The Mental Health Policy Implementation Guide

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1.   FOREWORD

We are delighted to be able to publish this Implementation Guide to support the delivery of adult mental health policy locally. This is both an exciting and challenging time for mental health services and it is only right that there should be an effective programme of implementation, with the Department of Health doing all it can to help every locality deliver and sustain change.

It is always difficult in any national publication to achieve the correct balance between clarity over <u>what</u> is to be done and local flexibility over <u>how </u>it is to be achieved. This is a guide not a prescription. Whilst certain service models are specified there is also emphasis placed on tailoring services to meet local needs. Engaging all local stakeholders in planning the change will be essential. The review of local mental health services required by "The NHS Plan Implementation Programme" will enable all LIT areas to reflect, refine and where necessary refocus patterns of treatment and care so as to ensure that any new services are not simply bolted on, but properly and systematically deployed.

This guide contains working material, to be used in debates and discussions locally. It will be developed as time goes on. We will publish further work on other areas mentioned in the NHS Plan, such as women's services, support to carers, and links with the criminal justice system when these are available. We are also developing more definitive work on areas such as dual diagnosis and personality disorder. We have not forgotten, either, the essential part residential services, including acute in-patient provision, have to play. We are taking forward work in this area.   All of the products of this "work in progress" can be added to this guide as time goes on.

The guide emphasises the need for whole systems development which will address the most conspicuous gaps in service provision. We cannot afford to focus on any single aspect of the mental health system and hope that this will provide a solution. We do, however, need to work progressively through any change process. Not everything can be done at once. Our mental health strategy points the way. Working systematically through the stages of providing safe, sound and supportive services will deliver a more focused mental health system and take us forward to our ultimate goal of a society more sensitive to mental distress, where people with mental health problems do not have to suffer discrimination and where recovery based on service user and carer aspirations is a real possibility for the majority.

Local action is critical, not just in delivering new services, but in remembering the value base that underpinned the Mental Health National Service Framework:

- The centrality of the service user and those who support them
- A proper focus on the diversity of need amongst those who use mental health services
- A full acknowledgement of the importance of our workforce in all its diversity – people taking forward excellent and essential work in not only the statutory provider sector but also in the voluntary and independent sectors, the service user movement, primary care, and, indeed all areas of the "whole system"
- The need to value the lessons we learn from each other and the need wherever possible to avoid the blight of the "not invented here syndrome".

We hope that if we can continue to use these values to underpin our work and deliver on the expectations Ministers have determined in national policy, we will have truly lived up to the status afforded to us by being one of the three national clinical priority areas.

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2. INTRODUCTION

2.1 Policy Context

The task of improving our mental health services requires both vision and commitment. The Mental Health National Service Framework for mental health (MHNSF), published in 1999, sets out a vision of a better service in its seven standards, spanning the full range of mental health care. It is a ten year strategy.

The NHS Plan, published in 2000, demonstrated a commitment to working towards this vision. Major investment is being made in the new models of service: crisis resolution; assertive outreach, early intervention in psychosis; primary care and gateway workers. Services are being redesigned to ensure the availability of women-only services, and additional staff are being recruited to increase the breaks available for carers, and to strengthen carer support networks. There is significant investment in secure accommodation, personality disorder and prison in-reach. As services are developed they should be evaluated over time and if necessary adapted to local circumstances.

The long-neglected infrastructure of mental health care - our workforce, facilities and information systems - is now being given the attention it merits.

The Main focus of the NSF for Mental Health and the mental health components of the NHS Plan is on services for working age adults. However the nation's mental health services span the full age range and services for adults need to ensure that transitions between them and those for children and the elderly are well managed. This implementation guide gives particular opportunities for co-operative planning and provision to take place between CAMHS and services for adults especially in the provision of early intervention services for people with psychosis, within primary care and within the field of mental health promotion.

Policy on care of older people with mental health problems has been developed in context of the Older Peoples National Service Framework. Similar to CAMH services the issue of transitions between services for adults of working age and those for older people will need to be managed effectively.

The framework of law within which mental health care operates is also being reformed. The current law reflects the 1950's, when it was conceived. The new White Paper "Reforming the Mental Health Act", also published in 2000, moves away from a presumption of institutionalised treatment, and will support the new models of service.

The case for all these reforms is now well established. Mental health services must be available 24 hours a day 7 days per week based on sound evidence of best practice. Mental health services must improve outcomes, enabling a better quality of life for service users, their families, and the whole community. Above all, mental health services must place the needs of families, other carers and service users at the **centre** of their planning and their practice.

The MHNSF expressed the case for reform in 11 principles, stating that people with mental health problems should expect that services will:

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

These principles govern the process of reform. Service users and their families persistently tell us that these existing models of service fail to meet their needs or their expectations particularly around help in a crisis which should be available 24 hours a day. The MHNSF and the NHS Plan aim to match these expectations. The new services outlined in this guide are designed to enhance the local mental health systems. **It is not intended that where good services are in place, like well functioning community mental health teams, that these services should be abandoned.** New investment in these new functionalised teams will help overburdened in-patient and community services.

Community Mental Health Teams (CMHTs), in some places known as Primary Care Liaison Teams, will continue to be a mainstay of the system. CMHTs have an important, indeed integral, role to play in supporting service users and families in community settings. They should provide the core around which newer service elements are developed. The responsibilities of CMHTs may change over time with the advent of new services, however they will retain an important role. They, alongside primary care will provide the key source of referrals to the newer teams.

They will also continue to care for the majority of people with mental illness in the community.

Other services are also critical to the mental health system including a good range of residential services including high quality in patient care and continuing need and specialist recovery services. It is for localities to determine the design of their own services incorporating the new teams required by the NHS Plan and ensuring that each service element links effectively to each other.

Throughout all services, the barriers should be broken which have traditionally divided health care from social care, primary care from secondary care, and those who provide services from those who receive them. All these groups will share a responsibility to achieve the standards towards which we are all working.

2.2 Whole Systems Change

To deliver this process of change, local health and social care communities will have to prepare effectively during 2001/02 and plan for full-scale implementation of the new models over the following two years. Over the early part of 2001/02, this will therefore require a comprehensive review of mental health provision to ensure that new services are delivered in a co-ordinated way. This will be an important time for reflection and refinement of service plans; progress will be monitored through the Autumn 2001 monitoring process. Further guidance on this review is given in section 8 of this guide.

Such a comprehensive programme of change cannot be achieved by a single agency or a single profession working in isolation. One of the defining characteristics of mental health services is the range of disciplines who frequently need to be involved in the care plan of a single individual; suitable accommodation, adequate income, meaningful occupation, and family support all play a part alongside competent diagnosis, treatment and care.

Services need to communicate across functions and across settings, and to ensure that their criteria, referral systems and protocols are co-ordinated and complementary. A change in the role of any individual service has implications for all others.
For all these reasons, the process of change must adopt a whole systems approach. Since 1999, local implementation teams (LITs) have been in place throughout the country, working to interpret and to implement the NSF in their area. Some LITs cover the catchment of a health authority, some of a local authority, and still others of a primary care group, depending on the configuration of local services and the needs of local

communities. All LITs include representation from health and social care managers, clinicians, statutory and voluntary sectors, professionals, service users and carers.

The whole systems approach goes beyond ensuring the inclusion of the full range of agencies and services. It also means looking within services to the underpinning systems and strategies and ensuring that they too support the new pattern of services. These underpinning strategies include approaches to financial management and workforce development. New ways of working are required, and services must ensure that sufficient staff with the right range of competencies can be recruited and retained. It is important that these staff reflect the diversity of the community they serve. New approaches to governance and performance management are also required, as are new information systems to improve both direct care and our overall understanding of the quality of care being delivered. Current guidance on all of these issues is identified in this guide.

The whole systems approach finally requires LITs to look outside the agencies and individuals directly involved in the planning and management of services - to the wider community, which may include groups and individuals whose needs are not being met by current services. This could be the result of clinical conditions and highly specialised needs. More commonly, it could be the result of age, sex, geography, disability or ethnic background. Whilst current policy, and the specifications in this guide, aim to give a clear sense of direction, it is important that this is balanced by the flexibility to respond to differences in local needs. To help LITs develop a policy understanding of any unmet or unrecognised needs an Aide-Mémoire for Equality Assessment is attached at Annex A.

It is essential that LITs interpret the NSF and the NHS Plan in the context of a thorough understanding of these local needs, and this guide offers advice on how to conduct this 'tailoring' of implementation.

2.3   Updates

This guide is in a ring-binder format because it is not intended as a one-off publication. Both the evidence base and the expectations of service users continue to develop, and the process of implementing the MHNSF and the NHS Plan will need to keep pace with developments.

It is intended to publish periodic updates for inclusion in the guide. These may add new specifications or new guidance. For example, when more definitive work is available on women's services and services for carers this will be issued. Copies of updates will be circulated automatically to all Health Authorities, Social Services, Primary Care Groups,

Trusts and NHS Trusts providing mental health services. Copies will also be available on request from Regional Offices of the NHS Executive.

