, commissioning and delivering services on how to bring the mental health needs of women into the mainstream. In 2003, 30 local implementation teams reported women-only day services.

All NHS trusts have been required to comply with guidance[11] on single sex accommodation – this aimed to improve the safety and privacy of female patients through women-only bathing and toilet facilities and day areas. According to 2004 star ratings,[12] 98% of mental health trusts reported satisfactory compliance.

In 2003, the National Institute for Clinical Excellence (NICE) published clinical guidance on the treatment of eating disorders, and a working party has been established to provide guidance on the commissioning of subspeciality services, including for eating disorders and perinatal disorders.

Women's secure services have been reorganised to reduce the number of women in high secure hospitals. As a result, the number of women patients in high security has fallen over the past five years from 193 to 100. The culmination of this change will be a single high secure service, at Rampton Hospital. A network of women-only medium secure units is developing across the country – these currently provide 120 beds and a further 70 are planned.

Initiatives for homeless people

Many of those sleeping rough have a mental health problem. The Department of Health (DH) has recognised this in the financial support it has made available to the national strategy for rough sleeping. This includes £7 million in 1999/2000 for mental health social care for rough sleepers outside London, and an additional £1 million for central London in 2000/02.

The Homelessness Directorate of the Office of the Deputy Prime Minister (ODPM), which now works closely with NIMHE, funds services in England to help homeless people with mental health and substance misuse problems. These include specialist workers in hostels.

By 2003, 29% of local implementation teams had community mental health teams working specifically with homeless people. There were 66 teams supporting over 3,000 people.

Opinion

'Health promotion strategies are now being implemented almost everywhere, supported by national campaign and development work. Expenditure on mental health promotion remains relatively low. There has been an increase in the number and range of services intended to promote social inclusion of people with serious mental illnesses.'

Mental Health Strategies

Areas for further action

Adequate financial investment

We need to see an increase in financial investment by local services in mental health promotion. Spending of £2.75 million was reported in 2003/04, unchanged from the previous year, and around half the sum reported in 2001/02. However, these figures may underestimate true spending – first, because they omit national initiatives and second, because spending on the activities outlined above may not be 'badged' as mental health promotion in the accounts of statutory agencies.

Although there are no directly comparable figures for spending on mental health promotion from other countries, expenditure on campaigns in England appears to be less than in Scotland (See Me), New Zealand (Like Minds Like Mine) and Australia (Stigma Watch and Mindframe).

Stigma and social exclusion

The new initiatives described above represent a major advance in policy but it is too early to see benefits.

Fewer than a quarter of adults with long-term mental health problems are in work. Over 900,000 adults in England claim sickness and disability benefits for mental health conditions, though many want to work and are capable of doing so with the right support.[8] The 2004 National Patient Survey of 27,000 adult users of mental health services in England [13] reported that only 48% of service users who felt they needed help with accommodation, and only 53% of those who needed help in finding work, received this help. Almost one-third had not received the help they wanted with benefits.

Changing attitudes is a long-term challenge. A survey commissioned by DH in 2003[14] showed that attitudes towards people with mental illness, although largely positive, had become less so since a previous survey in 2000. For example, 89% of respondents agreed that society has a responsibility to provide people with mental health problems with the best possible care – the figure in 2000 was 94%. 83% of people agreed that we need to adopt a far more tolerant attitude towards people with mental illness, compared with 90% in 2000.

The great majority of people with mental health problems represent no threat to the public and the perceived link between mental illness and public safety is a constant source of distress and frustration to them. The media are still likely to use pejorative and insulting terms in referring to mental health problems – equivalent terms of racial abuse would not be acceptable.

Initiatives for Black and Minority Ethnic groups

Services for black and minority ethnic (BME) groups have been under severe criticism and scrutiny. In particular, the report of the inquiry into the death of David Bennett [15] highlighted particular concerns over clinical practice and previous lack of progress in this area.

DH policy on BME mental health has been developed through the *Inside/Outside* [16] report and the consultation document *Delivering Race Equality*.[17] A final document will be published early in 2005, incorporating the Government's formal response to the recommendations from the David Bennett inquiry. A national steering group has been established to oversee progress, co-chaired by Rosie Winterton, Minister of State, and Lord Victor Adebowale, Chief Executive of Turning Point.

NIMHE's largest programme of work is on BME mental health. The programme focuses on better information and research, appropriate services, and community engagement. It is supported by Race Equality Leads in each of the NIMHE development centres. Money has been allocated to Primary Care Trusts (PCTs) to appoint 500 community development workers who will support the development of services that reflect the needs of local ethnic minority communities. 80 community engagement pilot projects are being funded.

A research unit, the Centre for Ethnicity and Mental Health, has been funded at the University of Warwick. The NHS University (NHSU) has agreed to give priority to the development of training for front-line staff in anti-discriminatory practice.

Perhaps most importantly, the planning guidance for the NHS for 2005/06–2007/08[18] includes a commitment to present findings on the experiences of BME service users as part of meeting its target to improve patient experience year on year.

These measures create the foundation for a long-overdue change in the way that the NHS responds to the mental health needs of BME communities. So far, however, those communities remain sceptical. Until clear signs of more accessible, more culturally sensitive services are seen – in the availability of modern treatments, the use of Mental Health Act powers, the ethnic composition of the workforce – mental health services will not have the confidence of the BME communities they serve, and of young black men in particular.

Direct payments

Direct payment schemes are an excellent means of promoting independence. However, take-up of direct payments in mental health has been very low, although it has risen a little – from 131 in March 2002 to 207 in March 2003. Possible reasons for the low take-up include lack of information and lack of help with the application process.

Positive practice

Engaging Black and Ethnic Minorities

The Cares of Life Project in Southwark (South London & Maudsley NHS Trust) aims to improve mental health services for African and Caribbean people by introducing graduate Community Health Workers to connect these communities with health care, housing, employment and education.

As well as including users and the community in decisions relating to healthcare, the project aims to enable professionals to gain a better appreciation of mental illness issues from an African and Caribbean perspective. It aims to build enduring local partnerships and social support networks to sustain people within their communities using satellite clinics. Since being established in 2002, it has mobilised the community and statutory stakeholders to determine the precise nature of intervention to be used by the Community Health Workers, and undertaken a social network analysis of partner stakeholders, including barbers, hairdressers, Black businesses, faith groups and Black voluntary organisations.

Positive practice

Experience of running a business

The First Step Trust in Lambeth, South London, has a variety of work projects for people with mental health problems and learning disabilities, including garden maintenance, cleaning and furniture restoration. Each project runs as a small business, trading with the local community (NHS trusts, local authorities and the private sector). Everyone at the project is encouraged to share in running the business. First Step Trust catering facilities provide training and employment in a Lambeth restaurant that is open to the public. The Trust has 380 workforce members across 11 projects. Most workers are on benefits, but 50% of salaried positions are held by staff who started as volunteers.

Positive practice

Social inclusion

South West London and St George's Mental Health NHS Trust employs over a hundred people with severe and enduring mental health problems on the same terms and conditions as other staff. It has increased its employment rate for this group since 1995. Evaluation suggests that for every person on the scheme, the project saved the Government £1,900 a year in reduced welfare spending and higher taxes, not including healthcare savings.

Occupational therapists and employment specialists work within the clinical teams to enable more people with severe mental health problems to access open employment and mainstream education. Ongoing support is included in care plans, with a focus on individual choice. In 2003–04, the Trust supported 271 people into open paid employment.

3. Standard 2: Primary Mental Health Care

The standard

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.*

Background

Most people with a mental health problem first seek help from primary care – a minority are referred to more specialist secondary care services. High-quality primary care is therefore the starting point for good mental health care.

What has been achieved?

New workforce

The NHS Plan, building on the NSF, proposed a new kind of staff for primary mental health care, known as graduate primary care workers. The 'graduate' referred to the likely pool of graduates, particularly psychologists, from which the new staff would be recruited. They were to be trained in brief therapy techniques for which there was good evidence of effectiveness, such as cognitive behaviour therapy (CBT). They were to be employed to provide first-line treatments within the primary care team and to support clinical governance in primary care. The NHS Plan set a target of 1,000 primary care workers to be in post by (December) 2004.

These staff are now coming into post. New education programmes are providing on-the-job training in mental health – the training is also available for existing primary care staff. The training is available at 17 higher education institutions.

In autumn 2003, 14% of LITs reported at least one graduate primary care worker in place and a further 63% had plans to introduce the role in 2004. By July 2004, there were 339 primary care workers in post and a further 258 posts funded for appointment in October. This is less than the commitment of 1,000 new staff but when strategic health authority local delivery plans for 2003–04 were finalised in July 2004, they confirmed that plans were in place to meet this target of 1,000 by the end of 2004 (see commentary).

Integration of primary and secondary care

There is evidence of progress in four important areas where primary and secondary care are expected to work closely together:

- shared registers of people with serious mental illness in 44% of LIT areas;

- shared referral protocols in 86% of LIT areas;

- shared protocols for exchange of information in 83% of LIT areas;

- specialist services in primary care settings in 72% of LIT areas.

Psychological therapy services

The number of primary care-based psychological therapy services has increased from 178 in autumn 2002 to 222 in March 2004.

There has been an increase in spending on psychological therapies nationally from £103 million in 2001/02 to £130 million in 2003/04, a real terms increase of 13%.

The National Institute for Clinical Excellence (NICE) has recently issued clinical guidelines on the treatment of anxiety-related disorders and on depression, both of which can be expected to increase the availability of psychological therapies.

Appropriate prescribing

Many people with depression receive no treatment while others may be inappropriately treated with benzodiazepine drugs. However, there has been a substantial rise in the prescribing of antidepressants in recent years, particularly for the SSRI class of drugs, with numbers of prescriptions for SSRIs more than doubling between 1997 and 2003.[19]

In 2004, 90% of PCTs scored satisfactorily on the star rating indicator referring to benzodiazepine prescribing.[12]

New contract in primary care

Under the new General Medical Services Contract, practices that meet quality standards in caring for people with mental health problems are rewarded, and PCTs can commission 'enhanced' services to provide, for example, specialist care for people with depression. The most important of the quality standards in the contract is the establishment of a register of patients with severe mental illness leading to regular (every 15 months) reviews of treatment.

The Primary Care Programme of NIMHE, working with service users and the voluntary sector, has produced information for patients about what the contract means for them, and guidance for PCTs and primary care staff on implementation.

Positive practice

During 2003/04, a development programme was delivered to local authority and NHS mental health commissioning staff working in London. Topic-based half days, based upon participants' expressed needs, covered new roles in primary care, the new General Medical Services (GMS) contract, mental health finance, modernisation and pathways of care. Participants are planning a new series of meetings at present.

Opinion

'New graduate primary care workers are coming into post, although somewhat behind target. Gateway workers are expected to be available in all areas by 2006. There has been significant progress in the integration of primary and secondary care, and substantial increases in the availability of psychological therapies.'

Mental Health Strategies

Areas for further action

Primary care worker development

Progress with the new graduate primary care workers has been slower than anticipated – full delivery of the NHS Plan commitment of 1,000 new staff remains vital. Despite the positive reports in the local delivery plans, local commissioners appear to have given a lower priority to the development of new workers than to specialist community teams (see commentary).

Self-management

Self-management is an essential component of a comprehensive mental health service, particularly in the case of long-term or recurring disorders. However, it has proved difficult to put together a convincing case for the effectiveness of self-management, on which local developments might be based. A review of the research evidence on self-help was commissioned in 2002.[20] It reported little high-quality evidence, for self-help interventions, although such approaches are clearly popular with users. A formal technology appraisal of computerised therapies was undertaken by NICE, but their report in 2003 stated that there was insufficient evidence on which to recommend them to the NHS. An early re-examination of the evidence is now planned for 2005.

Commissioning

In many areas, PCTs have developed quickly and are taking innovative approaches to commissioning – eg joint commissioning where several PCTs are working with a single mental health trust, or the redesign of care pathways in line with NHS plan team development.

However, it is a substantial challenge for over 300 PCTs to develop the knowledge and commissioning arrangements on which good mental health care depends – this has not yet happened. There is now a pressing need to support improvements in commissioning expertise. More fundamentally, concerns remain about the commissioning priority given to mental health – see section on finance.

Positive practice

Enhanced Services Specification for depression under the new GP contract:
a commissioning guidebook

This guide, published by the NIMHE North West Development Centre
(www.nimhenorthwest.org.uk), describes an enhanced service specification which points towards an
ideal model of care based on current best evidence. It is intended to assist commissioners in the
implementation of an enhanced service for depression.

It is recognised that the full implementation of this model of care may take time. Commissioners
may be required to take a staged approach to implementation, depending on local circumstances.
This service specification is not intended to be rigid, and is designed to function as a framework for
local service development. This guidance will be updated to keep abreast of current developments,
and may be usefully linked with other available guidance on mental health topics.

Positive practice

North Warwickshire and Rugby Crisis House

North Warwickshire PCT commissioned and supported service users in forming a working group to
explore the requirements of a crisis house in north east Warwickshire. The team of users, supported
by the user empowerment lead and PCT, have consulted across the area and received funding for a
property from the Strategic Health Authority. The service users have produced a mission and value
statement, aims and objectives for the house and base referral and support criteria.

The PCT made funding available to enable the team (with help from the Joint Mental Health
Commissioning Manager) to commission an independent consultant to prepare a brief with them to
tender out for an agency to find a suitable house.

4. Standard 3: Access to Services

The standard

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.*

Background

A key feature of a modern service is its availability at the time when it is needed. In addition, there were concerns among patients and carers about access at times of crisis.

What has been achieved?

New access workforce

The NHS Plan launched a new kind of role, referred to as the gateway worker, to coordinate and ensure prompt access to mental health care. Guidance on gateway workers was published in 2002.[21]

A third of LITs reported having at least one gateway worker in place in the autumn of 2003. Service mapping suggests that the majority of these staff are 'embedded' in community mental health teams. Local delivery plans now report that full national coverage of gateway workers will be achieved by the original target date of (December) 2004 (see commentary).

Round the clock access

Twenty-four hour access to services is intended to be a feature of crisis resolution/home treatment and assertive outreach teams. This is in addition to the 24-hour availability of on-call staff. In 2003, 62% of crisis resolution teams provided 24-hour cover. 70% of assertive outreach teams provided weekend and evening cover; 30% provided a 24-hour service.

NHS Direct

NHS Direct, launched in March 1998, now provides a national 24-hour nurse-led service for clinical advice and health information. It currently handles around 6.5 million calls per year and this is planned to increase to around 16 million calls by December 2006, mainly through integration with the GP Out of Hours services.

In April 2000, the NHS Direct Mental Health Team was set up to help NHS Direct respond effectively to callers with mental health problems. As a result, all nurse advisors have been trained to identify and manage mental health risk, and have access to comprehensive national and local mental health service directories.

Local protocols have been agreed for referrals between NHS Direct and local mental health crisis services. 48% of LITs now report that their protocols permit direct referrals and a further 44% have other forms of protocol. Only 9% report there is no local agreement in place.

Access to information

Access to services requires information, and 90% of local areas now provide a comprehensive directory of local services, compared to 46% in 2001. In addition, the national service mapping database provides a comprehensive picture of all mental health services throughout England, and NHS Direct provides a regularly-updated self-help guide to the most common mental health problems.

Choice in appointments

The NIMHE Access, Booking & Choice (ABC) programme has helped mental health services to address the NHS-wide booking targets. The number of people who have had the opportunity to choose and book their appointment time has increased from 0% in April 2003 to 88% in February 2004.

New money to improve crisis access

£17 million has been made available in 2004 to mental health trusts to improve access to services for people in crisis. Trusts are expected to use this sum to improve the coordination of crisis services, such as mental health teams providing liaison to emergency departments, crisis resolution teams and gateway staff.

Areas for further action

Round the clock access in primary care

Progress on access has been considerable in specialist services and through NHS Direct. However, information on access to primary care mental health services is limited, and we have no evidence of widespread change from the longstanding model of GP call-out.

Access in a crisis

Even the most available services are accessible only when people know about them. The National Patient Survey in 2004 [13] reported that only 49% knew the number they should ring in a crisis. Of those who had used the crisis number they had been given, 66% got through immediately and 20% within one hour.

Positive practice

County Durham and Darlington Mental Health Trust has implemented a full booking system, offering a free phone booking line for service users to agree an appointment time within one working day of the GP decision to refer. This has led to a 70% reduction in referrals classified as 'urgent' from primary care, a reduction in waiting times from five weeks to two weeks and a 90% satisfaction rate amongst service users using the full booking system.

Positive practice

West Norfolk PCT – the Mental Health Crisis Team was set up in September 2002 to provide a service for people who are experiencing a mental health crisis and a comprehensive, inclusive 'process-mapping' consultation exercise was undertaken, involving all stakeholder groups. Improved communication and coordination with A&E staff has led to a reduction in the waiting time to see a mental health professional in A&E. This was reduced from over four hours to a maximum of one hour.

Positive practice

SAFIRE (Swift Assessment for the Intensive Resolution of Emergencies) was set up in April 2003 to provide further assessment for patients from Manchester presenting in crisis at A&E and for whom in-patient admission seems likely. It offers a structured, well-staffed environment for a stay of up to 48 hours. SAFIRE has assessed over 300 patients and has found alternative programmes of care (without hospital admission) for over 50% of cases.

Opinion

NHS Direct has achieved full national coverage, and its mental health role is now expanding. Attendances at traditional psychiatric outpatients are now falling. Almost everywhere now provides a comprehensive directory of local services.

Mental Health Strategies

Positive practice

Cheshire West PCT Primary Care Mental Health Team

Cheshire West PCT Primary Care Mental Health team provides rapid access to mental health assessments and a range of psychological therapies in primary care to a population of 167,000.

The PCT managed team is community-based and is integrated with GP practice's ways of working. It has strengthened the primary/specialist service interface by joint working with Community mental health teams (CMHTs) and practices, and provides a single point of referral for all psychology services.

The team comprises mental health nurses, CBT therapists, graduate workers, social worker and support workers. The 'Stepped Care' approach has been implemented for patients with depression and includes guided self-help, signposting, CBT, and case management.

The team offer other interventions, including group work for anxiety disorders and post-natal depression, and a life skills course. They also offer relaxation, visualisation and breathing techniques for anxiety disorders.

Cheshire West PCT will be commissioning an 'Enhanced service for depression' from GP practices, under new GMS contract arrangements, to further strengthen and improve the practice level component of this whole system of care.

5. Standard 4: Specialist Care

The standard

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-coordinator;*
    - *advises their GP how they should respond if the service user needs additional help;*
    - *is regularly reviewed by their care coordinator;*

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

Background

This complex standard demands thorough and personalised care planning, but also services capable of responding appropriately to needs. The NSF presented the case for three new types of community mental health teams with specialist functions – assertive outreach, crisis resolution and early intervention. The NHS Plan aimed to strengthen community care by introducing these teams, and therefore to reduce the pressure on acute beds.

What has been achieved?

Assertive outreach

The NHS Plan envisaged 220 assertive outreach teams, building on the 170 teams proposed in the NSF. The target was met by the 2003 deadline and by March 2004, 263 teams were in place. These teams employ 2,282 staff providing intensive care for people with the most complex health and social needs.

Since 2002, 200 psychiatrists and 330 non-medical health staff have attended training on assertive outreach and crisis resolution. An additional 90 staff have been trained through a dedicated team leaders' programme as part of this initiative. As a result of the training programme, there are networks for teams and team leaders in some parts of the country.

A research programme has been evaluating the implementation and benefits of assertive outreach, with the aim of shaping future service developments.

Progress on crisis resolution

The NHS Plan proposed 335 dedicated teams across England by the end of 2004. These multi-disciplinary services provide 24-hour specialist assessment and treatment, enabling people to be cared for in their own homes. They are intended to provide the route into hospital for those who do need to be admitted.

In 2000, only 35 specialist crisis resolution teams existed. By March 2004, that number had risen to 168, employing 2,173 staff across the country. These teams mostly meet the criteria set out in the mental health policy implementation guide, although 64 of the 168 do not operate 24 hours a day, seven days a week. This has been an area of major new investment. Spending on access and crisis services rose from £152 million in 2001/02 to £229 million in 2003/04, a real terms increase of 51%.

The local delivery plans for 2004 report full delivery by the original target date, the end of 2004 (see commentary).

Progress on early intervention

The NHS Plan set a target of 50 early intervention teams by the end of 2004. Validated data show 41 teams nationally and local delivery plans predict full delivery by the target date (see commentary).

However, the existing 41 teams are mostly smaller than was envisaged, and employ in total only 174 staff. Only 3% of LITs considered their service to meet local needs in the 2003 autumn assessment, with a further 34% reporting some level of service, although not adequate for local needs. Spending on early intervention has risen from £3.7 million in 2001/02 to £12.8 million in 2003/04.

A major programme of research will evaluate the implementation and benefits of early intervention services.

Integrating care planning

Three-quarters of LITs now report that their community mental health services are fully integrated between health and social care, up from just 13% in 2000. Of the remaining quarter, the majority have made progress towards integration. Similarly, 80% of trusts reached the required standard on community mental health team integration in the 2004 star ratings. [12]

All LITs have made progress towards formally agreeing information-sharing protocols between local agencies, with 71% reporting this work complete in 2003, up from 53% in 2002. Exactly half of LITs have agreed transition protocols for transferring care between children's services, services for adults of working age, and services for older people – up from 21% in 2002.

Sub-speciality services

The autumn assessment process has tracked progress in providing for the needs of some specific groups.

92% of LITs report progress on agreeing roles and responsibilities between mental health and learning disability services. The proportion of LITs reporting satisfactory access to specialist services – for people with sensory impairment and mental illness, for eating disorders, and mother and baby services – rose from 27% in 2002 to 53% in 2003.

A working group has been established to provide guidance to commissioners on a range of specialised mental health services, including eating disorders, treatment-resistant psychosis and Asperger's syndrome. Guidance will be aimed at providing PCT commissioners with ready access to the information they need to support their commissioning of these services. The report of this working group will be published early in 2005.

Personality disorder services

Following publication of the guidance, *Personality Disorder – No longer a diagnosis of Exclusion*,[22] 11 new pilot services are being established across the eight NIMHE regions. The investment in these new services meets the target of 200 new specialist staff and six new outreach teams to begin the process of improving services for this challenging client group. This service development programme is supported by further investment to implement the *Capabilities Framework – Breaking the Cycle of Rejection*[23] with training initiatives to support specialist workforce development.

Areas for further action

Investment in new services

Investment in assertive outreach, crisis resolution and early intervention has not followed the intentions of the NHS Plan in all parts of the country. There are reports of the dismantling of existing services to provide staff for the new specialised teams. The most up-to-date figures for crisis resolution and early intervention suggest that the NHS Plan targets and target dates may prove too challenging. However, this year's local delivery plans present a more optimistic picture – it is vital that these plans turn into new services.

Even in the case of assertive outreach, the target for which has been met, services have been unable in one respect to meet the model set out for them in the mental health policy implementation guide: their hours of availability. Only 96 teams operate a full 24-hour on-call service.

Care plans

In the 2004 star ratings, information supplied by trusts was used for the indicator on the proportion of patients on enhanced Care Programme Approach (CPA) with copies of their own care plan. The national figure was 88%, compared to a figure of 76% in 2003.[12] However, this apparently good performance did not tally with the reports of patients themselves – in the 2004 National Patient Survey, the figure was 69%.[13]

Electronic information

Progress in developing electronic systems for handling care plans needs to pick up pace. The former Commission for Health Improvement (CHI) considered information capacity in mental health trusts seriously under-resourced.[24] Although 34% of LITs now have a regularly updated central database of care plans (up from 18% in 2002), only 13% of LITs have a single mental health electronic record spanning health and social care (up from 4% in 2002). However, a further 63% report agreed and funded plans to address this issue during 2004.

CHI found some 'considerable clinical resistance' to use of the CPA in some trusts – surprising for a policy that has been in existence for more than 10 years – and there remains work to be done to ensure consistent good practice in the process and administration of care planning. Despite these difficulties, 63% of trusts in the 2004 star ratings met the required standard on submitting care programme data through the Mental Health Minimum Dataset (MHMD).[12]

Dual diagnosis

Dual diagnosis, the occurrence of mental illness and substance misuse together, remains one of the main challenges to services. In May 2002, the DH published a dual diagnosis good practice guide[25] aimed at all those who commission and provide mental health, drug and alcohol services. The main messages of the guide were that services needed:

- joint planning between mental health and substance misuse services;

- a local strategy recognising the importance of substance misuse in mainstream mental health care, with provision of a lead clinician and training for staff.

NIMHE supported LITs in developing local plans to implement the guide.

The effect has been modest. For example, only 17% of LITs now have a dual diagnosis strategy, though this is up from 8% in 2002. While there is increasing evidence of effective partnership between drug action teams and LITs, there remains scope for improvement in the area of joint planning and commissioning.

However, assertive outreach teams provide care to many people with dual diagnosis, though their staff have often had no training in the management of substance misuse.

One fundamental problem is the lack of research evidence on which to base service development – there has been no large-scale treatment trial anywhere in the world. Now, finally, a multi-centre randomised controlled trial has begun in England, funded by the Medical Research Council (MRC) and the DH, investigating the benefits of a cognitive-behavioural intervention.

Opinion

'There can be little doubt that a base of better information is gradually being established.'

Mental Health Strategies

Positive practice

What crisis resolution services can achieve

The impact of crisis resolution services can be impressive. Newcastle-on-Tyne, for example, has already seen a reduction in the number of in-patient beds of 14%, with further reductions expected to total 22% overall. This has made possible the redevelopment of the remainder of the adult acute system. It has created the opportunity for consultant psychiatrist roles to become increasingly specialised. Out of area treatments (OATs) have ceased. Community Mental Health Teams are able to focus on continuing care, reducing crises arising within the community care system. Similarly, in Portsmouth OATs have been reduced and this has saved 200 bed days a month. See also Standard 5.

6. Standard 5: Hospital and Crisis Accommodation

The standard

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 coordinator, and specifies the action to be taken in a crisis.*

Background

In-patient services have been widely criticised in recent years, and the NSF signalled a determination to bring about improvement. In 2002, the DH issued guidance for adult in-patient care and minimum standards for psychiatric intensive care units (PICUs).[26] The task of implementing the guidance was adopted by NIMHE as one of its core programmes when it was first established in 2002.

There have been three main strands to this work:

- a series of initiatives to restore the therapeutic status of acute admission wards and redefine their role within a comprehensive system of care;

- the development of community-based alternatives to hospital admission – see also Standard 4;

- a programme of investment in medium secure, low secure and psychiatric intensive care beds, to ensure that patients needing secure care can have access to it, and do not need to remain on general psychiatric wards.

What has been achieved?

Acute in-patient initiatives

Several actions have been taken to improve what in-patient wards provide physically, environmentally and therapeutically.

In the three years from 2001/02, capital spending in mental health was between £350 million and £500 million per year (see finance section). An additional £40 million capital was made available over 2001/02 and 2002/03 for the refurbishment of in-patient wards. Examples of new units include the Sevenacres Mental Health Unit on the Isle of Wight (see photograph).

Sevenacres Mental Health Unit, Isle of Wight

Almost all mental health trusts have reported compliance with guidance on single sex accommodation, intended to improve safety, privacy and dignity on in-patient wards (see Standard 1). In 2003, the Patient Environment Action Team (PEAT) programme paid particular attention to mental health accommodation, visiting hundreds of units from small community residences to hospitals and secure units. In addition to assessing standards of cleanliness and the quality of the environment and food, PEAT assessments include whether a trust has met its obligations under the Safety, Privacy and Dignity initiative. None was assessed as less than acceptable and many were rated as good. In 2004, the PEAT programme was expanded to give a more accurate assessment of performance across a greater range of services, and many more sites were inspected. Three of the newly-inspected mental health units were found to have unacceptable standards of cleanliness but all have since made considerable improvements, and standards are now considered as acceptable.

NIMHE has supported a number of initiatives on acute wards, to increase the diversity and therapeutic standard of what is provided, based on service user needs. An acute care forum has been set up in each mental health trust, responsible for implementing a local service improvement plan, and 87% have begun working to an agreed plan of action.

In January 2004, NIMHE jointly established a project with the National Association of Psychiatric Inpatient Care Units (NAPIU) to improve service provision within PICUs and support the implementation of the national guidance. Eight project sites have been selected nationally to work as a learning network.

Education, training and continuing professional guidance for acute inpatient care was published in June 2004, in collaboration with the Mental Health Care Group Work Force Team and the Sainsbury Centre for Mental Health. This was issued as a supplement to the original acute in-patient policy guidance.

A £3 million programme of research on mental health in-patient care has been launched – the first research initiative on this area – by NHS Service Delivery and Organisation (SDO). Studies are underway or complete on:

- alternatives to traditional in-patient care;

- ward observation procedures;

- effective settings and in-patient care for young people;

- staff morale on in-patient units (literature review).

Suicide on in-patient wards has fallen – see Standard 7.

In January 2004, a national advisory and consultancy service was jointly established by NIMHE and the National Patient Safety Agency (NPSA) to support development centres, trusts, higher education institutions and individuals on the safe and therapeutic management of violence and aggression in acute care settings. This resulted in the publication of practice guidance on managing violence and aggression in in-patient settings in February 2004. In addition, a number of cross-government groups were established in March 2004 to:

- develop proposals for national accreditation and regulation of trainers and training programmes on the recognition, prevention and management of aggression and violence;

- review existing restraint techniques used in mental health settings;

- develop guidance for health and social care staff and the police on police liaison, confidentiality and the management of violence and aggression in mental health settings;

- develop a code of conduct for physical intervention trainers.

Alternatives to acute admission

The number of NHS short-stay (acute) beds for adult mental health fell from 14,420 in 1998–99 to 13,740 in 2002–03, a fall of 4.7%, while the number of NHS medium secure beds increased in the same period from 1,750 to 2,060, a rise of 18%.[27] The number of NHS admissions for all mental illness (15-64 years) fell from 135,460 in 1998–99 to 122,260 in 2002–03, a fall of 9.7%.[27] Median length of stay has been stable at around 18–19 days over the same period and average bed occupancy has remained at around 91%.[27] Taken together, these figures suggest that the pressure on acute units from numbers of admissions alone is reducing a little, but that it will have to reduce further before occupancy figures nationally fall to acceptable levels.

Perhaps most importantly, the use of the Mental Health Act has remained constant in recent years. The number of admissions under the Act was 26,909 in 1998–99 and 26,665 in 2002–03.[28] The number of people detained following admission shows a similarly stable pattern.

The NSF aimed to establish 320 24-hour staffed places by April 2001. This has been achieved. Community-based alternatives to hospital admission are now provided by 56 LITs.