This first edition of the guide is also being published as a CD-Rom. We hope this will enable wide dissemination of the content of the guide – not only amongst the LIT members themselves, but also as widely as possible amongst staff and members of all the agencies who are involved in implementation. Further copies of the CD-Rom are available on request from Regional Offices of the NHS Executive and Social Care.

2.4   Guide Format

The purpose of this guide is to enable LITs to create the changes in their local area. Neither the NSF nor the NHS Plan contained detailed implementation guidance. This document builds on comments received and observations made since the publication of the NSF and the NHS Plan, and aims to set out clearly the expectations placed on LITs.

Chief officers, members and chairs will need to satisfy themselves that their LIT has the membership, the support, the resources and the ability to deliver on these expectations.

The guide begins with a service specification for each of the three principal new service models: crisis resolution; assertive outreach; early intervention in psychosis. The following sections summarising current policy for mental health in primary care and the recently launched framework for mental health promotion. All the specifications identify:

- Who the service is for
- What it is intended to achieve
- What the service does
- How the service relates to other services
- Operational procedures
- Reference for further evidence

The next section identifies current guidance and best practice as to the processes of local tailoring. The levels of service to be provided and the detail of implementation require an understanding of local needs, and use of this section will enable this to be done.

The final section addresses the underpinning systems and strategies, again identifying current guidance and best practice. It will be essential for LITs to give due consideration to these issues, as lack of progress on issues of infrastructure is likely to seriously impede the necessary progress on direct services.

2.5   Acknowledgements

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- Sainsbury Centre for Mental Health
- Mental Health Taskforce members

*Service
Specifications*

3. CRISIS RESOLUTION/HOME TREATMENT TEAMS

3.1 Who is the Service for?

Commonly adults (16 to 65 years old) with severe mental illness (e.g. schizophrenia, manic depressive disorders, severe depressive disorder) with an acute psychiatric crisis of such severity that, without the involvement of a crisis resolution/home treatment team, hospitalisation would be necessary. (NB) In every locality there should be flexibility to decide to treat those who fall outside this age group where appropriate.

This service is not usually appropriate for individuals with:

- Mild anxiety disorders
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia
- Learning disabilities
- Exclusive diagnosis of personality disorder
- Recent history of self harm but not suffering from a psychotic illness or severe depressive illness
- Crisis related solely to relationship issues

3.2 What is the service intended to achieve?

People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care. The majority of service users and carers prefer community-based treatment, and research in the UK and elsewhere has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital. A crisis resolution/home treatment service should be able to:

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week

- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible
- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care
- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge
- Reduce service users' vulnerability to crisis and maximise their resilience

Experience indicates that the following principles of care are important:

- A 24 hour, 7 day a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers
- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs
- Learning from the crisis

3.3   What does the service do?

There are four phases to crisis resolution – assessment, planning, intervention and resolution. The table below discusses each of these phases in detail.

Table 3a

Key component	Key elements	Comments
AGE, CULTURE DISABILITY AND GENDER SENSITIVE SERVICE	• 24 hour access to translation services should be available • Single sex accommodation and gender sensitive services should be provided if needed (See section 8 of this guide for guidance on developing culturally sensitive services)	• The high prevalence of diagnosed psychosis in certain cultural groups emphasises the importance of developing a culturally competent service • Needs of different groups should be explored and services adapted appropriately
ASSESSMENT	• Initial screening to ensure service is appropriate for the patient • If inappropriate, make referral to other services and ensure adequate continuity of care • Physical health assessment where appropriate • If appropriate, multi-disciplinary assessment of service user's needs and level of risk • Assessment should actively involve the service user, carers/family and all relevant others e.g. GP	• Rapid – available within one hour of referral • Assessment to take place in service user's home wherever possible • Problem solving approach

PLANNING	• Produce a focused care plan • Decide on number of visits and level of input • Begin discharge planning at an early stage	• Team approach and team decision making • Active involvement of the service user • Include input from family/carers • Care plan must be flexible enough to respond rapidly to changes in the clinical situation
INTERVENTION - the following interventions should be available:		
Designated named worker	• Responsible for co-ordinating the service user's care • Provides continuity of care and ensures effective communication within the team	• Service user and family/carers involved in selecting named worker and aware of how to contact him/her
Intensive support	• Frequent contact (including home visits) throughout crisis • Ongoing risk and needs assessment • Service must have the capacity to follow service user throughout the crisis	• In the early phase, several visits a day may be needed

Medication	• Immediate, 24 hour access to medication • Delivery and administration of medication to service users who require intensive monitoring • Care designed to improve concordance (co-operation with treatment) • Service user involved in decision making and monitoring effects of medication • Standard side effect monitoring tools to be used regularly by service user and staff	• Staff need training in storage and use of medication as well as concordance training • Links with hospital and local pharmacies required to ensure continued supply • Careful attention to avoiding/reducing side effects vital if engagement and concordance are to be maintained
Practical help with basics of daily living	• Help with benefits, housing, childcare etc	• Empowering service users and respecting their independence is crucial • Service user/family/carers must be involved in all decision making
Family/carer support	• Ongoing explanation to family/carers • Education about the crisis and the service user's illness • Arrange practical help as needed	• Involvement of carers/family and provision of support during crisis are key components of recovery

Interventions aimed at increasing resilience	• Range of therapies for both service user and family/carers should be available including:
	  • Problem solving
	  • Stress management
	  • Brief supportive counselling
	• Interventions aimed at maintaining and improving social networks	

Relapse prevention	• Individualised early warning signs plan developed and on file • Plan to be shared with primary care, GP and others as appropriate • Relapse prevention plan agreed with service user and family/carers • Effort made to identify and reduce conditions that leave the service user vulnerable to relapse	• Changes in thought, feelings and behaviours precede the onset of relapse but there is considerable variation between service users. Development of individualised plans can be effective in reducing the severity of relapse
Crisis plan	• Service user and family understanding of when to call for help • 24 hour contact number supplied to client/family/carers	• Easy access to help 24 hours a day

Respite	- Access to respite facilities preferably in non hospital surroundings e.g. cluster homes, community hostels etc. - Access to day care facilities	- Community residential care should be in small , family style accommodation that emphasises 'normal living' and has an 'open door' policy - Day care can be very effective in helping both service user and family/carer cope with crisis and recover
Links with in-patient services	- If hospitalisation required, regular, formal joint (inpatient staff and home treatment staff) review of patients should take place to ensure that the service user is transferred to the lowest stigma/least restrictive environment as soon as clinically possible - Home treatment team to be involved in discharge planning process - Service user/family/carers to be actively involved in discharge planning process	Primary care and other services to be involved as appropriate and kept informed of discharge plans

RESOLUTION	• Discharge planning should begin early
	• Information about the crisis, interventions and ongoing care should be exchanged with relevant others (GP, CMHT)
	• Discharge possibilities will be dependant on clinical situation and local service provision but could include transfer of care to:
	  • Primary care
	  • Assertive outreach team
	  • Early intervention team
	  • Continuing care
	  • Other mental health services
		• Prior to discharge the team should ensure that:
		  • There is good understanding (service users, family, carers, relevant others) of why the crisis occurred and how it could be avoided in future
		  • Coping strategies have been explored with the service user and family/carers
		  • Relapse prevention plan is in place
		  • Service user/family/carer have had an opportunity to express their views about the service and contribute to service improvement

In some areas the assertive outreach service nor the early intervention service provides home visits out of hours. A key function of the crisis resolution/home treatment service is to provide this type of intervention and support out of hours. Links need to be established between the three teams so that:

- Handover and referrals are made easily
- Crises are anticipated and contingency plans are known to all involved in care
- Early intervention and assertive outreach service users are aware of whom to contact out of hours
- Staff from the assertive outreach team and/or early intervention team could participate in the crisis resolution/home treatment team out of hours rota
- Agreements for an out of hours crisis service for under 16 year olds can be established

3.4 Management of service and Operational Procedures

Model of service delivery

Crisis resolution/home treatment services are best provided by a discrete, specialist team that has:

- Staff members whose sole (or main) responsibility is the management of people with severe mental health problems in crisis
- Adequate skill mix within the team to provide all the interventions listed above
- Strong links with other mental health services and a good general knowledge of local resources

Formation of service

- An audit of pathways of care, current service provision and local epidemiology should be undertaken initially. Information from this audit should then be used to develop an implementation plan
- The employment of a project manager to oversee the formation of a crisis resolution/home treatment team should be considered

Caseload

- Each team is likely to cover a population of approximately 150,000 and have a caseload of 20 to 30 service users at any one time
- However, the size of population that each team covers will depend on a number of different factors. A needs assessment needs to be undertaken prior to the formation of a crisis resolution/home treatment team to calculate likely service usage. Factors to take into consideration include:

  - Geography of the area
  - Demography and epidemiology
  - Health and Social Service boundaries

(See section 8: *Tailoring Services to Local Needs* for more information)

Staffing

The table below gives details of suggested staffing levels and skill mix for a team with a caseload of 20 to 30 service users at any one time.