Investment in secure places

The NSF indicated an intention to increase medium secure provision by 300 beds and this has been achieved (see above). The NHS Plan also set a target of developing 200 extra long-term secure beds by December 2004, to aid the movement of inappropriately placed patients out of high secure hospitals. It is expected that this target will be achieved and over 400 patients will be transferred to more appropriate accommodation by the target date.

Between autumn 2002 and March 2004, the number of psychiatric intensive care beds rose from 719 to 818, while low secure beds rose from 517 to 751.

The proportion of LITs reporting no deficiencies in the availability of medium and low secure beds rose from 14% in 2001 to 26% in 2003. The proportion reporting significant deficiencies fell from 13% to 6%. The regular financial mapping shows that the national spend on secure and high dependency care

has risen from £295 million in 2001/02 to £428 million in 2003/04 (2003–04 prices), a real terms increase of 45%.

As part of the dangerous and severe personality disorder (DSPD) programme, the NHS Plan set a target to create:

- a hundred and forty new places in high secure hospitals, 70 each at Broadmoor and Rampton. The Peaks unit at Rampton started admitting its first patients in March this year. It is expected that the Paddock Unit at Broadmoor will open in June 2005 and in the meantime, a 10-bed DSPD pilot ward is operating within the main hospital.

- seventy-five new NHS places by the end of 2004. This commitment was later revised to 45 medium secure hospital places and 30 hostel places by 2004. Forty medium secure beds and 24 hostel places will be available by December 2004 with another five medium secure beds in February 2005.

Areas for further action

Ward environment

Despite a great deal of progress on in-patient care, the physical environment in numerous units remains poor and in need of refurbishment, re-design or re-building. The 2003 CHI report on mental health [24] raised continuing concern over this.

Guidance regarding the management of substance misuse on in-patient wards is being prepared in recognition of the difficulties which drugs and alcohol use pose on wards.

Staffing levels

Success in recruiting mental health nurses generally has not extended to in-patient care. Vacancy rates for in-patient nurses remain high at 4.7%, compared to 1.9% for community nurses and there is an over-reliance on agency staff – see also under workforce.[29]

Out of area treatments

Although this NSF standard refers to treating people as near as possible to their homes, most services do not have figures for the out of area referral of acute in-patient cases. There is, however, anecdotal evidence on how out of area treatments can be reduced in individual services and this good practice needs to become universal. In Portsmouth for example, the introduction of the crisis resolution team has reduced dependency on out of area treatments and saved 200 bed days per month. Nevertheless, non-forensic out-of-area placements represent a significant part of the care system for adults with severe and enduring mental illness and there is evidence that in certain instances, the care received outside the NHS is of poorer quality despite being expensive.[30]

In the 2003 financial mapping exercise, trusts reported out of area treatments as a major cost pressure – the national total was £157 million. However, much of this was spent on high-cost low volume referrals to forensic units, rather than on acute referrals caused by a local lack of acute beds.

Opinion

'There have been large increases in the availability of NHS secure and intensive care beds. Acute care forums have been established everywhere, and work to improve the quality of care is well underway. The overall number of acute admissions is beginning to fall.'

Mental Health Strategies

Positive practice

Refocusing in Bolton

Establishing Acute Care Forums in each Trust is the key vehicle for developing and modernising acute services in line with policy guidance. One of the pioneer Forums was the Refocusing project in Bolton, which won a NIMHE Positive Practice Award in 2003. This project aimed to improve patient care and the quality of staff working lives on four acute wards and demonstrate meaningful results quickly within existing resources. A multi-professional and service user group was established, which became the Acute Forum. Whole team training days for all staff were arranged to identify the factors which contribute to poor practice and work strain for staff and develop a solutions-focused approach. As a result of the project, wards became calmer, quieter, cleaner and safer, with patient care significantly improved with no significant additional expenditure. At the same time it retained people's commitment and protected time for development.

Positive practice

The first mental health collaborative

The Northern Centre for Mental Health (NCMH) established the first Mental Health Collaborative in the UK.[31] It ran from October 2000 to January 2002, and DH policy guidelines put it forward as a positive example of how to improve acute services. Subsequently, it was used by NIMHE as an exemplar model for the development of regional practice development networks, and was highly commended in NIMHE's 2003 Positive Practice Awards.

The aim of the project was to improve the service user's experience of acute inpatient care throughout the process of admission, stay and discharge, using collaborative methodology. Twenty-four improvement measures were developed and regularly monitored to chart progress being made. In all, 29 local project managers and 37 multidisciplinary clinical teams participated, with service users actively engaged as key members of the teams throughout the whole process. There was clear evidence that its collaborative methodology was successful in improving service users' experience of acute inpatient care and achieving better clinical outcomes.[31,32,33]

Acute in-patient collaboratives have now been established in the South East Regional Development Centre (RDC) and Eastern RDC. London RDC is starting an acute collaborative focusing on substance misuse and safety issues.

7. Standard 6: Support for Carers

The standard

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.*

Background

The NSF and the NHS Plan highlighted the need for services to recognise the vital role that carers play and to use the formal processes of care planning to support them.

What has been achieved?

Expansion in carers' services

The number of services provided for carers has been increasing. The following figures (Table 2) compare the position in September 2004 with that in September 2001, when these data first began to be collected.

Table 2: Services for carers

	Number of services for carers in September 2001	Number of services for carers in September 2004	Percentage increase 2001–04
Carer support service	243	299	23%
Carer support group	144	187	30%
Day services with carer support	223	237	6%

Spending on carers' services

Spending on carers' services has also been increasing. In 2001/02, £8.6 million was spent, and this rose to £13 million in 2003/04. In 2002/03, 7.3% of Carers' Grant expenditure was on carers of people with mental health problems. In 2003/04 plans, this had risen to 9.2%. Planned spending on carers' breaks increased by a quarter in 2003/04.[34]

Carer support workers

The NHS Plan launched a major initiative on carers – setting a target of 700 carer support workers to be in place by the end of 2004. Every strategic health authority has now confirmed that it plans to deliver the mental health targets in full and on time, although this remains a substantial challenge (see commentary).

Areas for further action

Care plan standard

The commitment on care plans at the heart of this standard remains some way from being met. In the 2003 autumn assessment, only 14% of LITs reported that all carers of people on enhanced CPA had their own written care plan, although another 38% reported that over 80% had one. This means that in almost half the country, more carers need to benefit from the requirements of this standard.

Carer involvement

CHI commented that the involvement of carers in planning local services is generally much less developed than service user involvement.[24]

Opinion

'Approximately half of services now undertake assessment of the needs of most carers of people on the enhanced Care Programme Approach. More services are now available to support carers, but carers remain less involved than service users in the planning and development of services.'

Mental Health Strategies

Positive practice

In the Avon and Wiltshire Mental Health Partnership NHS Trust, many families have benefited from an intervention that aims to increase their participation in service development. They can take part in research or staff training, help to prepare a carers' information pack or coordinate a carers' support group, and sit on trust committees.

One commented, 'Receiving family intervention was like having a light turned on in a very dark, frightening and lonely place. My recovery from the effects of my relative's mental illness began when we started family work.'

Positive practice

In the Brighton and Hove area, two support workers have been funded to carry out carers' assessments. Their wide-ranging role has been to:

- meet the April 2002 target to complete carers' assessments for carers of people on enhanced CPA;
- subsequently carry out assessments for carers of people on standard CPA and take referrals from primary care;
- implement care plans, assessing eligibility criteria for services;
- provide a twice yearly, ten-week education and information programme;
- provide family support where necessary;
- provide training for those carers who wish to take part in LITs, staff training or service design and development.

Carers in the area have welcomed this initiative. One comment was, 'We would be struggling without the support of this service. There was nowhere to turn before.'

8. Standard 7: Preventing Suicides

The standard

Local health and social care communities should prevent suicides by implementing Standards 1 to 6 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.*

Background

The White Paper, *Saving Lives: Our Healthier Nation*[35] set a target to reduce suicide by 20% by 2010, compared to a 1997 baseline. This target was reiterated in the new planning framework, *National Standards, Local Action* [18] Many of the measures relating to the earlier standards can be expected to contribute to the prevention of suicide. In addition, the following achievements in relation to suicide prevention can be reported.

What has been achieved?

A suicide prevention strategy

The first national suicide prevention strategy for England, developed by an expert group following a consultation document, was launched in September 2002.[36] Health and social care agencies, government departments and voluntary organisations are working to implement it, with NIMHE coordinating.

The strategy's goals are to:

• reduce risk in key high-risk groups, namely people under mental health care, people who harm themselves, young men, prisoners and those working in certain occupations;

• promote mental well-being in the wider population;

• reduce the availability and lethality of suicide methods;

• improve reporting of suicidal behaviour in the media;

• promote research on suicide and suicide prevention;

- improve monitoring of progress towards the *Saving Lives: Our Healthier Nation* target to reduce suicides.

Projects taking forward the suicide prevention strategy

Many new actions have addressed the goals of the national strategy. These include:

- publication by NIMHE of a toolkit enabling local services to implement the '12 Points to a Safer Service' proposed by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness;[37]

- publication by NICE of clinical guidance on the management of self-harm in emergency departments, primary care, ambulance services and mental health services;

- establishment of three mental health promotion pilots targeting young men in Camden, Bedfordshire and Manchester;

- introduction of computer-based assessment systems and specific training to enable NHS Direct nurses to offer support and referral to callers who may be contemplating suicide or self-harm;

- publication of a guide highlighting ways in which the media may report on mental health and suicides in a responsible manner, and introduction of workshops on suicide reporting for journalism students;[38]

- establishment of a national suicide research forum, funded initially to investigate suicide by co-proxamol overdose, hanging and firearms.

Improved mental health care for prisoners

The Prison Health Policy Unit and Task Force published a strategy for modernising mental health services in prisons in 2001.[39] Responsibility for implementing this passed to NIMHE in early 2003, and each of the eight NIMHE Development Centres now has a prison mental health lead and a prison mental health collaborative. Staff are being trained in how to use collaborative networks, and how to implement clinical improvements.

The NHS Plan target of having 300 prison mental health in-reach staff assessing and treating mental disorders in prison by the end of April 2004 has been met (there were 370 staff in post). These in-reach teams have brought a steady improvement in care, with one sampling exercise demonstrating that all prisoners with a severe and enduring mental illness now have a multidisciplinary care plan.[40]

Suicide risk management training schemes

The University of Manchester has developed and evaluated a suicide risk management training package known as STORM[41] funded by the MRC and NHS. The training has been shown to improve risk management skills in a range of staff from health care and other agencies. It is currently being disseminated through NIMHE in the north west and south east. A prison version is being piloted in five prisons in England.

Suicide audit in primary care

The indicators on which the star ratings of PCTs are based include one on suicide audit. In the 2004 star ratings, 291 out of 303 PCTs (96%) reported having a local system for suicide audit. [12]

Declining suicide rates

Suicide rates are clearly influenced by many factors beyond the control of mental health services. However, changes in national suicide rates are an important indication of the mental health of the country.

Saving Lives: Our Healthier Nation set a clear target – that by 2010 deaths by suicide should reduce by one fifth from the 1997 three-year average (ie 1995–97). This requires a reduction from 9.2 deaths per 100,000 population to 7.4 deaths per 100,000 population, as shown in Figure 1.
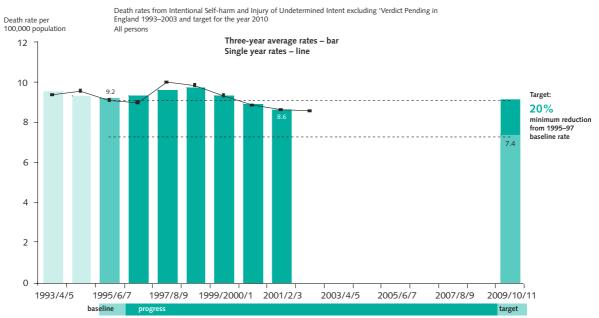
Figure 1: Mental health target

Death rate per 100,000 population

Death rates from Intentional Self-harm and Injury of Undetermined Intent excluding 'Verdict Pending in England 1993–2003 and target for the year 2010
All persons

**Three-year average rates – bar
Single year rates – line**

Target:
20%
minimum reduction from 1995–97 baseline rate

Rates are calculated using population estimates based on 2001 census, revised in light of the CNS Local Authority Population Study (2004).
Rates are calculated using the European Standard Population to take account of differences in age structure.
1993 to 1998 and 2000 have been coded using ICD9; 1999 and 2001 owards are coded ICD10.
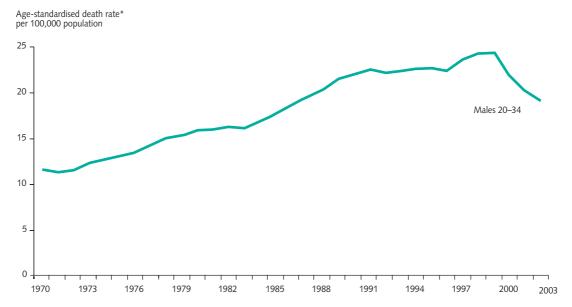
The suicide rate is now at its lowest recorded figure. The latest suicide monitoring data, for the period 2001–03 show a reduction of 6% from the 1995–97 baseline and a larger fall since the peak in 1998–2000. If the current downward trend, based on the last five years, continues, the target will be met.

There is also evidence of a sustained fall in the suicide rate in young men for the first time since their rate started rising in the 1970s.[42] Figure 2.

Figure 2: Mortality Rate from Intentional Self-harm and Injury of Undetermined Intent in young men (aged 20–34) in England

Three-year average rate, plotted against middle year of average (1969–2003•)

Age-standardised death rate*
per 100,000 population

Males 20–34

There are discontinuities in the trend, due to the change from ICD8 to ICD9 between 1978 and 1979, and the change to ICD10 over the period from 1999 to 2001. These discontinuities appear in all the three-year averages that touch on these years.
* Each age group has been separately age-standardised, ie adjusted for differences in the age structure of the population.
• 2003 data are provisional.
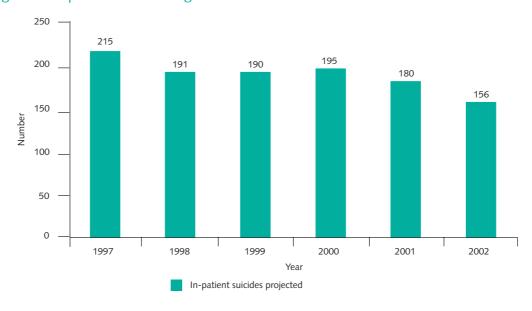
Improving in-patient safety measures

There has been a particular policy focus on in-patient safety. In 1999, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, funded by the DH, recommended greater emphasis on suicide prevention on wards, and specific measures such as the removal of ligature points from which hangings could occur.

In 2000, the Chief Medical Officer instructed trusts to take immediate steps to remove or replace all non-collapsible bed and shower curtain rails.[43] This was to be achieved by March 2002 and all services reported compliance.

Figure 3: In-patient suicides England 1997–2002

In-patient suicides projected

Areas for further action

Prison suicide rates

Suicide rates remain several times higher in prisons than in the general population. The age-standardised suicide rate in prison (England and Wales) in 1999–2000 was 129 per 100,000 for men and 184 per 100,000 for women.[44] The number of suicides among prisoners has not fallen, as shown in Table 3, but annual rates fluctuate. Current projections suggest a total of 98 suicides in prison by the end of 2004/05.

Table 3

Year	No. (rate) of self-inflicted deaths in prison
2000–01	71 (107 per 100,000)
2001–02	75 (105 per 100,000)
2002–03	105 (143 per 100,000)
2003–04	92 (123 per 100,000)

The prison service now has a comprehensive suicide prevention strategy, and its impact is being monitored.

Early follow-up following hospital discharge

In mental health services, risk of suicide is highest in the period immediately after hospital discharge. Services were previously required to provide data on the proportion of high-risk patients followed up within seven days of discharge but data returns were incomplete nationally. Even so, many services do provide early follow-up – it is one of the '12 Points to a Safer Service' that mental health trusts are asked to adopt as part of the national suicide prevention strategy.

In the recent guidance to the NHS on targets, covering the period 2005–08, a requirement for early follow-up has been revived. Trusts will expected to provide face-to-face or telephone contact within seven days of hospital discharge for people on enhanced CPA.

Positive practice

A new inter-agency initiative in Staffordshire Combined Healthcare NHS Trust involves users and carers in staff training. Two NHS trusts and two local authority social services departments work together to deliver the training to professionals working in mental health and learning disabilities services.

The Clinical Risk Management Training Initiative (CRMTI) began training its trainers in February 2003 in response to the requirements of the NSF for Mental Health. Its aim was to have strong training and support systems in place for those involved in managing risk. CRMTI is also developing 'bespoke modules' around specialist subjects, such as Mentally Disordered Offenders (MDO) and Child Protection in Mental Health.

CRMTI improves knowledge of risk management and increases staff confidence in supporting users who present special risks. This in turn leads to better experiences of services for users and their carers, and improved communication and will contribute to a range of activities aimed at suicide reduction and the effective management of self-harm, self-neglect, exploitation by others and harm to others.

More information about Staffordshire and Stoke on Trent CRMTI can be obtained from Samantha Dawson, Clinical Governance Support Manager at samanthaj.dawson@nsch-tr.wmids.nhs.uk or Jeremy Boughey, Deputy Director of Clinical Governance at jeremy.boughey@nsch-tr.wmids.nhs.uk

Positive practice

Reducing suicide risk on discharge

The Hartlepool post discharge service was developed after the NSF for mental health highlighted that people are more at risk of suicide within the first seven days after discharge from hospital care. The service ensures a comprehensive package of care tailored for the individual client and their carers.

The service offers short home visits to alleviate anxiety. All people who have been an in-patient within the mental health unit are visited at home within seven days, and within 48 hours if they have been at high risk. Individuals have said visits by someone familiar and reliable have reduced their worries about returning to the community.

The service aims to optimise engagement, prevent or anticipate crises and reduce risk. Ensuring the availability of a comprehensive package of community-based care has had a significant impact on psychiatric readmission rates within the Hartlepool locality.

9. Finance

Background

The NSF was backed by new money totalling £700 million over three years, compared to the 1999/2000 baseline. The NHS Plan committed a further £300 million of extra annual investment over the three years from 2000/01.

What has been achieved?

Increased spending

Figures on spending come from two sources. Firstly, DH collects information on the amount of money that has been spent by NHS Hospital and Community Health Services (HCHS) and by local authority Personal Social Services (PSS), and spending on mental health (all ages) can be calculated from this. The most recent figures available are from 2002/03. Secondly, NIMHE has carried out a financial mapping exercise annually since 2001/02, most recently in 2003/04. The two sources differ in that the financial mapping covers planned NHS spending in health and social care and in the independent sector and is limited to adults of working age. Financial mapping data is therefore mid-year predictions of spending by the year end, whereas DH data reflects actual spending, but the accuracy of financial mapping data when checked in the following year appears to be good.

DH data shows that mental health spending has increased annually as shown in Table 4:

Table 4

	Mental health spend (at 2002/03 prices)				
	HCHS		PSS		Total
	£m	% of total	£m	% of total	
1998/99	3,617	12	611	5.2	4,228
1999/00[(1)]	3,870	12.3	669	5.3	4,539
2000/01	4,166	12.7	700	5.3	4,866
2001/02	4,208	12.7	727	5.2	4,935
2002/03	4,598	13.1	815	5.4	5,413
(1) Figures before this period are not wholly comparable as the methods of calculating changed.					

In the financial year in which the NSF was published, 1999/2000, reported HCHS mental health spending on people of all ages was £3.87 billion. By 2002/03, this had risen to £4.60 billion (2002/03 prices in both cases). The increase in spending over this period was therefore £728 million (or 19% in real terms). The proportion of HCHS expenditure devoted to mental health had risen from 12.3% to 13.1%. If this calculation is carried out with total NHS spending figures rather than HCHS figures

(the difference is largely in primary care spending), the proportion spent on mental health is smaller but the pattern over time is similar.

Local authority PSS expenditure on adults with mental health needs in 2002/03 was £815 million (5.4% of total PSS expenditure). Over the period from 1999/2000 there was also a real terms increase in PSS resources devoted to mental health services of £146 million (at 2002/03 prices).

Taken together, NHS (HCHS) and local authority (PSS) expenditure on mental health increased in real terms by almost £874 million. This is a real increase in resources of over 19% in the period 1999/00 to 2002/03.

The financial mapping data provides figures for the three years to 2003/04. Table 5 identifies a real increase in total planned investment in adult mental health services between 2001/02 and 2003/04 (at 2003/04 prices) of £440 million or 12.6% over the whole period. However, the increase in 2003/04 is small in comparison to that in earlier years and, if this is repeated over the next few years, increased investment in mental health will fall behind the increase in investment in the NHS as a whole.

Table 5

Total investment in adult mental health services (at 2003/04 prices)		
Year	Total (£m)[1]	% increase on previous year
2001/02	3,504	–
2002/03	3,858	10.1
2003/04	3,944	2.2
(1) Where data has not been reported (which has happened with a small number of LITS or where data is incomplete, an adjustment has been made to derive a total planned investment figure. This adjustment for 2003/04 was small at £33 million (or 0.8% of the total planned investment for the period).		

Allocations

The formula for allocating money to primary care trusts contains a component for mental health that covers both mental illness and learning disability. These figures are not published and PCTs are entitled to spend their overall allocations according to their assessment of local need. In other words, they may legitimately spend on mental health more or less than the amount allocated for it. Mental illness and learning disability cannot be disentangled in the allocation formula for the years after the publication of the mental health NSF.

Despite these difficulties in interpreting mental health allocations, analysis of figures from 1999/2000 to 2002/03 shows that:

• the proportion of the total NHS allocation that is notionally intended for mental health (mental illness and learning disability) increased from 14.9% to 15.9%;

• the total amount allocated nationally was consistently less than the total amount spent. This comparison takes no account of need, ie the amount that should be spent;

• allocations are not an independent predictor of spending in local services – the main determinant of spending is previous spending. This means that historical patterns of spending tend to persist. Wide discrepancies in spending (see below) are not related to allocations;

- the difference between allocation to and spending by a PCT is no longer inversely related to need. A previous study[45] reported that underspending in relation to allocation was greatest in areas of greatest need. This pattern is no longer seen.

Capital

Data for capital spending by mental health trusts is held by DH for the three years from 2001/02. These are respectively £457 million, £508 million and £354 million *(figures not adjusted for inflation) – 23%, 23% and 16% of total capital spending in the NHS in those years. Most of these sums were spent on buildings.

The figures confirm that substantial amounts of capital have been spent in mental health services in recent years. What they cannot show is spending in relation to need. Despite the building of new mental health units in many trusts, there are still wards that do not provide a satisfactory therapeutic environment.

Areas for further action

Spending on NHS Plan services

The profile of planned investment in the major service categories between 2001/02 and 2003/04 (at 2003/04 prices) is shown in Table 3. It shows a 51% increase in investment in access and crisis services – the category most closely reflecting the NHS Plan initiatives – with the proportion of total investment on these services increasing from 4.3% to 5.8%. It also shows a small fall in percentage terms in spending on clinical services (comprising predominantly inpatient spend) from 19.5% to 18.6%.

Table 6

	Total investment in £000s (at 2003/04 prices)		
Direct service investment	**2001/02**	**2002/03**	**2003/04**[1]
Access and crisis services	152,269	181,401	229,438
Accommodation	269,422	281,359	333,843
Carer's services	9,281	9,476	13,236
Clinical services	683,158	673,273	733,026
Community mental health teams	431,691	469,912	478,987
Continuing care	312,366	332,455	343,166
Day services	158,972	145,778	155,035
Direct payment	6,659	2,349	5,043
Home support services	53,046	56,167	63,318
Mental health promotion services	5,034	2,739	2,752
Other community and hospital professional teams/specialists	46,106	45,076	42,765
Personality disorder services[2]	0	0	704
Psychological therapy services	111,484	126,934	129,352
Secure and high dependency provisions	294,704	335,650	428,235
Services for mentally disordered offenders	30,879	29,615	48,226
Support services	32,884	41,851	38,755
Total direct service investment	*2,596,954*	*2,734,036*	*3,045,882*
Indirect investment[3]	907,197	1,123,513	897,624
Total planned investment	**3,504,151**	**3,857,549**	**3,943,506**

(1) 2003/04 data are provisional
(2) New category in 2003/04
(3) Capital charges, indirect costs and overheads

The figures do not show the exact investment in new NHS Plan services but, as Table 7 shows, spending on crisis resolution, assertive outreach and early intervention teams had reached just over £150 million by 2003/04. This probably represents most of the investment in the six new teams and new workers in the three years following the publication of the NHS Plan.

One concern frequently raised about recent investment in mental health is that it has primarily gone into secure care, which tends to be high-cost and for few people. These figures confirm that there has been a 45% increase in investment in secure care in these years. Real terms spending on secure and high dependency provision has increased by £133 million, 30% of all additional investment. As a percentage of all estimated spending, secure care has increased from 8.4% to 10.9%.

Table 7

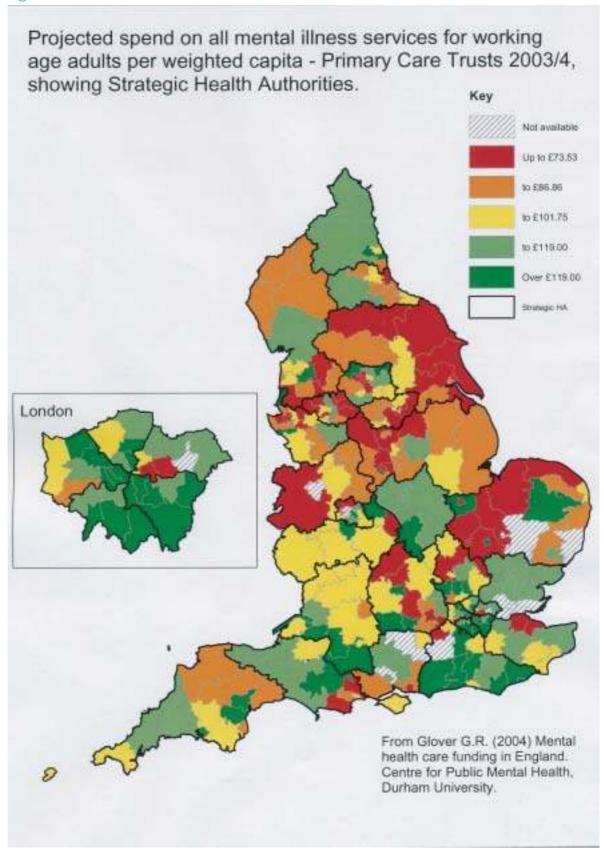|	Total Investment in £'000s (at 2003/04 Prices)		
Area	**2001/02**	**2002/03**	**2003/04**
Assertive outreach	52,195	64,641	78,502
Crisis resolution/home treatment teams	42,751	48,594	59,892
Early intervention in psychosis services	3,950	6,636	12,839
Total	**98,896**	**119,871**	**151,233**

Geographical differences

The profile of planned weighted investment per head across the geographical areas served by NIMHE Development Centres is highlighted in Table 8. The analysis highlights increasing real investment in adult mental health across England, though with variations in the level of weighted investment per head around the average of £123. The difference in these figures follows a geographical pattern, investment in the south generally being greater than further north.

Table 8

	Overall investment per head in £ (at 2003/04 prices)		
NIMHE Development Area	**2001/02**	**2002/03**	**2003/04**
London	124	142	144
Eastern	111	89	132
South West	116	118	130
South East	105	124	123
West Midlands	87	96	111
North East/Yorkshire	103	110	110
North West	94	96	108
East Midlands	90	108	108
National planned investment	**109**	**120**	**123**

This pattern is also found when spending by PCTs is examined. Figure 4 shows a pattern of greater spending per weighted head of population in the south compared to the north (though with exceptions). A similar pattern is evident when the difference between allocation and spending is examined. This north-south difference in the discrepancy between allocation and spending increased in 2001/02 and 2002/03.

Figure 4

Projected spend on all mental illness services for working age adults per weighted capita - Primary Care Trusts 2003/4, showing Strategic Health Authorities.

Key

Not available

Up to £73.53

to £86.96

to £101.75

to £119.00

Over £119.00

Strategic HA

London

From Glover G.R. (2004) Mental health care funding in England. Centre for Public Mental Health, Durham University.

10. Workforce

Background

The NSF cannot be delivered unless its workforce requirements are met. The mental health workforce needs more people, new people, new skills and new ways of working.

A Workforce Action Team (WAT), set up to consider the workforce implications of the NSF, published its findings in 2001.[46] These form the basis of many current developments. Development of the mental health workforce is overseen by the National Workforce Programme (NWP) within NIMHE and put into practice by a Workforce Implementation Team.

What has been achieved?

More people

There are two main sources of data on the number of people within mental health services – the annual national workforce census and the service mapping carried out within mental health services.

Workforce census figures (Table 9) show that, between 1999 and 2003, the number of consultant psychiatrists (whole-time equivalents) went up by 25%, while mental health nurses rose by 13% and clinical psychologists by 42%. Vacancy rates remain a concern, however – the most recent figures show a vacancy rates of 11% for consultant psychiatrist posts and 3% for nursing posts.[29]

An action plan on the recruitment and retention of psychiatrists was published in March 2004, the result of a joint initiative by the Royal College of Psychiatrists and DH.[47] This followed a series of studies carried out by the College Research Unit and funded by DH – on retention of junior psychiatrists, consultants' retirement intentions and consultant workload. The recommended actions cover the whole career pathway from initial recruitment of medical graduates into psychiatry through to the timing of retirement. They include:

- examination of factors in medical schools that lead to high rates of recruitment into psychiatry (there is a three-fold difference between medical schools);

- greater emphasis in consultant job plans on supervision of psychiatrists in training;

- more flexible working, including for psychiatrists who are considering retirement;

- opportunities for psychiatrists in non-consultant career grade (NCCG) posts to join the specialist register;

- international recruitment.

Flexible working is one of the main features of Improving Working Lives (IWL),[48] published by DH in 2001, and compliance with this policy document is a performance indicator for star ratings. All mental

health trusts achieved their IWL targets for the 2004 ratings. All NHS trusts are now working towards the third level of IWL-Practice Plus, demonstrating that they are embedding good human resource management at the heart of service delivery.

Modernising Medical Careers (MMC)[49] aims to bring the training, skills and career structures of doctors in line with the demands of the modern NHS. A report published last year[50] outlined the implications for NCCG doctors, who can now find themselves in a 'professional cul-de-sac'. It proposed a number of actions to ensure that entry to career grades is governed by clear criteria, that career pathways are explicit and that formal opportunities are available to resume training. In addition, the Postgraduate Medical Education and Training Board (PMETB) which is soon to be established will create new routes to the specialist register and to the consultant grade for appropriately experienced NCCGs.