Table 3b	
Designated named workers:	Total 14 per team
Key skills: - High energy level - Team player - Ability creatively to engage service users - Understanding of needs of service users, including specific needs related to cultural background/age/gender etc - Able to co-ordinate care and provide broad range of interventions	Team leader plus up to 13 others Designated named workers include: CPNs ASW OT Psychologists Support workers including service users Appropriate mix of staff is needed to ensure that all the interventions listed can be provided within the team

Medical staff • Active members of the team • 24 hour access to senior psychiatrists able to do home visits is vital	• Involvement from both consultant and middle grade psychiatrists • Level of psychiatric input to be determined by local need and service configuration
Specialist skills • These skills should be available within the team either by employing a fully qualified practitioner or by training other team members • External supervision, support and training needed for 'non specialists' providing these interventions	• OT/OT skills • Psychologist/psychology skills • ASW/strong links to social services and ability to undertake thorough assessment and activate services as needed
Support workers • People with health, social care or appropriate life experience or personal experience of mental health problems/treatment	• Number of support workers to be determined by the team • Support workers to reflect the demography of the local population
Programme support	• 1 wte administrative assistant • IT, audit and evaluation support may also be needed

Hours of operation

- The service should be available 24 hours a day, 7 days a week
- A shift system reflecting differing working patterns is required. A minimum of two trained case workers should be available at all times
- Evening/through the night working is usually an on-call system
- Medical on call rota should allow senior psychiatrist to undertake home visits 24 hours a day
- Assessment team for acute assessment of new referral (available 24 hours a day): two trained case workers and a senior psychiatrist
- Home visits to known service users (available 24 hours a day): two case workers

Referrals

Referral to the service should be easy and pathways of care clear to all involved. The service should have a system in place that allows direct referrals from primary care, community mental health teams, ASWs, staff on inpatient wards, the criminal justice system, non-statutory agencies, former service users and their family/carers, A+E departments and other parts of the acute medical service.

Risk assessment and policy on violence

- Each team should have a written policy outlining the level of risk the team is able to manage
- Operational policy should explicitly address staff safety

Staff training should include:

- Principles of the service, cultural, gender and anti-racist training
- Skills in delivering all of the interventions listed above
- Team building, colleague support and working within a team framework
- Medication - storage, administration, legal issues, concordance training, side effect awareness
- Use of Mental Health Act and alternatives to hospital treatment
- Benefits to service user and family/carers of home treatment approach

Service user information

Service users and their family/carers should be provided with the following information:

- Description of the service, range of interventions provided and what to expect
- Name and contact details of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice and help
- Care plan and comprehensive information about medication
- Relapse prevention and crisis plan
- Discharge plan
- How to express views on the service.

Continual service improvement

Regular audit of the service should be undertaken to ensure that gaps in service provision are filled. Audit should always include feedback from service users and their family/carers.

3.5 Evidence for further reference

Outcomes of Care

Audini, B., Marks, I.M., Lawrence, R.E., Connolly, J.C., Watts, V. (1994). 'Home-Based Out-Patient/In-Patient Care for People with Serious Mental Illness Phase11 of a Controlled Study' British Journal of Psychiatry, 165, pp. 204-210

Boomsma, J., Dassen, T., Dingemans, C. and van den Heuvel, W. (1999). 'Nursing interventions in crisis-orientated and long term psychiatric home care', Scandinavian Journal of Caring Sciences. 13 (1), pp.41-48

Hoult, J., Reynolds, I., Charbonneau-Powis, M., Weekes, P., Briggs, J. (1983). 'Psychiatric Hospital Versus Community Treatment: The Results of a Randomised Trial', Australian and New Zealand Journal of Psychiatry, 17, pp. 160-167

Marks, I.M., Connolly, J., Muijen, M., Audinin, B., McNamee, G. and Lawrence, R.E. (1994). 'Home-Based Versus Hospital-Based Care for People with Serious Mental Illness', British Journal of Psychiatry, 165, pp. 179-194

Muijen, M., Marks, I., Connolly, J. and Audini, B. (1992) 'Home-Based Care and Standard Care for Patients with Severe Mental Illness: A Randomised Controlled Trial' British Medical Journal. 304.pp.749-754

Reynolds, I. And Hoult, J. (1984) 'The Relatives of the Mentally Ill: A Comparative Trial of Community Oriented and Hospital Oriented Psychiatric Care' Journal of Nervous and Mental Disease 172.pp. 480-489

Dean, C., Phillips, J., Gadd, E., Joseph, M. and Emgland, S. (1993) 'Comparison of a community-based service with a hospital-based service for people with acute, severe psychiatric illness' British Medical Journal. 307, 473-476

Ford R & Kwakwa J (1996) 'Rapid reaction, speedy recovery' Health Service Journal. 106 (5499) 30-31

Marks IM, Connolly J, Muijen M, Audini B *et al.* (1994) 'Home-based versus hospital based care for people with severe mental illness' British Journal of Psychiatry. 165, 179-194

Defining the Service

Dean, C & Gadd E (1990) 'Home treatment for acute psychiatric illness' <u>British Medical Journal.</u> 301, p 1021-1023

Minghella, E. (1998). 'Home-based emergency treatment'. <u>Mental Health Practice,</u> 2 (1) pp. 10-14

Rosen, A. (1997). 'Crisis Management in the Community', <u>Medical Journal of Australia,</u> 167 (11/12), pp.633-638

Smyth, M.G., Hoult, J., Pelosi, A.J. and Jackson, G.A. (2000). 'The Home Treatment Enigma', <u>British Medical Journal,</u> 320, pp. 305-309

Szmukler, G.I (1987). 'The place of crisis intervention', <u>Australian and New Zealand Journal of Psychiatry.</u> 21 (1), pp. 24-34

Wasylenki, D., Gehrs, M., Goering, P. and Toner, B. (1997). 'A Home-Based Program for the Treatment of Acute Psychosis', <u>Community Mental Health Journal,</u> 33 (2), pp.151-165

Callahan, J. (1994) 'Defining crisis and emergency' <u>Crisis</u> 15 (4), pp 164-171

Phelan, M. (1996) 'Models of Crisis Intervention. In. *Effectively Managing Mental Health Service Development.* Thompson K & Strathdee G (eds). Sainsbury Centre for Mental Health. London.

Sustaining the Service

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P. and Thornicroft, G. (1996) 'Mental Health 'burnout' and job satisfaction among hospital and community-based mental health staff', <u>British Journal of Psychiatry.</u> 169 (3), pp. 334-337

Harper, H. & Minghella, E. (1997) 'Pressures and rewards of working in community mental health teams' <u>Mental Health Care.</u> 1 91) pp. 18-21

Keobel, P., Fuller, F. & Misener, T. (1991) ' Job satisfaction of nurse practitioners: an analysis using Herzberg's theory'. <u>Nurse Practitioner.</u> 16 (4) pp. 43-46.

Knapp, M., Beecham, J., Koutsogeorgopoulou, V., Hallam, A. *et al.* (1994) 'Service Use and Costs of Home-Based versus Hospital-Based care for people with severe mental illness'. <u>British Journal of Psychiatry.</u> 165, pp. 195-203.

Setting up the Team

Dean, C., Phillips, J., Joseph, M. & England, S. (1993) 'Comparisons of a community based service with a hospital based service for people with acute, severe psychiatric illness' <u>British Medical Journal.</u> 307, pp. 642-646

Phelan, M., Strathdee, G.& Thompson, K. (1997) 'Setting up a crisis intervention service: a checklist of service development issues. In. *Mental Health Service Development Skills Workbook.* Thompson K, Strathdee G, & Wood H (eds), Sainsbury Centre for Mental Health: London.

Implementation

Minghella, E., Ford, R., Freeman, T., Hoult, J., McGlynn, P.& O'HalloranP (1998) ' Open all Hours: 24 hour response for people with mental health emergencies' <u>London: The Sainsbury Centre</u>

Strathdee, G. (1994) 'The GP, the community and shared psychiatric care' <u>Practitoner, Nov</u> 238 (1544) pp. 751-754

Carr S & Wood H (1988) "Locality Services in Mental Health – The Sainsbury Centre and North Birmingham MH Trust

4.   ASSERTIVE OUTREACH

4.1   Who is the service for?

Adults aged between 18 and approximately 65 with the following:

1. A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability
2. A history of high use of inpatient or intensive home based care (for example, more than two admissions or more than 6 months inpatient care in the past two years)
3. Difficulty in maintaining lasting and consenting contact with services
4. Multiple, complex needs including a number of the following:

   • History of violence or persistent offending
   • Significant risk of persistent self-harm or neglect
   • Poor response to previous treatment
   • Dual diagnosis of substance misuse and serious mental illness
   • Detained under Mental Health Act (1983) on at least one occasion in the past 2 yrs
   • Unstable accommodation or homelessness

4.2   What is the service intended to achieve?

Within any population there is a small number of people with severe mental health problems with complex needs who have difficulty engaging with services and often require repeat admission to hospital.