There are few ways of increasing the consultant workforce quickly. One of these is direct recruitment of doctors from other countries into the consultant grade. DH has established an international fellowship scheme to recruit consultants for periods of two years. Since the launch of the International Fellowship scheme in 2002, 130 consultants have taken up post in the NHS, 85 of whom (65%) have been psychiatrists.

CHI noted recruitment difficulties in inpatient services.[24] However, there is evidence that these are improving – only 11% of Local Implementation Teams now report significant problems with recruitment and retention, down from 24% in 2001.

CHI also reported that there is now 'only a handful' of trusts where staff morale could be considered generally poor.

Table 9

	Mental health workforce (whole-time equivalents)			
	1999	**Sept 2003**	**Change**	**% Change**
Consultant psychiatrists	2,524	3,155[1]	631	25%
Mental health nurses	34,974	39,383	4,409	13%
Clinical psychology	3,763	5,331	1,568	42%
Psychotherapy	365	631	266	73%
Art/music/drama therapy	416	477	61	15%
Occupational therapy[2]	10,792	13,053	2,261	21%
Approved social worker	N/A	4,200		
1 DH medical and dental workforce census June 2004 2 Generic – not specialist mental health				

New people

The NHS Plan acknowledged that in modernising mental health care it would be insufficient to develop new roles for existing staff. New people, entering the NHS without joining one of the traditional professions, would also be needed. This was behind the proposal to employ 1,000 'graduate workers' in primary care to deliver brief psychological therapies and help people to find the help they need elsewhere, including through self-help (see Standard 2).

The Support, Time and Recovery (STR) Worker is another new role specifically designed around the needs of service users and one that gives greater recognition to previously unqualified staff. Three thousand STR workers are to be recruited by December 2006. There are currently 69 sites and 100 organisations nationally included in the Accelerated Development National Roll Out Programme, committed to establishing 25 STR workers each by September 2005 (1,725 workers in total). This is an ambitious task – there are currently 193 workers in post.

The Changing Workforce Programme has piloted other new roles, many of which are now being rolled out: these include the psychology associate and the dispensing assistant (see example). Individual trusts have also taken a creative approach to addressing staff shortages (see example).

National Mental Health Workforce Strategy

Published in August 2004, the National Mental Health Workforce Strategy sets out the values, vision and principles that should guide workforce design and development, recruitment and retention, new ways of working, new roles, education and training, and leadership.[51]

To support the strategy, the NWP has produced, sponsored or supported a large number of publications on workforce policy and practice. These include Mental Health National Occupational Standards,[52] a good practice guide on user and carer involvement in education and training,[53] a report on new ways of working for psychiatrists[54] and a framework for the mental health workforce *The Ten Essential Shared Capabilities.*[55]

Positive practice

Graduate Mental Health Workers

Trent has a target of 49 Graduate Mental Health Workers, and by August 2004 45 posts had been successfully filled. Local PCTs and Mental Health Trusts along with HEI providers in Derbyshire, Lincolnshire and Nottingham are collaborating in developing the training package to meet the requirements of the Graduate Worker role:

- Trent will pilot a 'book by prescription' scheme in 2005, based on the Cardiff scheme successfully implemented in Northamptonshire and Devon.
- Derbyshire PCTs are developing a county-wide supervision coordinator role to support the ongoing clinical development of Graduate Mental Health Workers and other members of the primary care team.
- Lincolnshire has developed proposals to employ graduate mental health workers for BME and migrant worker populations.

Positive practice

New approach to employing mental health workers

Some people are not attracted to a career in mental health because lengthy training (typically three years for nursing) combines with a relatively low bursary or student grant.

Local mental health service providers are collaborating with the University of Southampton to address this by introducing an innovative 'earn and learn' approach.

The (Associate) Mental Health Practitioner programme aims to provide graduates who have a health- or social care-related first degree with an opportunity to develop a career in mental health care. Trainees will be fully employed by service providers and attend the academic element of the university's Postgraduate Diploma in Mental Health Studies programme on a part-time basis over two years. As the trainees will be employees, they will start on an annual salary in the region of £14,200 in the first year, rising incrementally to over £17,000 on successful completion of the programme. They will work in in-patient and community team settings and have care coordination responsibilities in that context.

Positive practice

Support, Time and Recovery Workers

Stoke-on-Trent Social Services Mental Health Team, in partnership with local voluntary bodies, has recruited 28 STR Workers in their day services. This has:

- strengthened the focus on service users, through drop-in groups;
- encouraged engagement in socially inclusive activities, through STR worker/service user relationships;
- engaged people using day and other services to become supported volunteers and STR workers themselves;
- provided a positive role model for recovery and social inclusion for other services.

Positive practice

The pilot work on consultant roles and teams in Newcastle, Northumberland and Tyneside NHS Trust is being undertaken alongside a major service review and change programme.

Their plan is to move away from a traditional sectorised approach with consultants working across in-patient wards, CMHTs and primary care. The increasing complexity of service provision meant that consultants found it difficult to provide adequate levels of input consistent with a specialist service. For the last 30 months they have reviewed their roles and workload and agreed role changes as part of an overall service redesign process.

In September 2004, 12 consultants in Newcastle will begin to move from generic to specialist roles. Consultants will then work exclusively with either in-patient and crisis teams or community multi-disciplinary teams. Specialist consultants will be able to focus on their particular area of service. It is hoped that this will enable:

- strong clinical leadership and direction;
- easy access for the patient to an expert assessment and review;
- easy availability of support, discussion and supervision to members of the Multi-disciplinary team (MDT), other specialists and primary care;
- better joint working between senior professionals and managers;
- greater availability of supervision and training of junior medical staff and other staff.

Changes will have to be made to junior doctors' roles and job plans will have to be rewritten.

Areas for further action

New skills

Despite an impressive series of policy documents, we have yet to bring about the universal improvement in the skills of frontline staff that a modern mental health service needs.

A systematic review of the research evidence on the benefits of training in mental health[46] showed that there are few areas of clinical practice in which there is high-quality evidence. This means that much of the training provided is unproven. It is estimated to cost a minimum of £110 million per annum to provide pre- and post-registration training for nurses and clinical psychologists.

A number of specific training initiatives have taken place or are planned – on assertive outreach (see under Standard 4), on suicide risk management (see under Standard 7), on the management of aggression and violence (see under Standard 5) and on anti-discriminatory practice (see under Standard 1).

In autumn 2003, 80% of LITs assessed themselves as red or amber on the development of local education and training plans.

New ways of working

New services and a new recognition of the needs of service users require new ways of working for all professions – the new ethos of the NHS is now that a person's role should be determined by their skills rather than their professional background.

There are signs that changes are occurring. There are now 130 mental health nurses who have been trained in supplementary prescribing. There are 150 nurse consultants in mental health or substance misuse. There are 230 'modern matrons' in mental health trusts. More controversially, the Mental Health Bill proposes to broaden the current Approved Social Worker role under the Mental Health Act (1983) to other, suitably trained mental health professionals.

But changes have been slow, and have not been widespread in psychiatry, despite pioneering work (see Newcastle, Northumberland and Tyneside positive practice example). A new initiative, bringing together NIMHE, the Royal College of Psychiatry and others is a highly promising opportunity to redesign professional roles in a way that will also improve workload pressures and morale.

Locum and agency staff

In the 2003 finance mapping, trusts reported that locum doctor and agency nurse costs were a major cost pressure – estimated to be £141 million in the financial year 2003/04. High locum fees – with doctors taking advantage of the under-supply of consultant psychiatrists and using up local development resources in the process – are a frequent complaint of substantive medical staff and managers. Agreement between trusts on levels of pay to locums has been a helpful step in some areas.

11. Research and development

Background

The NSF and the NHS Plan both made a commitment to developing strong, national research and development (R&D) programmes to support implementation.

What has been achieved?

Strategic review of NHS research and development

A review of mental health R&D[56] has been carried out to assess research activity in the NHS, identify overlaps and gaps, consider the need for further development in infrastructure, and look towards a long-term strategy.

It found that:

- although there were more than 30 externally funded research units, centres and programmes, there were relatively few large-scale, multi-centre projects in progress;

- randomised controlled trials were few;

- many projects were small and had no external funding;

- there was a lack of systematic reviews of research evidence;

- there was a lack of expertise in many NHS organisations carrying out mental health research;

- there was little research carried out within social services departments;

- there was a lack of funding sources for mental health research;

- there were significant gaps in research relating to NSF standards, such as mental health promotion, access to care, and the types of services needed to support carers;

- there is a need to ensure involvement of mental health service users and carers at all stages of the research process, including the identification of priorities for research.

A national research plan

The review contributed to an R&D programme in mental health which is intended to ensure that policy and service development are backed by the best possible evidence. For each NSF standard, the most important research questions have been given priority for funding. Where appropriate, systematic reviews have been carried out – these are listed in Annex 1, Table 1.

A total of 69 projects costing over £9 million have been commissioned – these are listed in Annex 1, Table 2. These projects cover primary, secondary and social care, and particular groups of service users such as those from black and other minority ethnic groups, prisoners and patients in secure hospitals.

The priorities have included:

• *Inpatient care*

The NHS Service Delivery Organisation (SDO) has commissioned £1 million of research over the three years from 2003 to 2006 to provide a stronger evidence base on inpatient care. Studies are being undertaken on alternatives to admission, ward observation, inpatient care of young people and staff morale.

• *Carers*

Five research projects have been commissioned in support of services for carers of people with mental health problems by the DH Service Delivery and Organisation Programme. An initial study (see Annex 1) examined the range of services for carers currently available, and identified what further research was needed. Research is now in progress on what is important to carers' quality of life, the range of respite services available, the usefulness of carer assessments and good practice in sharing information between health professionals and carers.

• *Assertive outreach*

The DH Policy Research Programme has commissioned an expert workshop followed by a programme of work on assertive outreach. This includes a randomised trial of assertive outreach services, a nation-wide survey of how services are organised, research on whether successful treatment outcomes can be predicted and a comparison of how Afro-Caribbean and white men engage with services.

• *Dual diagnosis*

The MRC, with additional funding from NHS R&D, has funded the first multi-centre, randomised controlled trial of treatment for people with 'dual diagnosis' – mental illness and substance misuse. The trial will cost £2 million and will take place over three years from 2004.

• *Suicide*

In support of the target to reduce suicides by 2010, a Suicide Research Forum has been convened. An investigation of methods of suicide using coroners' records has recently been completed, and a range of research projects has been commissioned by the DH Policy Research Programme.

• *Forensic services*

The DH Forensic Mental Health R&D programme addresses the needs of a difficult and, at times, vulnerable group of service users. It has commissioned an evaluation of new, in-reach mental health services for prisoners, and of the use of telepsychiatry to facilitate consultations with experts working outside the prison service. A prison health research network has been established to build research infrastructure. Since 2001/02, the programme has invested almost £4 million in research.

• *Early intervention services*

NHS R&D is committed to funding an evaluation of early intervention teams, aimed at finding out what works best and who benefits most in these new services. Other planned topics are listed at Annex 1, Table 3.

Mental health research growth

Trust R&D reports for 2002/03 show that 154 of the 1,522 R&D programmes in the NHS were related to mental health, and 49 NHS organisations had one or more mental health programmes (linked research projects around a theme relevant to national priorities). Programmes were assessed against criteria such as quantum of research funding, extent of research collaboration and numbers of research publications, and 68% of programmes were rated as strong (on a scale of strong/moderate/weak). Service users are now widely involved in research – setting priorities, commenting on research proposals, and undertaking research themselves. Examples are shown at the end of this chapter.

Funding of mental health studies by the MRC has increased by a third, from £29 million in 2000 to £39 million in 2004. The amount of funding for research into services and interventions has more than doubled, though it remains a minority of total funding in mental health by the MRC.

Research infrastructure

To support clinical practice better, research needs to be carried out on the priorities of the service front line, as seen by clinicians and service users, without delay and on a large scale. A new, national research infrastructure has therefore been established – the Mental Health Research Network – initially commissioned as a part of NIMHE.

It aims to:

- deliver large-scale research projects to inform policy and practice;

- broaden the scope of research and gain full involvement from service users and carers;

- identify the research needs of front-line staff, managers, service users and carers;

- develop research capacity.

The Network is managed on behalf of NIMHE by a partnership between the Institute of Psychiatry and the University of Manchester, and currently includes 18 universities, 26 NHS trusts and more than 40 PCTs.

In March 2004, new funding for science was announced. This included further funding of £1 million annually for the Mental Health Research Network and mental health was included in five priority areas for increased R&D funding of £100 million by 2008.

In addition, the MRC and DH have provided £2 million to establish a national cohort of first episode psychosis patients under an e-science initiative. This will allow the investigation of interventions and outcomes in real-life clinical settings.

Areas for further action

Research in key areas

Mapping NHS mental health research programmes against the seven standards of the NSF[56] demonstrated there was a clear need for more high-quality research relevant to mental health promotion, primary care, access to services, services to support carers and suicide. More focused research is particularly needed on issues relating to black and ethnic minority groups, and to women's service needs.

Research dissemination

Services are still slow to adopt research findings in their ways of working. The link between research and service development is at the heart of the Mental Health Research Network. Clinical staff will be more closely connected to research in their service. NIMHE will have a crucial role in disseminating evidence.

Processes of disengagement and engagement with assertive outreach

Objective

This user-focused, qualitative study aimed to analyse why and how assertive outreach (AO) patients first disengaged with services and later engaged with AO teams.

Methods

The focus of the research was the perspectives of the patients themselves. The study used a thematic analysis of in-depth individual interviews with patients who had a history of previous disengagement with secondary mental health services and later engagement with AO. All were diagnosed as having psychosis.

Findings

Four core themes of the disengagement process were identified:

- *Loss of control due to medication and its effects*
  Patients reported effects of medication that were unpleasant in themselves but, more importantly, demonstrated to the patients a loss of control over their own life and functions.
- *Lack of active participation in own care and poor therapeutic relationship*
  Patients felt they were treated as passive recipients of care rather than active participants, and their autonomy was compromised by the powerlessness they felt in relationships with services. As a result, relationships with clinicians, particularly psychiatrists, either were not established or broke down, although most patients did not blame individual clinicians.
- *Incompatibility of patient role with original aspirations*
  While many patients acknowledged a long acceptance process of mental illness, they emphasised that the patient role seemed incompatible with original positive aspirations for professional and social achievements.
- *Critical incidents*
  Patients did not seek or perceive early interventions from primary care. Hospital experience was often extremely negative and repeatedly equated with 'prison'.

The engagement process with AO teams was characterised by the following three themes:

- *Time and commitment*
  Patients appreciated the input of time and the commitment of clinicians in AO teams to provide care in a flexible manner. Building a relationship of mutual trust and respect had often taken a long period of time.
- *Option for engagement without a focus on medication*
  For many patients it was very important to be provided an option to engage with mental health services without a focus on medication. This shift made it easier for patients to accept medication, which now was part of a comprehensive care approach and not the sole focus of clinical interest. Patients saw greater value in interventions that focused on practical, social, housing and welfare issues.
- *Partnership model of therapeutic relationship*
  A relationship that involved patients in all relevant decisions with mutual trust was regarded as central to engagement. As a means to becoming more actively involved in treatment, people wanted to be listened to and for their views to be respected and taken seriously.

Scoping study: services to support carers for people with mental health problems

Up to 1.5 million people in Great Britain may be involved in caring for a relative or friend with a mental illness or some form of dementia. The Government is committed to meeting the practical, health and emotional needs of this group of carers. Consequently, it is important to find out what is known about the effectiveness and cost-effectiveness of services in this area. The National Coordinating Centre for NHS Service Delivery and Organisation R&D commissioned the Social Policy Research Unit at the University of York to summarise the research evidence, to identify key gaps in existing knowledge and to identify priority areas for further research in this area.

There were two elements to the study. A review was conducted of national and international research reports evaluating interventions for carers of people with mental health problems published between 1985 and 2001. In addition, a consultation exercise was undertaken with three groups of stakeholders, including national and local organisations, and carers.

The literature review found:

- a lack of clear evidence to support any specific interventions for the target group, although almost all studies were able to identify some positive outcomes of services provided;
- cost savings reported for a range of interventions, resulting from decreased use of hospital-based care. However, there were methodological weaknesses in all studies with this conclusion.

On the basis of the evidence from the literature review and the consultation, the following recommendations were made for further research:

- evaluations of individual interventions directly or indirectly relevant to the implementation of recent legislation and major policy initiatives. These include: carers' assessments; breaks from caring; family support; family; support; educational and training programmes; support groups for carers; telephone and computer-based technology; provision of information; advice and independent advocacy;
- research focusing on interventions for specific groups of carers, particularly young and young adult carers, and black and minority ethnic carers;
- further economic research on all interventions, with the possible exception of AO for patients with severe mental illness;

- studies of services and interventions in their natural or everyday health and social care context;
- alternatives to standard outcome measures.

Research on suicide

- Establishment of Research Forum to plan research in relation to National Suicide Prevention Strategy.
- Evaluation of impact of legislation to reduce pack sizes of paracetamol and salicylates.
- Demonstrated long-term reduction in deaths, liver transplantation and size of non-fatal overdoses.
- Investigation of coroners' records to gain fuller understanding of methods of suicide (hanging, firearms, poisonings where death occurs in hospital, and co-proxamol overdoses) to inform prevention strategies.
- Projects to evaluate new initiatives for provision of help and support to young males with emotional problems.
- Establishment of multicentre monitoring of deliberate self-harm.

Service-user involvement in research

A service-user panel to determine research priorities

The Strategic Review of Mental Health in the NHS included a panel of service users with experience of either undertaking research themselves or of being included in research.

The panel was asked to comment on current research priorities and also to brainstorm its top priorities for research.

Among the panel's recommendations were the following:

- The research agenda needs to be more proactive in relation to government policy.
- Existing priorities do not adequately address issues of race and culture.
- A more holistic model of mental distress should be researched rather than solely the 'medical model'.
- Research should always include user-defined outcomes.
- Service users should be supported to contribute at all stages of the research process.

Forensic service-user involvement in prioritisation and peer reviewing of research proposals

This is being undertaken with the Patients' Council at Rampton High Secure Hospital in Nottinghamshire. By establishing links with the local advocacy service, researchers and the hospital management team, the Forensic Mental Health R&D Programme has initiated a process of communication and involvement with the Patients' Council. Representatives from the Programme have worked with the Council to improve their understanding of research commissioning and methodology through introductory talks and the provision of written material such as a user-friendly research glossary and the development of dedicated user involvement material.

The Council has reviewed and prioritised applications for funding received by the Forensic Programme. Council members are provided with a lay summary of the research and, through a facilitated group session, give a consensus opinion of the proposed research in terms of its ability to improve service provision and meet service-user needs, feasibility and the level of user involvement.

Members of the Council showed great enthusiasm for the process and were very vocal in their opinions. Research applications to the Forensic Programme are routinely reviewed by both academic and service-user reviewers. The preliminary results indicate that both the academic and forensic service users short-listed similar proposals and, despite being articulated differently, their overall concerns were similar.

12. Information and performance

Background

The NSF gave rise to a framework of local and national measures to drive change. 176 LITs oversee the development of mental health services in their own geographical areas. LITs represent all the main stakeholders in local mental health services, and service users and carers are expected to be core members. At national level, the drivers for change are performance indicators, targets and standards.

What has been achieved?

Annual assessment of progress

To support the LITs, an annual process of assessing and planning services was introduced in 2000 – now called the Autumn Assessment.

The Autumn Assessment has developed since the NSF was first launched. It now provides a rich picture of progress across the country – not only through hard facts about team numbers and delivery, but also through information from local groups about how they view their progress in crucial areas of service development.

The assessment now:

* gathers data on total spending on adult mental health in the LIT area – known as finance mapping;

* maps services provided in the LIT area;

* allows LITs themselves to assess their progress against a range of targets;

* asks LITs to explore at least one major theme – in 2003 they reviewed their own functioning, focusing on how users and carers are involved.

When findings from 2002 and 2003 are compared, progress in 2003 is seen in every self-assessment item, but especially in the areas of acute in-patient services, commissioning, transition protocols, access to specialist services, and developing a workforce which more closely represents the ethnicity of service users.

The Autumn Assessment in 2003 has been the basis of some of the evidence on progress in this report.

With support from the Healthcare Commission (formerly the CHI), **the Priorities and Planning Framework targets 2003–06**[57] **(derived from NSF/NHS Plan targets)** were worked into the performance indicators that are drawn together for the national star rating system for mental health trusts. On some indicators, trusts were rated for 'preparedness' in the year before a target was due to be delivered, and for delivery in the year after the due date. This allowed the indicators to track service development; it also meant that the star rating 'hurdle' was raised in 2004.

Indicators for star ratings can be divided into key targets (the main determinants of whether trusts receive a star rating of 0 or 1) and 'balanced scorecard' indicators (used to upgrade a rating to 2 or 3). They can also be generic across all NHS trusts or specific to mental health. The indicators used in the 2004 star ratings are listed in Table 10.

Table 10

2004 indicators for mental health trusts	
Key targets	**Balanced scorecard**
Assertive outreach team implementation	Better hospital food
	Child and Adolescent Mental Health Services (CAMHS) service mapping
	CAMHS increased service
CMHT integration	Clinical governance composite indicator
	Clinical negligence
	Consultant appraisal
CPA systems implementation	CPA/complex care indicator
	Crisis resolution team indicator
Financial management	Hospital episode statistics and workforce datasets
	Junior doctors' hours
Hospital cleanliness	Missed outpatient appointments
	Out-of-catchment-area treatments (adults)
Improving working lives	Out-of-catchment-area treatments (older people)
	Outpatient bookings
Mental Health Minimum Data Set implementation	Patient complaints
	Patients with copies of their own care plan
	Physical environment
	Privacy and dignity
	Psychiatric readmission (adults)
	Psychiatric readmission (older people)
	Service user survey – access and waiting
	Service user survey – better information
	Service user survey – health safety and incidents
	Service user survey – safe, high quality coordinated care
	Staff opinion survey – health safety and incidents
	Staff opinion survey – human resource management
	Staff opinion survey – staff attitudes
	Suicide rate
	Transition of care between adult services and older people's services
	Transition of care between CAMHS and adult services

In 2004, 83 trusts providing mental health services were rated. Fifteen received three stars, 38 two stars, 23 one star and 7 zero stars. The number of zero-star trusts increased from three in 2003 but overall the numbers were similar in the two years – 64% received two or more stars in 2004 compared to 65% in 2003.

The ratings for PCTs also include mental health indicators. The indicators in 2004 were: carrying out suicide audit; prescribing of benzodiazepine, and commissioning of the NHS Plan deliverables.

Targets and standards

A new set of targets and standards for the NHS was published in July 2004, covering the period 2005–08.[18] During this period, there will be only 20 nationally set targets. The following are particularly relevant to mental health services:

• *Improvement in patient experience*

This target will be measured by national patient surveys. The national results will be presented by ethnic group (see under Standard 1).

• *Chronic disease management*

The target will be to reduce emergency bed days by 5% by 2008 (from the expected 2003–04 baseline) through better management of long-term conditions. Mental disorders are a major part of the long-term conditions treated by health and social care staff, whether in people with co-morbid physical and mental disorders or in their own right. Mental illness in England is estimated to cost the economy £23.1 billion in lost output caused by people being unable to work.[58]

• *Health of the population*

The *Saving Lives: Our Healthier Nation* target to reduce suicide by 20% by 2010 compared to 1995–97 will continue under *National Standards, Local Action* (see also under Standard 7).[18]

In addition, one broad target from the Priorities and Planning Framework 2003–06 will be retained, namely to 'improve life outcomes of adults and children with mental health problems through year on year improvement in access to crisis and CAMHS services'.[57]

Areas for further action

Information technology

The collection of information requires good information systems. Mental health services have been slow to invest in IT. However, NIMHE's Information and Knowledge Board has drawn together key stakeholders from DH, the NHS Information Authority and the National Programme for IT to ensure a focused and coordinated approach in future.

Outcome measurement

A programme of work has been overseeing the development of routine outcome measurement in mental health services.[59] Data collection has been piloted in four sites.

This programme is linked to the development of the Mental Health Minimum Data Set (MHMDS), a comprehensive clinical data set for working-age and older adults. The MHMDS incorporates information central to care planning and includes outcome data.[60] It therefore creates the opportunity for better information support to clinical care, better communication between agencies and better

measurement of what services achieve. However, progress in adopting the MHMDS has been slow and incomplete. As a result, its development was made a key target for star ratings in 2004 and 25 out of 83 trusts obtained a satisfactory rating.[12]

The outcomes programme has now been relaunched with the aim of connecting it to the new NHS standards, local target setting and the work of the Healthcare Commission.

13. Clinical guidelines

Background

NICE is commissioned by DH to provide clinical guidance to support the NSF. NICE has produced two types of guidance relevant to mental health services: technology appraisals and clinical practice guidelines. Technology appraisals consider the evidence that a particular treatment is effective or cost-effective for a specific condition. Clinical guidelines consider all treatments and services that could be used for a condition or group of conditions.

What has been achieved?

Technology appraisals

NICE has published a series of appraisals on treatments for mental disorders, as follows:

- *Guidance on the use of newer (atypical) antipsychotic drugs for the treatment of schizophrenia (2002)*

The appraisal supported the use of atypical drugs in first episode schizophrenia and in service users who were experiencing side-effects from conventional antipsychotics.

- *Guidance on the use of computerised cognitive behaviour therapy (CCBT) for anxiety and depression (2002)*

The appraisal found insufficient evidence to recommend widespread use of CCBT, but a review is planned for publication in 2005.

- *Guidance on the use of electro-convulsive therapy (ECT) (2003)*

The appraisal recommended the use of ECT only to achieve rapid and short-term improvement in severe symptoms after other options have proved ineffective and/or the condition is life-threatening, in severe depression, catatonia and prolonged or severe mania.

- *Guidance on the use of donepazil, rivastigmine and galantamine for the treatment of Alzheimer's disease (2001)*

The appraisal recommended the use of these drugs as one component of the management of people with mild to moderate Alzheimer's disease provided assessment has been undertaken by a specialist.

- *Guidance on the use of methylphenidate for attention deficit/hyperactivity disorder in childhood (2000)*

The appraisal recommended the drugs use as part of a comprehensive treatment programme for children with a diagnosis of severe attention deficit-hyperactivity disorder; however, its use should be initiated only by a specialist.

- *Guidance on the use of Olanzapine and valproate semisodium in the treatment of acute mania associated with bipolar disorder (2003)*

The appraisal recommended that these drugs be considered as options for the control of acute symptoms associated with the mania.

- *Guidance on the use of zaleplon, zolpidem and zopiclone for the short term management of insomnia (2004)*

The appraisal recommended that drug treatment for insomnia be prescribed only for short periods of time after non-drug therapy has been considered. It concluded that there was no compelling evidence to use these newer drugs in preference to short-acting benzodiazepines.

Technology appraisals in development are:

- Alzheimer's disease – donepazil, rivastigmine, galantamine and memantine (review due May 2005);

- attention deficit/hyperactivity disorder – methylphenidate, atomoxetine and dexamfetamine (review due August 2005);

- dementia (non-Alzheimer's) – new pharmaceutical treatments (due May 2005);

- depression and anxiety – CCBT (review due July 2005);

- drug misuse – methadone and buprenorphine (due November 2006);

- drug misuse – naltrexone (due November 2006).

It is probably too early to draw firm conclusions about the impact of these appraisals on the treatments offered by front-line mental health services. For example, the use of atypical antipsychotic drugs was already increasing before the NICE appraisal was published. Even so, the appraisal is seen as encouraging the use of atypical drugs and may have its greatest benefit in parts of the country that have been slow to use them.

Nationally, the use of atypical antipsychotic drugs has risen approximately fourfold since 1999[19] (Figure 5).
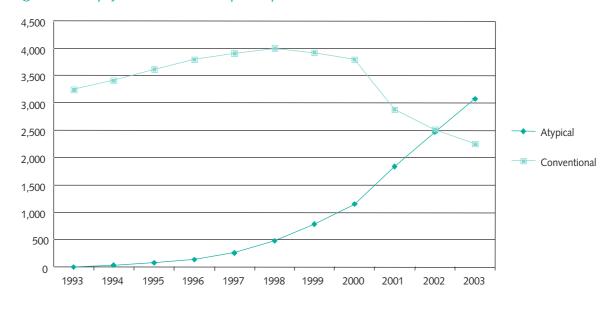
Figure 5: Antipsychotic number of prescriptions

Source: Prescription Cost Analysis

Clinical guidelines

NICE has published clinical guidelines on the following topics:

- *Schizophrenia – Core interventions in the treatment and management of schizophrenia in primary and secondary care (December 2002)*

This guideline emphasises the complexity of the condition and the need for a complete service response. It stresses the need for early intervention, collaborative engagement, the provision of good information and consideration of the use of atypical antipsychotic medication as a first-line choice. It also highlights the role of crisis resolution/home treatment and assertive outreach teams. In addition, it recommends that there should be a service-user focus and that CBT and family interventions should be available.

- *Eating disorders – Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (January 2004)*

This guideline recommends that people with anorexia should generally be treated as outpatients with appropriate psychological therapy. When in-patient care is necessary, it should be in a setting providing skilled re-feeding and careful physical monitoring in combination with psychosocial intervention. It also recommends that people with bulimia should be given evidence-based self-help and/or an antidepressant drug and access to CBT if necessary. Families should also be appropriately involved.

- *Self-harm – The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (July 2004)*

This guideline is aimed at emergency departments, ambulance services and primary care as well as mental health services. It emphasises the need to treat people who harm themselves with respect, the importance of early physical treatment and psychosocial assessment, and the need for training.

Depression – its management in primary and secondary care (December 2004)

The guideline recommends that for mild to moderate depression, appropriate psychological treatments such as problem-solving therapy, CBT and counselling should be offered as treatment options. When antidepressants are prescribed, SSRIs are recommended rather than tricyclic antidepressants for routine care. For severe depression, CBT should be used along with antidepressant medication.

Anxiety: management of anxiety disorder (panic disorder, with or without agoraphobia and generalised anxiety disorder) in adults in primary, secondary and community care (December 2004)

For anxiety, patients should be offered any of three interventions – psychological therapy, medication such as SSRIs, and self-help such as bibliotherapy based on CBT principles. The guideline also emphasises the advantages of treatment for anxiety in a primary care setting rather than a hospital setting, access to information, and effective partnerships with healthcare professionals in promoting better outcomes.