Assertive outreach (or 'PACT' – Program of Assertive Community Treatment) has been shown to be an effective approach to the management of these people. Using an assertive outreach approach can:

• Improve engagement
• Reduce hospital admissions
• Reduce length of stay when hospitalisation is required
• Increase stability in the lives of service users and their carers/family
• Improve social functioning
• Be cost effective.

The service should be able to:

- Develop meaningful engagement with service users, provide evidence-based interventions and promote recovery
- Increase stability within the service users' lives, facilitate personal growth and provide opportunities for personal fulfilment
- Provide a service that is sensitive and responsive to service users' cultural, religious and gender needs
- Support the service user and his/her family/carers for sustained periods
- Promote effective interagency working
- Ensure effective risk assessment and management

Evidence indicates that the following principles of care are important:

- Self-contained team responsible for providing the full range of interventions
- A single responsible medical officer who is an active member of the team
- Treatment provided on a long-term basis with an emphasis on continuity of care
- Majority of services delivered in community
- Emphasis on maintaining contact with service users and building relationships
- Care co-ordination provided by the assertive outreach team
- Small caseload - no more than 12 service users per member of staff (see *Staffing* section within 4.5 for more details).

4.3   What does the service do?

Assertive outreach has a number of key components. Each must be in place if the service is to operate effectively.

Table 4a

Key component	Key elements	Comments
ASSESSMENT	• Initial multidisciplinary screening to ensure service appropriate for the service user • Comprehensive multi-disciplinary needs assessment • Physical health assessment where appropriate • Comprehensive multi-disciplinary risk assessment • Use of standard assessment measures to monitor change and identify progress (for example Life Skills Profile) • Statement of needs and production of care plan	• Assessment should focus on identifying the service user's strengths, goals and aspirations. This approach helps engagement and on-going relationship with team • Assessment should be culturally competent
TEAM APPROACH	• Each service user assigned a care co-ordinator who has overall responsibility for ensuring appropriate assessment, care and review by themselves and others in the team • Staff know and work with all service users. Continuity of care provided by the team as a whole • Written and verbal means of ensuring good communication between team members	• Note that although the care co-ordinator is responsible for co-ordinating care, treatment should be given within a team framework • Factors to take into consideration when assigning staff to provide care: skills of the individual team member, strength of relationship between individual team member and service user and service user's preferences

AGE, CULTURE AND GENDER SENSITIVE SERVICE	• 24 hour access to translation services should be available • Single sex accommodation and gender sensitive services should be provided (See section 8 of this guide for guidance on developing culturally competent services)	• The high prevalence of diagnosed psychosis in certain cultural groups emphasises the importance of developing a culturally competent service • Needs of different groups should be explored and services adapted appropriately

REGULAR REVIEW	• Brief daily review meetings at which:
	  • all service users are reviewed
	  • a member of the medical staff is involved
	  • risk is reviewed
	• Weekly review meetings with consultant psychiatrist where action is agreed and changes in treatment discussed by the whole team
	• Progress and outcomes regularly monitored
	• Care plan formally reviewed at least six monthly
		• Multi-disciplinary, service user focused review
		• Include service user and family/carer/people important to the service user in review of care plan
		• Risk should be formally reviewed on regular basis

INTERVENTIONS - The following interventions should be provided:		

Assertive engagement	• High priority given to providing services and support to service users and family/carers in the initial stages of engagement • Persistent approach to engagement – repeated attempts at contact	• Focus on strengths and interests of service user and benefits that contact with the service can bring • Assertive means being tenacious, creative and innovative NOT aggressive
Frequent contact	• Capacity to visit 7 days a week • Capacity to respond rapidly to changes in need and provide intensive support in the community	
Basics of daily living	• Care plan should address all aspects of daily living • Practical support *provided by the team itself* should be available e.g. help with shopping, domestic work (cleaning and improving living conditions), budgeting etc. • Daily living skills training to raise independence of service user	• Empowering service users and respecting their independence is crucial • The team's 'hands on' involvement in improving service users' living conditions is a vital tool in establishing and maintaining meaningful engagement • The team, on behalf of the service user, may need to be 'assertive' with other services to ensure better living conditions are provided and maintained

Family/carers and significant others support and intervention	• Care plan for carers to be produced and reviewed regularly • Psycho-education provided to family / carers / significant others • Behavioural family therapy available over extended periods of time as appropriate	• Practical support for family/carers should be provided as needed
Medication	• Delivery and administration of medication to service users who require intensive monitoring • Care designed to improve concordance (co-operation with treatment) • Service user involved in decision making and monitoring effects of medication • Standard side effect monitoring tools to be used regularly by service user and staff	• Staff need training in storage and use of medication as well as concordance training • Links with hospital and local pharmacies required to ensure continued supply • Careful attention to avoiding/reducing side effects vital if engagement and concordance are to be maintained
Cognitive behavioural therapy	• A range of techniques should be available within the team and used appropriately	• Cognitive behavioural therapy can be of considerable benefit to service users

Treatment of co-morbidities	Regular assessment of common co-morbidities: • Substance misuse • Depression/suicidal thoughts • Anxiety disorders	• The Assertive Outreach Team should have the core skills to assess and manage common problems • Specialist help for any of these conditions should be available. Care co-ordinator should co-ordinate provision of care as appropriate. If referral is necessary, AOT should continue to have overall responsibility for the service user
Social systems interventions	• Intervention should be provided to maintain and expand social networks and peer contact and reduce social isolation	
Attention to service user's physical health	• Physical health problems including nutritional and dental needs should be identified and addressed • Health promotion and access to screening services should be encouraged • Team to provide help in keeping appointments with GP/hospital etc	• Help and encouragement should be given to the service user to access health services

Help in accessing local services and educational, training and employment opportunities	Assertive outreach team should provide help so that: • Service users keep important appointments (e.g. job interviews) • A pathway to education and valued employment can be mapped and help in achieving this provided	• Skills to assess aspirations and opportunities should be present within the team • Referral to specialist education/occupation services for help with placement should be readily available
Relapse prevention	• Individualised early warning signs plan developed and on file • Plan to be shared with primary care, GP and others as appropriate • Relapse prevention plan agreed with service user and family/carers • Effort made to identify and reduce conditions that leave the service user vulnerable to relapse	• Changes in thought, feelings and behaviours precede the onset of relapse but there is considerable variation between service users. Development of individualised plans can be effective in reducing the severity of relapse

Crisis intervention	• Intensive support in the community should be provided by the team during a crisis • If acute care is thought to be required, joint assessment should take place between assertive outreach team, crisis team and/or acute care team so that the least restrictive/stigmatising setting for care is arranged	• Avoidance of hospitalisation and restrictive care wherever possible • As much treatment provided in community / service user's home as possible
Inpatient and respite care	• Avoidance of hospitalisation and provision of alternatives to hospital care wherever possible • If inpatient care is needed assertive outreach team to maintain contact during stay and be involved in decision making • Regular joint, formal review to ensure service user is transferred to the lowest stigma/least restrictive environment as soon as clinically possible • AOT involved in the discharge planning and in ensuring home environment is ready for discharge	• Service user/carer/family involved in decision making and discharge planning as much as possible • Primary care and other services to be involved in discharge planning as appropriate and kept informed of discharge plans

DISCHARGE AND TRANSFERS	• As long as there is evidence of benefit, assertive outreach should continue indefinitely • If a good recovery is made, care could be transferred to a community mental health team providing less intensive intervention • Rapid re-referral must be possible if service user discharged • If service user moves home, assertive outreach team to ensure care is transferred effectively and engagement is continued. Contact to continue until engagement with new team established	• Boundaries between different health care services need to be flexible to respond to different needs • Service user/carer/significant others to be involved in discharge planning process • Primary care actively involved in discharge planning

Links with crisis resolution/home treatment team

The crisis resolution/home treatment team can provide crisis care out of hours - see crisis resolution/home treatment service specification (section 3 of this guide).

4.4   Management of service and operational procedures

Model of service delivery

Assertive outreach services are best provided by a discrete, specialist team that has:

- Staff members whose sole (or main) responsibility is assertive outreach
- Adequate skill mix within the team to provide all the interventions listed above
- Strong links with other mental health services and a good general knowledge of local resources

Formation of assertive outreach service

- An audit of pathways of care, current service provision and local epidemiology should be undertaken initially. Information from this audit should then be used to develop an implementation plan (see *section 8: Tailoring Services to Local Needs)*
- The employment of a project manager to oversee the formation of the assertive outreach team should be considered

Caseload

- Each team to have a caseload of approximately 90 service users. Service user to care co-ordinator ratio maximum 12:1 (ideally 10 to 1)

Table 4b

Care co-ordinators include:	Not to be classified as care co-ordinators:
• CPNs • ASW • OT • Team leader • Psychologist	• Medical staff • Support workers

- Each team is likely to cover a population of approximately 250,000. However, the size of population that each service covers will depend on a number of different factors. In inner city area each will cover significantly smaller populations. A health needs assessment needs to be undertaken prior to the formation of an AOT to calculate likely service usage and the optimal size of the population to be covered. Factors to take into consideration include:

- Geography of the area
- Demography and epidemiology
- Health and Social Service boundaries

(S*ee section 8: Tailoring Services to Local Needs* for more information)

Staffing

The table below gives details of suggested staffing levels and skill mix for a team with a caseload of 90 service users. The team make up should reflect the local demography.