The following guidelines are in development:

- disturbed (violent) behaviour: the short-term management of disturbed (violent) behaviour in in-patient settings (due January 2005);

- anxiety: management of post-traumatic stress disorder in adults in primary, secondary and community care (due March 2005);

- anxiety: management of obsessive-compulsive disorder in adults in primary, secondary and community care (due June 2005);

- depression in children: identification and management of depression in children and young people in primary care and specialist services (due August 2005);

- bipolar disorder: the management of bipolar affective disorder (manic-depressive illness) (due January 2006);

- puerperal/perinatal mental health: clinical management and service guidance (due November 2006);

- dementia: management of dementia, including use of antipsychotic medication in older people (due February 2007);

- drug misuse: guidance on the management of, and care packages for, drug misusers in the community and prison settings (date to be confirmed);

- attention deficit/hyperactivity disorder: pharmacological and psychological interventions in children, young people and adults (publication date to be confirmed).

Areas for further action

Implementation of guidelines

Implementation of clinical practice guidelines is widely recognised as a significant challenge for NICE and the NHS.[61] There is no statutory requirement on PCTs to fund guideline implementation – in contrast to technology appraisals.
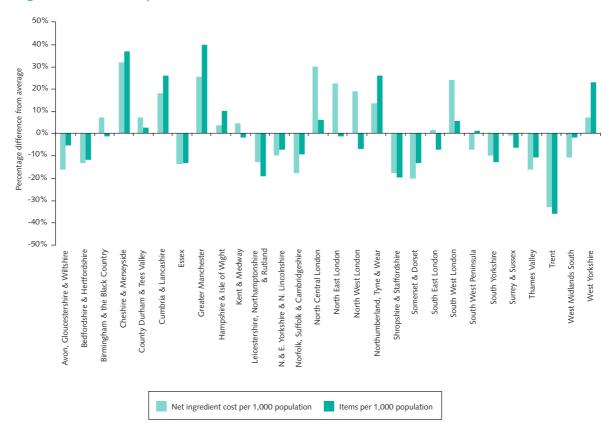
The new standards for the NHS published in July 2004 [18] refer to the need to implement guidelines from NICE and other authoritative sources. The Healthcare Commission has a key role in assessing how local services respond to the standards, although exactly how this will be done is still under consideration.

In addition, NICE has been working with NIMHE and the National Collaborating Centre for Mental Health on a programme to support the implementation of NICE guidance.

Geographical variations

One aim of the NSF was that patients living in different parts of the country would receive the same standard of care. However, despite the NICE appraisal on atypical antipsychotic drugs, variations in prescribing persist (Figure 6).

Figure 6: Rates per 1,000 population for atypical antipsychotics dispensed in the community in England – all SHAs, April 2003–March 2004

14. Commentary

The NSF for mental health was a hugely important step for mental health care. It set out a broad blueprint for services throughout England. Its message was: wherever you live, this is the kind of service you can expect to receive; wherever you work, this is the kind of service you should aim to deliver. It went beyond the previous policy emphasis on severe mental illness, though this remained crucial, by setting standards on primary care and mental health promotion.

The NHS Plan, in which mental health was confirmed as one of the priorities of the NHS, was a different kind of document. Where the NSF set broad standards, the NHS Plan launched specific clinical initiatives. Its aim was to make community care work. It set out to strengthen community services in a way that would take the pressure off acute in-patient care. New services were proposed to fill the most conspicuous gaps in what was being provided in the majority of places – assertive outreach, home treatment, early intervention, psychological therapies in primary care, carer support and access. Targets were set and money was allocated.

In my opinion, the NSF and the NHS Plan are the two most influential policy documents in the lifetime of anyone currently working in mental health. Their importance is not only in what they say but in what they signify – a transformation in the status of mental health within the NHS and in the responsiveness of services to patient need.

These two documents present a vision of high-quality mental health care that:

- treats service users with dignity – listening to their views on how services should change, acknowledging cultural diversity and providing suitable settings for the recovery of distressed people;

- respects the role and the skills of carers;

- makes the most effective treatments widely available;

- links provision to need – so that the people with the most acute illnesses have the most urgent access to care, and so that the people with the most complex needs have the most comprehensive packages of care;

- emphasises safety – particularly the safety of the service users themselves;

- is delivered by a skilled and motivated workforce.

After the NSF and NHS Plan, there is a third stage to the transformation of mental health care, the creation of the NIMHE. NIMHE has the job of supporting local services in service re-design.

This review shows that a great deal of progress has been achieved since 1999. Key achievements are listed below.

Treating services users with dignity

The 2004 national patient survey[13] reported that the overwhelming majority of patients were positive about the way they were treated by mental health professionals. They reported feeling that they were treated with respect and dignity, that they were listened to and given time, and that they had trust and confidence in staff (Table 11). Three-quarters rated their care as good, very good or excellent. 9% said it was poor, or very poor.

Table 11

National Patient Survey 2004 – Mental Health Service User Views											
Professional	**Respect and dignity (% of patients)**			**Listening carefully (% of patients)**			**Trust and confidence (% of patients)**			**Time to discuss condition and treatment (% of patients)**		
	Yes	**Some extent**	**No**	**Yes**	**Some extent**	**No**	**Yes**	**Some extent**	**No**	**Yes**	**some extent**	**No**
Psychiatrist	79	18	4	68	27	5	59	33	10	60	27	13
Community psychiatric nurse	81	12	2	81	16	3	73	20	7			
Other health professional	83	14	3	77	19	4	69	25	8			

In addition:

• the requirements of *Safety, Privacy and Dignity* – such as single sex day areas and washing facilities – have been adopted in almost all mental health trusts;

• service user input to service development is widespread, through LITs, trust boards and local service user groups.

Respect for carers

The number of carer services and the amount spent on them have increased nationally.

Treatments widely available

• There has been a large increase in the number of staff who can deliver psychological therapies – psychologists and primary care mental health workers.

• A four-fold increase in the use of modern (atypical) antipsychotic drugs has occurred since 1999.

Linking provision to need

• Assertive outreach teams are now established across the country for people with complex needs.

• Crisis resolution and early intervention teams are improving the accessibility of specialist care.

Safety

•   A National Suicide Prevention Strategy has been published and acted upon.

•   Suicide rates, including in young men and in-patients, have fallen.

Workforce

•   There have been substantial increases in the numbers of psychiatrists, psychologists and mental health nurses.

•   New roles have been created for skilled staff eg nurse consultants.

Most of what has been achieved has been in specialist mental health services. We should be unapologetic about that – it is also where the greatest problems were, as well as the people with the greatest needs.

However, this year should see new specialist community teams in most parts of the country and next year their caseloads will expand in line with the projections of the NHS Plan. It is time to move the emphasis of service reform on to primary care and the broader community. This has already been signalled with the publication of the Social Exclusion Unit report on mental health, the anti-stigma initiative *From Here to Equality*, and the planned publication of *Delivering Race Equality*, early in 2005.

There are also aspects of specialist mental health services that have not yet been adequately addressed and now need urgent attention. These are in-patient wards, dual diagnosis, support for carers, and information technology (see under future direction).

This review has followed the remit of the mental health NSF – adults of working age. Comprehensive mental health care needs to go beyond this, to provide similar benefits for older people, children and adolescents and people with a learning disability. The CHI report on mental health[24] commented that adult services were making progress but that this was creating inequalities in care across the age range. There is now a need to develop equivalent services for people of all ages and to highlight areas of interface, such as the care of children affected by parental mental illness, and clinics for dementia in young adults.

For this to happen, we have to continue the emphasis on multi-agency working. At the heart of this collaboration is the relationship between health and social care and communities' responsibility not only to tackle illness and vulnerability, but to promote well-being and independence. The current consultation on the future of social care should help develop this positive role. Joint working, however, should extend beyond this, to include the voluntary and private sectors, housing, employment and training.

Finance

Underlying any discussion on what has or has not been achieved is the question of resources. Has the amount of money spent on mental health increased to reflect its status as a clinical priority? The answer is not a simple yes or no.

It is clear that the financial picture is more positive than recent reports have suggested. The amount of money that has been spent on mental health services has greatly increased in real terms since the publication of the NSF, by between a fifth and a quarter in the first four years. An increase of this magnitude would have seemed highly unlikely just a few years ago. The commitment of £700 million

over three years, as promised in the NSF, has been surpassed by a large amount, as has the £300 million increase in annual spending committed in the NHS Plan.

However, this positive overall message must be qualified in several ways. Firstly, an increase of this magnitude is found only when the conventional inflation figure (based on gross domestic product) is assumed. If the higher 'NHS inflation' figure is assumed, as a way of excluding rising NHS costs and estimating true new spending, smaller increases are found.

Secondly, some of the money that has reached front-line services has been spent on the wrong things. It has been used to shore up the old services that the NSF and NHS Plan were intended to change – out of area admissions, medium secure beds for people who could be admitted locally, locum and agency costs. It has been swallowed up by historical deficits in a local health economy, whether or not these could be traced to mental health services.

Thirdly, the increase is not universal. There are trusts that report little new money available for investment for several years. Although they may have reached their NHS Plan targets, they have done so by making savings in other parts of their services.

Fourthly, although after the NSF was published spending on mental health services increased more than in the rest of the NHS, this pattern appears to be changing. Spending on the NHS reached £63.4 billion in 2003/04 and is expected to rise to £92 billion by 2007/08.[62] This figure represents a large proportionate increase, larger than could be predicted for mental health based on the current rate of increase. Our status as an NHS clinical priority is not just a matter of relative spending because the costs of service developments are not equivalent in all specialities. Even so, it will be hard for some people to accept that our priority status has been fulfilled if spending on mental health does not at least keep pace with spending on the NHS as a whole.

Fifthly, there is a difference in the pattern of spending between the north and the south of the country and the gap is widening. This is not to say that there is no problem of investment in the south. Part of the problem appears to be that the formula for allocating money to PCTs is not yet resolving historical disparities in mental health spending. Previous spending – rather than the amount allocated or, far less, the true need of the population – remains the chief determinant of current spending.

Overall, therefore, the national picture on mental health spending has only partially reflected its clinical priority status. It is without doubt a positive picture, but not positive enough.

Why has this happened? Ultimately, because many – though certainly not all – PCTs, faced with their own financial pressures, have not given sufficient priority to mental health care in comparison to other priorities such as access targets and waiting lists. In a devolved system of commissioning, there is very little earmarking of money allocated, and spending on mental health has been left to local organisations to argue over.

More could have been done. Many PCTs have failed to follow through on the Government's commitment to mental health. They have made the funding of acute trusts a greater priority. They have continued the historical under-funding of mental health that created the problems that we are now grappling with.

Responsibility also lies with strategic health authorities and the DH who have overseen investment. This is not because they lack concern for mental health care but because when money is tight – and it always seems to be tight, even when (as now) investment is expanding – it is accepted that improving access and reducing waiting times are even more important.

Officially, all priorities are equal but in reality some are more equal than others.

Yet the signs are that this is changing and that mental health is increasingly at the centre of NHS reform. Since strategic health authorities were established in 2002, the attention they have given to addressing the needs of their mental health trusts has become steadily more obvious. The result is a clear commitment on mental health services in the recent *National Targets, Local Action* and in the Local Delivery Plan process (see below).

Delivery of NHS Plan commitments

The NHS Plan described nine new clinical initiatives. For most, the target date for setting up the services was 2004 and in some there was an additional commitment on the number of people who would be treated by 2005.

In three, the funding was held centrally – prison in-reach services, accelerated discharge from high secure hospitals and services for DSPD patients. All three have happened as planned or have slightly revised, but definite, delivery dates. In the other six, funding was given to PCTs. In one of these, assertive outreach, the proposed number of teams has been put in place. For the other five (crisis resolution, early intervention, primary care and gateway workers, and carer support staff), the strategic health authority Local Delivery Plans for 2004 show that full delivery is planned by the end of this year.

Final figures on delivery will be available once validation of strategic health authority data has been completed. The current indications are, however, that in some areas, there is a risk that the proposed number of workers or teams may not be achieved.

To address this potential problem, the following actions are now underway or planned:

- the DH's Recovery and Support Unit is working with Strategic Health Authorities that are at risk of not meeting their share of NHS Plan team numbers and new workers and patient numbers;

- the performance management system for 2005 will reward PCT and mental health trusts that meet these commitments;

- NIMHE will be asked to provide developmental support where this is needed;

- the original estimates of the number of people to be treated will be independently re-examined in the light of national experience of setting up new services – to ensure that local services have confidence in the 2005 commitments.

15. Future direction

Since the NSF and the NHS Plan were published, much has changed about specialist mental health services. Services across the country have been reshaped to reflect what people need from them most. The NHS as a whole has also changed – there have been important initiatives on patient choice, workforce skills, and now chronic disease management and public health[63,64] to which mental health must respond.

What then are the areas for development in the next five years of this ten-year period of transformation? While the standards in the NSF still provide the right framework – the future emphasis for change will be on the following areas.

The mental health of the whole community

We are entering a new phase in which the emphasis will move on from specialist mental health care, crucial though that will remain, to the mental health and well-being of the community as a whole. Central to future developments will be the recent Social Exclusion Unit report, the new anti-stigma programme *From Here to Equality*, prison mental health and work to improve mental health care for ethnic minorities.

The last of these is at the top of the national programme of work in mental health. The forthcoming publication of *Delivering Race Equality* will launch a long overdue period of change in how we oppose discrimination and provide mental health care for a diverse society. Key elements will be:

- a national training programme in cultural competence and anti-discriminatory practice;

- sustained improvements in ethnic minority patient experience;

- abolition of unacceptable inequalities, eg in the use of the Mental Health Act.

The recent White Paper on public health, *Choosing Health*, highlights the importance of community mental health as well as occupational stress. It asks me to bring forward specific proposals on these areas by March 2005.

Primary care

We now need a vision of mental health care in primary care that can guide service development nationally, in the same way that the NHS Plan set out a new model of what a modern specialist service should consist of. Our programme of work on primary care will reflect the concern of the NHS with chronic disease management (or long-term conditions) and health inequalities – people with mental illness have high rates of important public health problems including smoking-related diseases. The aims of the programme will be:

- to increase the numbers of primary care mental health workers and practitioners with special interests;

- to develop a more flexible division of responsibilities between primary and secondary care;

- to increase the availability of self-management;

- to improve care of physical and mental co-morbidity;

- to reduce emergency admissions to mental health wards through better continuing care for people with long-term mental disorders;

- to reduce smoking in people with severe mental illness;

- to develop commissioning expertise.

Access to psychological therapies

Despite a large increase in the number of staff who can deliver psychological therapies, long waiting lists remain in many places. The need to address this problem was a key message of the Choice consultation in mental health. A new programme of work in NIMHE will explore ways of expanding the availability of talking treatments. These are likely to include:

- improved psychological therapy skills in frontline staff;

- new staff, including primary care mental health workers;

- self-help technologies;

- a broader choice of providers of therapy, in the NHS and the independent sector.

Suicide prevention

The prevention of suicide remains an overall aim of mental health policy and practice. The target to reduce the suicide rate by 20% by 2010 has recently been reconfirmed.[19] The recent focus on suicide prevention is sometimes criticised as an over-concern with risk, but it is much more than this. Changes in suicide rates reflect the mental health of the community and every action to improve mental health may contribute to suicide prevention. There are particular concerns about suicide by young men – it is now the commonest cause of death in men under 35, and the higher rate in unskilled men contributes to health inequalities. This broad approach is reflected in the National Suicide Prevention Strategy, which combines measures to protect high-risk groups and to improve the well-being of the community.

All strategic health authorities will be asked to contribute to the national suicide prevention target. Mental health trusts will be asked to demonstrate that they are working to prevent suicide and, in particular, providing early follow-up to high-risk patients who are discharged from hospital.