Table 4c	
Care co-ordinators • Service user to care co-ordinator ratio should be maximum 12 to 1. Key skills: • High energy level • Team player • Ability creatively to engage service users • Understanding of needs of service users, including specific needs related to cultural background/age/gender etc • Able to co-ordinate care and provide broad range of interventions	Total 8 wte care co-ordinators Team leader must have an active caseload Appropriate mix of psychiatric nurses, ASWs, OTs, psychologists needed to ensure that all the interventions listed can be provided within the team
Medical staff • Active members of the team • Dedicated sessions	0.5 wte consultant psychiatrist 0.5 wte non career grade psychiatrists
Specialist skills • These skills should be available within the team either by employing a fully qualified practitioner or by training other team members • External supervision, support and training needed for 'non specialists' providing these interventions	• OT/OT skills • Psychologist/psychology skills • ASW/strong links to social services and ability to undertake thorough assessment and activate services as needed

Support workers • People with health, social care or appropriate life experience or personal experience of mental health problems/treatment	• Number of support workers to be determined by the team • Support workers to reflect the demography of the local population
Programme support	• 1 wte administrative assistant • IT, audit and evaluation support may also be needed

Hours of operation

- Working hours: 8am to 8pm seven days a week
- Out of hours: one member of staff on call for phone advice. No provision for home visits. If visit required, referral to crisis resolution/home treatment team

Referrals

- Assertive outreach should accept direct referrals for assessment from primary care, community mental health teams, early intervention teams, continuing care teams, forensic services
- Links should be established with local homeless service, police and voluntary agencies so direct referrals for assessment can easily be made.

Risk assessment and policy on violence

- Each team should have a written policy outlining the level of risk the team is able to manage
- Operational policy should explicitly address staff safety

Staff training should include:

- Principles of the service, cultural, gender and anti-racist training
- Skills in delivering all of the interventions listed above
- Team building, colleague support and working within a team framework
- Medication – storage, administration, legal issues, concordance training, side effects
- Use of Mental Health Act and alternatives to hospital treatment
- Engaging and interacting with other services
- Benefits to service user and family/carers of an assertive outreach approach
- Suicide awareness and prevention techniques

The training period is likely to take about 4 weeks. During the initial stages of establishing the service, the caseload should be increased gradually.

Service user information

Service users and their family/carers should be provided with the following information:

- Description of the service, range of interventions provided and what to expect
- Name and contact of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice and help
- Information about assertive outreach approach and benefits of maintaining regular contact
- Care plan and comprehensive information about medication
- Relapse prevention and crisis plan
- How to express views on the service

Continual service improvement

Regular audit of the service should be undertaken to ensure that gaps in service provision are filled. Audit should always include feedback from service users and their family/carers (*see section 8 -Tailoring services to local needs and 9.5 -'Performance management').*

4.5   Evidence for further reference

Abbott, S., Smith, S., Clarke, R., Curson, C., De Souza Gomes, J., Heslop, K. Trainer, E and Yellowlees, P.(1197). ' Who is a heavy service user? Preliminary development of a screening instrument for prospective consumers of a mobile intensive treatment team', Australian and New Zealand Journal of Psychiatry, 31, pp.744-750

Bond, G.R., Miller, L.D., Krumwied, R.D. and Ward.R.S. (1998). 'Assertive case management in three CMHCs: A controlled study', Hospital and Community Psychiatry, 39 (4), pp.411-418

Burns, T. and Guest, L. (1999). 'Running an assertive community treatment team', Advances in Psychiatric Treatment 5, pp. 348-356

Dincin, J., Wasmer, D., Witheridge, T.F., Sobeck, L., Cook, J and Razzano, L. (1993). 'Impact of assertive community treatment on the use of State hospital inpatient bed-days', Hospital and Community Psychiatry, 44 (9), pp. 833-838

Drake, R.E (1998) 'Brief history, current status, and future place of assertive community treatment', American Journal of Orthopsychiatry, 68(2), pp. 172-175

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.T., Xie, H., Miles, K. and Ackerson, T.H. (1998). 'Assertive community treatment for patients with co-occurring severe mental illness and substance abuse disorder', American Journal of Orthopsychiatry, 68 (2), pp. 201-215

Essock, S.M., Frisman, L.K. and Kontos, N. (1998). 'Cost-effectiveness of assertive community treatment teams', American Journal of Orthopsychiatry, 68 (2), pp. 179-190

Gauntlett N. Ford R. Muijen M. (1996) 'Teamwork, Models of Outreach in an Urban Multicultural Setting (the Tulip Report)' Sainsbury Centre

Hambridge, J.A. and Rosen, A. (1994) 'Assertive community treatment for the seriously mentally ill in suburban Sydney: a programme description and evaluation' Australian and New Zealand Journal of Psychiatry, 28, pp.438-445

Hemming, M, Morgan, S. and O'Halloran, P (1999). 'Assertive Outreach: Implications for the development of the model in the United Kingdom', Journal of Mental Health, 8 (2), pp.141-147

Herinckx, H.A., Kinney, R.F., Clarke, G.N and Paulson, R.I.(1997) 'Assertive community treatment versus usual care in engaging and retaining clients with severe mental illness' Psychiatric Services, 48 (10), pp. 1297-1306

Issakidis, C., Sanderson, K., Teeson, M, Johnston, S. and Buhrich, N. (1999). ' Intensive case management in Australia: a randomised controlled trial', Acta Psychiatrica Scandinavica, 99, pp. 360-367

Johnston, S., Salkeld, G., Sanderson, K., Issakidis, C., Teeson, M. and Buhrich, N. (1998). 'Intensive case management: a cost effectiveness analysis', Australian and New Zealand Journal of Psychiatry, 32, pp. 551-559

Kent, S and Yellowlees, P.M.(1994). 'Psychiatric and social reasons for frequent hospitalisation', Hospital and Community Psychiatry, 45 (4), pp. 347-350.

Lachance, K.R. and Santos, A.B. (1995). 'Modifying the PACT model: Preserving critical elements', Psychiatric Services, 46 (6), pp. 601-604

Lang, M.A., Davidson, L., Bailey, P. and Levine, M.S. (1999). 'Clinicians' and Clients' Perspectives on the Impact of Assertive Community Treatment'. Psychiatric Services, 50 (10), pp. 1331-1340

Latimer, E.A. (1999). 'Economic Impacts of Assertive Community Treatment: A Review of the Literature'. Canadian Journal of Psychiatry, 44, pp. 443-445

Lehman, A.F., Dixon, L.B., Kernan, E., DeForge, B.R. and Postrado, L.T. (1997). 'A randomised trial of assertive community treatment for homeless persons with severe mental illness', Archives of General Psychiatry, 54 (11) pp. 1038-1043

Lowe J. (1999) 'A New Model for a New Challenge – Tulip Assertive Outreach Services'. The Mental Health Review 4:1999 Pavillion Publishing

McGrew, J.H., Bond, G.R., Dietzen, L., McKasson,. M. and Miller, L.D. (1995). 'A multisite study of client outcomes in assertive community treatment' Psychiatric Services, 46 (7), pp. 696-701

McHugo, G.J., Drake, R.E. Teague, G.B. and Xie, H. (1999). 'Fidelity to Assertive Community Treatment and Client Outcomes in the New Hampshire Dual Disorders Study'. Psychiatric Services. 50 (6), pp. 818-824

Morgan, S., Hemming, M, and Davidson, D.(1999). Implementing Assertive Outreach. Unpublished statement by the Sainsbury Centre for Mental Health and supporting agencies.

Museser, K.T.,Bond, G.R., Drake, R.E. and Resnick, S.G. (1998) ' Models of Community Care for Severe Mental Illness: A Review of Research on Case Management', Schizophrenia Bulletin, 24 (1), pp.37-74

Rapp, C.A. (1998). 'The Active Ingredients of Effective Case Management: A Research Synthesis', Community Mental Health Journal, 34 (4, pp. 363-380

Salyers, M.P., Masterton, T.W., Fekete, D.M., Picone, J.J and Bond, G. (1998). 'Transferring clients from intensive case management: Impact on functioning,' American Journal of Orthopsychiatry, 68 (2), pp. 233-245

Santos, A.B., Deci, P.A., Lachance, K.R., Dias, J.K., Sloop, T.B., Hiers, T.G and Bevilacqua, J.J (1993). ' Providing assertive community treatment for severely mentally ill patients in a rural area', Hospital and Community Psychiatry, 44 (1), pp. 34-39

Stein, L.I. and Santos A.B.(1998) 'Assertive Community Treatment of Persons with Severe Mental Illness' Norton, Pavillion, UK

Teague, G.B., Bond, G.R. and Drake, R.E. (1998). 'Program fidelity in assertive community treatment: Development and use of a measure', American Journal of Orthopsychiatry, 68 (2), pp. 216-232

Witheridge T.F (1989) 'The Assertive Community Treatment Worker: An Emerging Role and its Implications for Professional Training' Hospital and Community Psychiatry 40 (6): 620-624

5.   EARLY INTERVENTION IN PSYCHOSIS

5.1   Who is the service for?

- People aged between 14 and 35 with a first presentation of psychotic symptoms
- People aged 14 to 35 during the first three years of psychotic illness

5.2   What is the service intended to achieve?

Psychosis is a debilitating illness with far-reaching implications for the individual and his/her family. It can affect all aspects of life – education and employment, relationships and social functioning, physical and mental wellbeing. Without support and adequate care, psychosis can place a heavy burden on carers, family and society at large.