Specialist mental health services

Priority areas for specialist mental health services will be:

In-patient wards

In many mental health trusts, new in-patient units have been built and older ones refurbished, and the popular image of squalid mental health wards is outdated and unrepresentative. Nevertheless, there are in-patient wards in use that are not suited to the care of distressed people. A comprehensive, sustained programme of repair and replacement is now required.

A new programme to modernise in-patient care will now be established with the following aims:

•   to eradicate all unsuitable wards through increased capital investment, beginning this year with the allocation of an additional £30 million to mental health trusts with the greatest needs;

•   to develop new models of in-patient provision to reflect its multiple purposes – acute care, rehabilitation, crisis admission and specialist treatment;

•   to improve integration with community mental health services;

•   to improve the therapeutic environment by tackling drug misuse and violence;

•   to improve safety of patients, staff and others;

•   to improve therapeutic skills among staff;

•   to improve recruitment and retention of staff and their morale;

•   to work with organisations that share these aims, such as the NPSA and the King's Fund.

Dual diagnosis

One of the most pressing problems facing mental health services day to day is dual diagnosis, and we now need to see the broad coordinated response that it demands. Work in this area will highlight:

•   the importance of assertive outreach teams and dedicated services for dual diagnosis;

•   the need for better collaboration between community drug and alcohol teams and mental health teams;

•   training for mental health staff in the assessment and clinical management of substance misuse;

•   the need for intensive efforts to prevent drug misuse, including cannabis use, in people with severe mental illness;

•   the prevention of drug misuse in in-patient units.

Carers

We have too little to report on improving the support we provide to carers, in line with Standard 6 of the NSF. Carers want prompt access to help when the person they care for is becoming ill. They want information, practical advice, emotional support and occasional respite. Most of all, they want decent care for their loved ones. Many trusts, though they may have made good progress on responding to service users, have less contact with carers. A good trust will have made a commitment to carers, providing comprehensive care plans with arrangements for when crises arise.

New ways of working

There is an opportunity now for a radical transformation of the mental health workforce – for every one of the mental health professions to re-examine its role in a modern service, taking into account changes in service user needs. Similarly, there is a need for all trusts to examine the way they use the skills of their workforce. Central to this initiative is the New Ways of Working programme in which new roles are adopted by psychiatrists and non-medical staff with benefits to service delivery, job satisfaction and workload pressures. And there is a need also for NIMHE to grasp the training agenda in a systematic programme to improve the skills of front-line staff in key areas of clinical practice – such as psychological therapies, risk assessment and the management of substance misuse.

Information systems

Good information technology is one of the foundations of service change. It promotes good practice through structured recording of clinical information. It makes it easier for mental health and related agencies to communicate. It allows the recording of data on what services achieve, especially on the benefits of mental health care to individual service users. Yet information systems remain primitive in mental health and the information we collect is not sophisticated enough for a modern service. We must now build on the National Programme for Information Technology pilots in mental health – we have to improve in this area by an order of magnitude.

Conclusion

In conclusion, the mental health NSF has had substantial benefits and has triggered a period of major change in the care that service users receive. The record of achievement has been impressive on services for severe mental illness (Standards 4 and 5), on suicide prevention (Standard 7), on research and on clinical guidance. It has been reasonably good on primary care and access (Standards 2 and 3), on finance and on workforce development, but there is much still to do. Less has been achieved on mental health promotion and social exclusion (Standard 1), on support for carers (Standard 6) and on information and IT.

We are now 5 years into a 10-year programme of reform. No one would yet claim that the problems that have affected mental health care for decades have been solved, or that we yet have the services nationally that service users deserve and that staff can feel proud of. We have seen, however, large increases in spending and staff numbers, greatly increased use of modern treatments, over 500 new specialist community teams and the lowest suicide rates on record. It is an exciting, impressive and promising start.

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Annex 1 – Research and development

Literature reviews and scoping exercises supporting the Mental Health National Service Framework

Table 1

NSF Standard	Title	Start date of award	Amount of award (£k)
1	Occupational outcomes of mental health interventions	2001	34.8
1 + 2	Self-help interventions for mental health problems	2001	29.7
2 + 3	Primary care mental health workers	2001	10.9
2 + 3	Effectiveness of post-qualification mental health training in primary and secondary care	2001	29.9
4 + 5	Assertive outreach: workshop on research priorities	2001	20.0
4 + 5	Dual diagnosis: workshop on design of Randomised Control Trial	2001	(2)
4 + 5	Early intervention and management of first episode psychosis	2001	41.4
4 + 5	Treatment of sex offenders: workshop	2001	0.2
4 + 5	Clinical effectiveness and cost consequences of SSRIs in the treatment of sex offenders	2001	90.0
4 + 5	Psychological treatment for sex offenders	2002	34.0
4 + 5	Psychological treatment for juvenile sex offenders	2004	25.5
4 + 5	Prevention strategies for the population at risk of engaging in violent behaviour	2002	66.0
4 + 5	Effectiveness of pharmacological and psychological strategies for the management of people with personality disorder	2002	63.0
4 + 5	In-patient care for mental health problems: a review of research and identification of researchable questions	2001	5.0
4 + 5	A literature review of staff morale on in-patient units	2003	59.5
4 + 5 + 6	Rehabilitation of people with severe personality disorder	2001	7.0
6	Services to support carers of people with mental health problems	2001	76.8
6	Measuring outcomes for carers of people with mental health problems	2003	64.0
6	Respite services for carers of people with dementia	2003	75.5
7	Suicide prevention: workshop	2001	3.0
7	Scoping review of services for people bereaved by suicide	2004	29.9
All	Thematic review of NHS R&D-funded mental health research in relation to the NSF for mental health	2000	27.0
All	Scoping review of the effectiveness of mental health services	2000	40.0
All	Researchable questions to support mental health policy	2000	(3)
All	Women-only and women-sensitive mental health services: an expert review	2001	35.0
All	Development of prison mental health services	2002	75.0
TOTAL FUNDING			**943.1**

(1) Included in National Primary Care R&D Centre Programme
(2) Funded by Medical Research Council
(3) Information not available

Projects supporting the Mental Health National Service Framework

Table 2

NSF Standard	Title	Start	Total cost (£k)
1	Occupational outcomes of mental health interventions	2001	34.8
1 + 2	Self-Help Interventions for Mental Health Problems	2001	29.7
2 + 3	Primary Care mental health workers	2001	10.9
2 + 3	Effectiveness of post-qualification mental health training in primary and secondary care	2001	29.9
2 + 3	Primary care mental health workers: best practice to facilitate managed care pathways in primary care settings	2004	(1)
2 + 3	Graduate primary care mental health workers	2003	53.0
2 to 5	Comparing needs and satisfaction with services between psychiatric patients in prison and forensic mental health teams	2001	104.5
2 to 5 + 7	Development of prison mental health services	2003	75.0
2 to 5 + 7	Development and evaluation of a new telepsychiatry service for prisoners	2001	110.0
4 + 5	Assertive outreach: workshop on research priorities	2001	20.0
4 + 5	Dual diagnosis: workshop on design of Randomised Control Trial	2001	(2)
4 + 5	Early intervention and management of first episode psychosis	2001	41.4
4 + 5	Treatment of sex offenders: workshop	2001	0.2
4 + 5	Clinical effectiveness and cost consequences of SSRIs in the treatment of sex offenders	2001	90.0
4 + 5	Psychological treatment for sex offenders	2002	34.0
4 + 5	Psychological treatment for juvenile sex offenders	2004	25.5
4 + 5	Development of a scale to measure sadism in sex offenders	2001	81.0
4 + 5	Feasibility study for Randomised Control Trial of treatments for sex offenders	2002	17.2
4 + 5	Use of polygraph in the monitoring of high-risk behaviour on community supervision	2001	59.0
4 + 5	Processes of disengagement and engagement with assertive outreach for African-Caribbean and white British men	2002	24.0
4 + 5	In-patient care for mental health problems: a review of research and identification of researchable questions	2001	5.0
4 + 5	A literature review of staff morale on mental health in-patient units	2003	59.5
4 + 5	Large-scale change in multi-professional organisations: the impact of leadership factors in implementing change in complex health and social care environments NHS Plan clinical priority for mental health crisis resolution teams	2003	295.6
4 + 5	A national study of the association between observation practice and adverse events on acute psychiatric wards	2003	298.5
4 + 5	Social and cognitive correlates of anti-social and violent personality disturbance	2002	108.0
4 + 5	Differential access to services for individuals with severe personality disorder	2001	186.0

(1) Included in National Primary Care R&D Centre Programme
(2) Funded by Medical Research Council
(3) Information not available

NSF Standard	Title	Start	Total cost (£k)
4 + 5	Prevention strategies for the population at risk of engaging in violent behaviour	2002	66.0
4 + 5	Interpersonal processes and their importance in the treatment of personality disorder	2002	112.1
4 + 5	Black and minority ethnic groups' pathways into forensic mental health services	2002	135.0
4 + 5	Intensive multi-modal cognitive behaviour therapy programme for adolescent offenders in secure care	2003	143.2
4 + 5	Clinical, genetic and environmental risk factors for juvenile ASPD in a high-risk group	2003	146.0
4 + 5	Aetiology and developmental pathways related to the emergence of psychopathic tendencies in children	2003	144.0
4 + 5	Pilot study of a new intervention for hard-to-treat children with conduct disorder	2003	43.0
4 + 5	Services for older people moving out of high secure hospitals	2002	158.0
4 + 5	Assertive outreach in England: a national survey of service organisation	2004	133.0
4 + 5	Operational and individual predictors of outcome of assertive outreach throughout England	2005	233.0
4 + 5	The City 128 Study observation and outcomes on acute psychiatric wards	2003	298.5
4 + 5	In-patient alternatives to traditional in-patient care	2004	301.9
4 + 5	Psychological intervention for clients with schizophrenia and co-morbid substance abuse (MIDAS)	2004	1,871.9
4 + 5	Development of prison mental health services	2003	75.0
4 + 5 + 6	Structured community-based treatment for people with personality disorders	2001	183.0
4 + 5	Evaluation of pilot training packages on personality disorder for NHS staff	2004	200.0
4 + 5	Outcomes of involuntary hospital admission in England	2003	329.0
4 + 5	Survey of black and minority ethnic service user views of cultural competency of in-patient services	2004	200.0
4 + 5	Effectiveness of pharmacological and psychological strategies for the management of people with personality disorders	2002	63.0
4 + 5	A meta-regression study to explain the heterogeneity in assertive outreach study outcomes	2002	66.0
4 + 5	A randomised controlled trial of assertive outreach services in North London	2002	112.0
4 + 5 + 6	Structured community-based treatment for people with personality disorders	2001	183.0
4 + 5 + 6	Rehabilitation of people with severe personality disorders	2001	7.0
6	Services to support carers of people with mental health problems	2001	76.8
6	Measuring outcomes for carers of people with mental health problems	2003	64.0
6	Respite services for carers of people with dementia	2003	75.5
6	Enabling partnerships in carer assessments: the way forward	2003	299.1

(1) Included in National Primary Care R&D Centre Programme
(2) Funded by Medical Research Council
(3) Information not available

NSF Standard	Title	Start	Total cost (£k)
6	Professionals sharing information with carers: examples of good practice in mental health	2003	80.0
7	Suicide prevention: workshop	2001	3.0
7	Suicide prevention: research training fellowship	2002	109.0
1 + 7	Evaluation of a health promotion intervention for suicide prevention in young men	2004	50.0
7	Investigation of methods of suicide using coroners' records	2004	122.0
7	Scoping review of services for people bereaved by suicide	2004	29.9
7	Multi-centre monitoring of deliberate self-harm	2004	(3)
All	Thematic review of NHS R&D-funded mental health research in relation to the NSF for mental health	2000	9.6
All	Scoping review of the effectiveness of mental health services	2001	40.0
All	Researchable questions to support mental health policy	2001	(3)
All	Women-only and women-sensitive mental health services: an expert review	2001	30.0
CC	Psychiatric morbidity survey	2001	492.2
CC	Outcome measurement in mental health – evaluation of pilots	2001	229.0
All	Development of prison mental health services	2002	51.0
All	Prison academic network	2004	598.9
All	Psychiatric morbidity and mental health treatment needs among women in prison mother and baby units	2003	36.5
TOTAL			**9,392.8**

(1) Included in National Primary Care R&D Centre Programme
(2) Funded by Medical Research Council
(3) Information not available

Research being planned in support of the Mental Health National Service Framework

NSF Standard	Title
2 + 3	Primary care mental health workers in child and Adolescent Mental Health Services: a survey of organisation, management and role
2 + 3	Evaluation of access into the mental health system: gateway workers, NHS Direct, walk-in centres, and other routes into the system (both primary and secondary care)
2 + 3	Evidence of effectiveness of complementary healthcare for mental health problems: a review
2 + 3	Co-morbid physical and mental conditions, contribution of better mental health care to chronic disease management
4 + 5	A programme of research on crisis resolution
4 + 5	Staff morale on mental health in-patient units
4 + 5	Clinical effectiveness and cost consequences of SSRIs in the treatment of sex offenders
4 + 5	National evaluation of early intervention in psychosis services
4 + 5	Evaluation of pilot personality disorder services in the community
4 + 5	Evaluation of medium-secure personality disorder services
4 + 5	Update of systematic review of the Mental Health Act
7	Suicide risk among lesbian women and gay men
6	Quality of and access to family visiting facilities
All	Mental health services for homeless people
All	Health benefits and social outcomes of participation in the arts
All	Priorities for mental health research across the full age range: a consultation exercise
All	Supplementary nurse prescribing in mental health
All	Evaluation of four workforce themes in mental health

Annex 2 – Glossary of Abbreviations

A & E	Accident and emergency
ABC	Access, Booking and Choice programme (NIMHE)
ADHD	Attention deficit hyperactivity disorder
AO	Assertive outreach
BME	Black and minority ethnic
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behaviour therapy
CCBT	Computerised cognitive behaviour therapy
CHI	Commission for Healthcare Improvement
CMHT	Community mental health team
CPA	Care programme approach
CRMTI	Clinical Risk Management Training Initiative
DH	Department of Health
DSPD	Dangerous and severe personality disorder
ECT	Electro-convulsive therapy
GDP	Gross Domestic Product
GMS	General medical services
GP	General practitioner
HCHS	Hospital and Community Health Services
HES	Hospital episode statistics
IWL	Improving Working Lives
LIT	Local implementation team
MDO	Mentally disordered offenders
MHMDS	Mental Health Minimum Data Set
MHP	Mental health promotion
MMC	*Modernising Medical Careers*
MRC	Medical Research Council
NAPIU	National Association of Psychiatric In-patient Care Units
NCCG	Non-consultant career grade
NCMH	Northern Centre for Mental Health

NHS	National Health Service
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health (England)
NPSA	National Patient Safety Agency
NSF	National Service Framework
NHSU	National Health Service University
NVQ	National Vocational Qualification
NWP	National Workforce Programme
ODPM	Office of the Deputy Prime Minister
Ofcom	Office of Communications
ONS	Office for National Statistics
PCTs	Primary care trusts
PEAT	Patient Environment Action Team
PICU	Psychiatric intensive care unit
PMETB	Postgraduate Medical Education and Training Board
PSS	Local authority Personal Social Services
R & D	Research and Development
SAFIRE	Swift Assessment for the Intensive Resolution of Emergencies
SDO	NHS Service Delivery and Organisation
SEU	Social Exclusion Unit
SSRI	Selective serotonin re-uptake inhibitor
STORM	Skills based training on risk management
STR	Support, time and recovery (worker)
WAT	Workforce Action Team