The mean age of onset of psychotic symptoms is 22 with the vast majority of first episodes occurring between the ages of 14 and 35. The onset of this disease is therefore often during a critical period in a person's development.

At present it can take up to two years after the first signs of illness for an individual and his/her family to begin to receive help and treatment. Lack of awareness, ambiguous early symptoms and stigma all contribute to the delay in appropriate help being offered and taken up.

Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm. One in ten people with psychosis commits suicide - two thirds of these deaths occur within the first five years of illness.

Intervening early in the course of the disease can prevent initial problems and improve long term outcomes. If treatment is given early in the course of the illness and services are in place to ensure long-term concordance (co-operation with treatment), the prospect for recovery is improved.

An early intervention service should be able to:

- reduce the stigma associated with psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment.
- reduce the length of time young people remain undiagnosed and untreated
- develop meaningful engagement, provide evidence-based interventions and promote recovery during the early phase of illness

- increase stability in the lives of service users, facilitate development and provide opportunities for personal fulfilment
- provide a user centred service i.e. a seamless service available for those from age 14 to 35 that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services
- at the end of the treatment period, ensure that the care is transferred thoughtfully and effectively

Evidence indicates that the following principles of care are important:

- Culture, age and gender sensitive
- Family orientated
- Meaningful and sustained engagement based on assertive outreach principles
- Treatment provided in the least restrictive and stigmatising setting
- Separate, age appropriate facilities for young people
- Emphasis on normal social roles and service user's development needs, particularly involvement in education and achieving employment
- Emphasis on managing symptoms rather than the diagnosis.
- A typical early intervention service will aim to meet the needs of a million total population. The service will comprise 3 or 4 teams and appropriate respite facilities. By April 2004 each early intervention service will have established its first team. The overall service will be established during the lifespan of the NSF through the initial investment and service restructuring/reinvestment. The exact configuration of the 50 services will be established on a regional basis.

5.3   What does the service do?

The service has a number of key components. Each must be in place if the service is to operate successfully.

Table 5a

Key components	Key elements	Comments
GENERAL		
Raising awareness of psychotic illness	• Active involvement in community-based programmes to reduce stigma associated with psychotic illness • Symptom awareness programmes for primary care, educational institutions, social services and other relevant agencies	• See service specification for Mental Health Promotion Framework (section 7 of this guide) for information on effective programmes • Awareness programme needs to emphasise the often ambiguous and subtle ways in which psychotic illness can develop
Focus on symptoms	• All professionals need to understand the many and varied ways in which psychosis can develop and the spectrum of 'normal' mood and behavioural changes that can occur during adolescence and early adulthood • Professionals and agencies working at the first point of contact must feel free to refer young people for an expert assessment based on suspicion rather than a certainty of psychosis • Treatment needs to focus on management of symptoms and sufficient time needs to be allowed for symptoms to stabilise before a diagnosis is made	• Diagnosis can be difficult in the early phases of a psychotic illness. The services should be able to adopt a 'watch and wait' brief when the diagnosis is unclear

Age, culture and gender sensitive service	• Effective links with youth and young person's services should be established • 24 hour access to translation services should be available • Single sex accommodation and gender sensitive services should be provided (See section 8 for guidance on developing culturally competent services)	• Onset of symptoms usually occurs in adolescence or early adulthood. Services need to reflect this. • The high prevalence of diagnosed psychosis in certain groups emphasises the importance of culturally competent services • Specialist services that comply with the Children Act are needed for service users who are 14 to 18 years old
ASSESSMENT		
Early detection	• Training programmes and written guidance for GPs and other key agencies are needed on the importance of early detection and how to refer people with potential early psychosis • Regular audit of effectiveness of referral pathways and training programmes	• Pathways of care must be explicit and understood by all involved • Access to assessment should be easy and rapid

Assessment	• Service user centred, multidisciplinary assessment co-ordinated by care co-ordinator • Sufficient time should be allowed to develop a relationship and let symptoms stabilise • Physical Health Assessment where appropriate	Comprehensive assessment to include as a minimum: • Psychiatric history • Mental state examination • Risk - including suicide risk • Social functioning and resource assessment • Psychological assessment • Occupational assessment • Family/support assessment • Service user's aspirations and understanding • Contribution from people important to the service user
Production of comprehensive care plan	• Initial care plan produced within a week of assessment • Initial care plan comprehensively reviewed at three months • Care plan updated at least six monthly	• Care plan flexible enough to adapt to changes in the level and type of care required
INTERVENTIONS		
Early and sustained engagement	• Allocation of dedicated community-based care co-ordinator to each service user • Assessment should take place in the service user's home or other low stigma setting • Sustained engagement using an assertive outreach approach so that no service users are 'lost to follow up'. • Failure to engage in treatment should not lead to case closure.	• Lack of clear diagnosis should not lead to case closure. Instead an active 'watching brief' should be adopted if there is a suspicion of psychotic illness but no firm diagnosis. • See Assertive Outreach Service Specification (section 4 of this guide) for more information on the assertive outreach approach • Focusing on the strengths and interests of the service user and the benefits that contact with the service can

		bring can help improve engagement and concordance (co-operation) with care
Medication	• Use of **low** dose or atypical neuroleptics first line and consideration of mood stabilisers and antidepressants if appropriate • Service user involved in decision making and monitoring effects • Care designed to improve concordance • Standard side effect monitoring tools to be used regularly by staff and service user	• Local evidence-based prescribing and therapy protocols should be developed and used • Choice of medication dependant on clinical condition • Specialist support from CAMHS expertise needed when prescribing for under 16 year-olds • Avoidance of and careful attention to side effects are important to ensure effective treatment and long term engagement with services

Psychological therapies	• Use of cognitive behavioural therapy as appropriate • Psycho-education • Information provided to service user about local recovery or service user groups	• Cognitive behavioural therapy can be of considerable benefit to service users • Promotion of coping skills is vital
Family/carers/ Significant others involvement and support	• Family/carers/significant others should be involved in assessment and treatment process as early as possible • Provision of psycho-education, family therapy and support • At least monthly contact with family/carers/significant others • Connexions workers	• Engagement of family/friends improves assessment, and the long term outcomes of the service user, and can alleviate stress within the family. • Care must be taken to engage and support **all** those important to the service user. This is particularly important if the service user has left home
Addressing basics of daily living	Care plan should address all aspects of daily living	• Unstable living and financial circumstances are known vulnerability factors for relapse. • However, early reliance on disability allowance can hamper rehabilitation and chances of finding valued employment. Every effort must be made to provide an effective pathway to valued education and occupation

Providing pathway to valued education and occupation	• Vocational assessment (if required) should take place within 3 months of referral • An education or training plan/pathway to valued employment should be produced within 3 months	• Formal links with key agencies and schemes such as local careers advisory services, ConneXions, New Deal, Training and Enterprise Agency, further education colleges, voluntary organisations etc. must be established. • Early referral is vital. The longer an individual remains out of work/education in the early phase, the harder it becomes to gain employment/participate in education later on.
Treating co-morbidity	Regular assessment of common co-morbidity's particularly: • Substance misuse • Depression/suicidal thoughts • Anxiety disorders	• Early intervention team should have core skills to assess and deal with common co-morbidities. • Specialist help for any of these conditions should also be available. Care co-ordinator should co-ordinate provision of care as appropriate. If referral is necessary, early intervention team should continue to have overall responsibility for the service user.

Relapse prevention plan	• Individualised early warning signs plan developed and on file • Relapse prevention plan agreed with service user and involve family/carers	• Changes in thought, feelings and behaviours precede the onset of relapse but there is considerable variation between service users. Development of individualised plans can be effective in reducing the severity of relapse.
Crisis plan	• Service user/family/carers know when and how to call for help • Intensive support in the community provided by the team during the crisis • If acute care is thought to be required, joint assessment should take place between early intervention team, crisis team and/or acute care team so that the least restrictive / stigmatising setting for care is arranged	• Avoidance of restrictive / stigmatising care wherever possible • As much treatment provided in the community/service user's home as possible • Links with crisis team to ensure 24 hour crisis team available

Inpatient and respite care	• Avoidance of hospitalisation if possible and provision of alternatives to hospital care e.g. community hostels, cluster homes, day care
	• If hospitalisation is needed
	    • Separate age, gender and culture appropriate accommodation should be provided
	    • Regular, formal joint (inpatient and early intervention staff) review to ensure service user is transferred to the lowest stigma/restrictive environment as soon as clinically possible
	    • Early intervention team to be actively involved in discharge planning
		• Avoidance of trauma and stigma associated with hospitalisation is important to reduce harm and ensure long term engagement
		• Service user/family/carers involved in decision making and discharge planning as much as possible
		• Primary care and other services to be involved in discharge planning as appropriate and kept informed of discharge plans

Regular review	• Regular team review of effectiveness of care • Second and third line pharmaceutical and range of psychological treatments considered where necessary	• Local evidence-based prescribing and therapy protocols should be developed and used • Avoidance of and careful attention to side effects are important in ensuring effective treatment and long term engagement with services • Service user actively involved in decision making and side effect monitoring

Discharge	The following discharge possibilities could be considered: • If stable and well - discharge to primary care with yearly joint consultant/primary care review • If unstable and fulfilling criteria for assertive outreach, refer to the Assertive Outreach Team • If many negative symptoms and unwell, refer for rehabilitation and ongoing care • If well but concerns about ability of primary care to care for service user - follow up as an outpatient • If service user moves home before three years, the Early Intervention Team should continue care until care package established in new area	• Usually a service user will require care from the Early Intervention Team for three years. • There should however be flexibility regarding the 'three years' with early discharge arranged for stable service users and later discharge possible if engagement and stabilisation were problematical early in the course of illness • Continuity of care is vital. Early intervention team should not disengage with the service user until adequate contact with other services has been established

Links with crisis resolution/home treatment team

For users aged 14 or over, the crisis resolution/home treatment team can provide crisis care out of hours – see crisis resolution/home treatment service specification for more details (section 3 of this guide).

Local arrangements have to be made between the crisis resolution/home treatment team, the early intervention team and child and adolescent mental health services (CAMHS) to ensure service users who are under 16 years old have adequate and rapid access to an out of hours crisis service.

As one of the principles of early intervention services is the maintenance and re-establishment of the integration of users with age appropriate mainstream community services, there need to be a wide range of close links fostered. This will include close ties with primary care, education, youth agencies, leisure providers and a variety of other services across the voluntary and statutory sectors.

5.4   Management of Service and operational procedures

Joint commissioning

A joint commissioning approach involving PCGs/PCTs, HAs and social services should be adopted with commissioners being advised by the advisory group (see under formation of service).

Model of service delivery

Early intervention services are best provided by a discrete, specialist team that has:

- Staff members whose sole (or main) responsibility is the management of people in the early phase of psychotic illness
- An adequate skill mix within the team to provide all the interventions listed above
- Strong links with other mental health services and a good general knowledge of local resources.
- Clarified medical responsibility for patients. This would normally be integrated within the team and maximally supportive of the team intervention.

Formation of service

Year 1 (2001-2002)

- Set up a project management team (PMT) to include as a minimum adult mental health services (health and social care) and child and adolescent mental health services (health and social care)
- The employment of a project manager to oversee the formation of the early intervention service should be considered [moved up and team altered to service]
- Set up an advisory group that includes a broad range of stakeholders (e.g. young service users, their carers, youth agencies, education, criminal justice, drug and alcohol, leisure, primary care)
- Develop an implementation plan that includes
- the overall long-term plan to establish the early intervention service over the lifespan of the NSF
- B) the detailed plan to establish the first team between April 2002 and March 2004

- The PMT should set up an audit of pathways of care, should map current service provision and establish the number of people aged 14-35 with possible psychosis presenting to mental health services for the first time. Information from this audit should then be used to develop an implementation plan and be reported in the comprehensive review of services (see Chapter 8).

Years 2 and 3 (2002-2004)

- The first team should be set up, recruited, trained
- There should be ongoing development of the overall service including ongoing population-based audit of how the needs of young people with first episode psychosis are being met.

Caseload

Ideally each Early Intervention Service should manage 150 new cases per year and have a total caseload of approximately 450. It is envisaged that each Early Intervention Service will cater for a population of around 1 million people. An understanding of local epidemiology is needed as the size of population covered will depend on a number of different factors including:

- Geography of the area
- Health and Social Service boundaries
- Demography and epidemiology

Teamwork is vital for success. Dividing the service into a number of teams (three or four), each managing a caseload of 30 to 50 new cases per year and 120 to 150 in total, optimises the benefits of working within a team framework. Each service should therefore consist of a number of teams.

Staffing

The table below gives details of suggested staffing levels and skill mix for a team with a caseload of 120 to 150.

Table 5b	
Care co-ordinators Key skills: • High energy level • Team player • Ability creatively to engage service users • Understanding of needs of service users, including specific needs related to cultural background/age/gender etc • Able to co-ordinate care and provide broad range of interventions • Works well with young people	Total 10 wte care co-ordinators with service user to care co-ordinator ratio maximum 15 to 1 Team leader must have an active caseload Appropriate mix of psychiatric nurses, ASWs, OTs, psychologists needed to ensure that all the interventions listed can be provided within the team
Psychiatrists – adult mental health • Active members of the team • Dedicated sessions	0.5 wte adult consultant psychiatrist 1.0 wte non career grade psychiatrists
Psychiatrists – CAMHS • Active members of the team • Dedicated sessions	0.1 wte CAMHS consultant
Specialist skills - adult • These skills should be available within the team either by employing a fully qualified practitioner or by training other team members • External supervision, support and training needed for 'non specialists' providing these interventions	• OT/OT skills • Psychologist/psychology skills • ASW/strong links to social services and ability to undertake thorough assessment and activate services as needed
Specialist skills – CAMHS	0.2 wte clinical psychologist with special interest in CAMHS
Support workers • People with health, social care or appropriate life experience or personal experience of mental health problems/treatment	• Number of support workers to be determined by the team • Support workers to reflect the demography of the local population
Programme support	• 1 wte administrative assistant • IT, audit and evaluation support may also be needed

Hours of operation

- Core working hours should be 8am to 8pm, 7 days a week
- Out of hours (8pm to 8am) - advice should be available from staff at the community respite facility or alternative (either by telephone or by visiting the unit) or from an on-call member of the Early Intervention Team
- Note there is no provision for home visits out of hours. Service users should be referred to crisis resolution/home treatment team/out of hours CAMHS service if home visit is required (see above).

Referrals

Early intervention is a specialist service. The service should take direct referrals from CMHTs, CAMHS, primary care, crisis resolution/home treatment team, forensic services, assertive outreach, other mental health services, acute medical services (including A+E).

Provision of alternative residential care

Each service requires easy access to community respite care appropriate to each age group:

- Respite beds for adults over 22 years of age (separated from other mental health facilities)
- Young person's beds (adults aged 16 to 22)
- Regional unit adolescent beds

Risk assessment and policy on violence

- Each team should have a written policy outlining the level of risk the team is able to manage
- Operational policy should explicitly address staff safety

Staff training should include:

- Principles of the service
- Training in all key components listed above
- Team building, colleague support and working within a team framework
- Medication – storage, administration, legal issues, concordance training and side effect management, prescribing to under 16 year olds
- Use of Mental Health Act and alternatives to hospital treatment
- Understanding of the Children Act

- Benefits to service user and family/carers of this service
- Suicide awareness and prevention techniques

Service user information

Service users and their family should be provided with the following information:

- Description of the service, key elements and what to expect
- Name and contact details of care co-ordinator and other relevant members of the team
- Contact details for out of hours advice/intervention
- Information about assertive outreach approach and benefits of maintaining regular contact
- Ongoing care plan and information about medication
- Relapse prevention and crisis plan
- How to express views on the service

5.5   Evidence for Further Reference

Birchwood, M. Jackson, C. and Todd, P. (1998). The critical period hypothesis. *International Clinical Psychopharmacy* **12**: 27-38.

Birchwood, M. McGorry, P. and Jackson, H. (1997). Early Intervention in Schizophrenia. *British Journal of Psychiatry.*

Birchwood, M. and Smith, J. (1987). Expressed emotion and first episodes of schizophrenia. *British Journal of Psychiatry.*

Birchwood, M. Hallett, S. and Preston, M. (1998). *Schizophrenia: An Integrated Approach to Research and Treatment.* Harrow, Essex: Longman.

Burnett, R. Mallett, R. and Bhugra, D (1999). The first Contact of Patients With Schizophrenia with Psychiatric Services. *Psychological Medicine,* **29**: 475-484.

Chattergree, A. and Liberman, J. (1999). Studies of biological variable in first Episode of Schizophrenia: A comparative review. In P.D., McGorry and H.J. Jackson (eds) *The recognition and management of early psychosis.* Cambridge. Cambridge University Press.

Emsley R.A. (1999). Rispiridone in the treatment of first-episode psychotic patients: a double-blind multicentre study. *Schizophrenia Bulletin,* **25**: 721-729.

Fadden, G. (1998). Family Intervention in psychosis. *Journal of Mental Health,* (7) 115-122.

Falloon, I.R.M. (1992). Early Intervention for first episode of schizophrenia: A preliminary exploration.. *Psychiatry,* **55**: 4-15.

Garety, P. Fowler, D. Kuipers, E. Freeman, D. Dunn, G. Bebbington, P. Hadley, C. and Jones, S. (1997). The London and East Anglia randomised controlled trial of cognitive behaviour therapy for phychosis. II: Predictors of outcome. *British Journal of Phychiatry,* **171**: 420-426.

Harrow, M. Macdonald, A.W. Snads, J.R. and Silverstein, M.L. (1995). Vulnerability to delusions over time in schizophrenia and affective disorders. *Schizophrenia Bulletin,* **21** (1): 95-109.

Kuipers, L. and Bebbington, P.E. (1994). The predictive utility of expressed emotion in schizophrenia: an aggregate analysis. *Psychogical Medicine,* August 1994, **24** (3): 95-109.

Kulkarni, J. and Power, P. (1999). Initial treatment in first episode In McGorry, P. and Jackson, H. (eds) *The recognition and management of early psychosis.* Cambridge. Cambridge University Press.

Lieberman, J.A. Jody, D. Geisler, S. Alvir, J. Loebel, A. Szymanski, S. Woerner, M. and Borenstein, M. (1993). Time course and biologic correlates of treatment response in first episode schizophrenia. *Archives of General Psychiatry,* **50**: 369-376.

Lincon, C. and McGorry, P. (1999). Pathways to care in early psychosis: Clinical and Consumer perspectives. In P.D.McGorry and H.J. Jackson (eds). *The recognition and management of Early psychosis.* Cambridge. Cambridge University Press.

Mason, P. Harrison, G. Glazebrook, C. Medley, I. Dalkin, T. and Groudace. (1995). Characteristics of outcome in schizophrenia at 13 years. *British Journal of Psychiatry.* **167**: 596-603.

McEvoy, J.P. Hogarty, G.E. and Steingard, S. (1991). Optimal dose of neuroleptic in acute schizophrenia: a controlled study of the neuroleptic threshold and higher haloperidol. *Archives of General Psychiatry,* **48**: 739-745.

McGorry, P.D. et al. (1997). *Very low dose nueroleptic treatment of first episode psychosis – is it feasible in routine clinical care?* Poster Prestation. 6th International coingress of Schizophrenic Research, Oloorado Springs.

McGorry P.D. (1991). Paradigm failure in functional psychosis: review and implications. *Australian and New Zealand Journal of Psychiatry* 1991, **26**: 3-17.

McGorry, P.D. The concept of recovery and secondary prevention in psychotic disorders. *Australian and New Zealand Journal of Psychiatry* 1992, **26**: 3-17.

McGorry, P.D. Edwards, J. Mihalopoulos, C. Harrigan, S.M. and Jackson, H.J. EPPIC: An evolving system of early detection and optimal management. *Schizophrenia Bulletin* 1996, **22** (2): 305-326.

McGorry, P.D. MacFarlane, C. Patton, G.C. Bell, R. Hibbert M.E. Jackson, H.J. and Bowes, G (1995). The prevalence of prodromal features of schizophrenia in adolesence: a preliminary survey. *Acta Psychiarica Scandinavia,* October 1995, **92** (4): 241-249.

McGorry, P. Chanen, A. McCathey, E. Van Riel, R. McKenzie, D. and Singh, B. (1991). Post Traumatic stress disorder following recent onset psychosis: an unrecognised post psychotic syndrome. *Journal of Nervous and Mental Disease,* **179**: 253-258.

McGorry, P. Edwards, J.G. Mihalopoulos, C. Harrigan, S. and Jackson, H.J. (1996). EPPIC: an evolving system of early detection and optimal management. *Schizophrenia Bulletin,* **22**: 305-326.

McGorry, P. and Jackson, H. (1999) *Recognition and management of Early psychosis. A preventative approach.* Cambridge University Press.

NEPP (1998). Australian Guidelines for Early Intervention.

Rooke, O. and Birchwood, M. (1998). Loss, humiliation and entrapment as appraisals of schizophrenic illness: a prospective study of depressed and non-depressed patients. *British Journal of Clinical Psychology,* **37**: 259-268.

Shepherd, G. (1998). Models of Community Care. *Journal of Mental Health,* **7** (2): 165-178.

Syzmanski, S.R. Cannon, T.D. Gallacher, F. Erwin, R.J. and Gur, R.E. (1996). Course of treatment response in first episode and chronic schizophrenia. *American Journal of Psychiatry,* **153** (4): 519-525.

Tarrier, N. Yusopoff, L. Kinney, C. McCarthy, E. Gledhill, A. Haddock, G. and Morris, J. (1998). Randomised controlled trial of intensive cognitive behaviour therapy for patients with chronic schizophrenia. *British Medical Journal,* August 1998, **317**: 303-307.

Thara, R. Henreyeta, M. Joseph, A. Rajkumar, S. and Eaton, W. (1994). Ten year course of schizophrenia. The Madras longitudinal study. *Acta Psychiatrica Scandinavia,* **90**: 329-336. Warner, R. (1994). *Recovery from Schizophrenia: Psychiatric and Political Economy, second edition. London: Routledge*: 57-81.

Wiersma, D. Nienhuis, F.J. Sloof, C.L. and Giel, R. (1998). Natural course of schizophrenic disorders: A 15 year follow-up of a Dutch incident cohort. *Schizophrenic Bulletin,* **24** (1): 75-85.

Wyatt, R.J. (1991). Neuroleptics and the natural course of schizophrenia. *Schizophrenia Bulletin,* **24**: 78-85.

6. PRIMARY CARE MENTAL HEALTH

6.1 A vision for the future

For primary care mental health, improving partnerships between health, social and voluntary sector provision will help to ensure faster access to effective treatment for people with common mental disorders, faster access for people in crisis, effective care for those with stable, severe mental illness and services closer to people's homes. In addition, better training and education for existing staff, new ways of working and new staff will also be needed.

6.2 Service configuration

By 2004 all Primary Care Groups (PCGs) will have become PCTs. The number of GPs entering contracts to provide Personal Medical Services (PMS) as against General Medical Services (GMS) will also increase. Inherent in this is a move towards more integrated service planning and delivery.

However, at present, very few Primary Care Trusts (PCTs) provide as well as commission the full range of mental health services. Typically, more specialised services are provided by mental health trusts, and a variety of key services are provided by local councils as well as in the non-statutory sector, and the charitable and voluntary sectors. This means that the quality of work at the interfaces between primary and specialised services, or between health and social care, or statutory and non-statutory services are very important.

Primary and specialised care

A number of models exist for the provision of primary and specialised mental health care, designed and to improve the quality of partnerships at the interfaces. For example, the National Primary Care Research and Development Centre has estimated that, by the 1980s, one fifth of all general psychiatrists in England and Wales and half in Scotland, were spending some proportion of their time in primary care. This is one way to promote more effective partnerships between primary and specialised services, and ensure that patients can access services more easily.

A new model of a fully integrated primary care liaison team, (which has replaced the CMHT), is currently being evaluated in North Birmingham. The `Primary care liaison team' supports primary care to provide services for patients with common mental health

problems who require specialist psychiatric or psychotherapeutic treatment. They also provide support for people with a severe mental illness, as well as people with Severe Personality Disorder, who cannot be supported in primary care alone.

Health and social care

Boundaries between health and social care also represent an obstacle to effective partnership working, and reduce the scope to provide `seamless' services for patients. Differences in employment, pay, terms and conditions for staff delivering aspects of health and social care can result in divisions between them. The Health Act 1999 removes barriers to joint working by introducing powers to enable health and local authorities to bring their resources together into a pooled budget accessible to both commission and provide services.

Commissioners (Health Authority, Primary Care Trusts or Social Services Authority) are enabled to transfer funds and delegate functions so that one authority can take responsibility for commissioning both health and social care, thereby ensuring more integrated provision. Similarly, NHS Trusts and PCTs are able to provide social services beyond their current ability under income generation powers, and local authorities are able to provide some services formerly only available in the NHS. However, to date, relatively few PCTs and specialised mental health trusts have taken advantage of the opportunities in the Health Act and there is scope for further development in this area.

The NHS Plan sets out the preliminary plans to take partnerships between health and social care further. Care trusts will be enabled to provide even closer integration of health and social services. They could evolve from specialised mental health trusts and/or from PCTs. Care trusts are likely to develop first where partnership arrangements are already working well, and the partners want to establish single, multi-purpose legal bodies to commission and be responsible for all health and social care. Guidance on Care trusts will be issued in due course.

An integrated system of care

Integration of the health and social care aspects of mental health is an important early priority. In all cases, closer integration between primary and specialised services will also be important. In addition to meeting the standards and targets set out in the National Service Framework and the NHS Plan, proposals for new service configurations should therefore:

- Retain integrated management of inpatient and community services
- Retain sufficient critical mass to protect the seniority of management and provide appropriate leadership
- Reduce fragmentation and improve partnerships between elements of the service
- Build on the commissioning partnerships already established through Local Implementation Teams.
- Demonstrate evidence of ability to deliver MHNSF and NHS Plan requirements
- Show clear mechanisms for engaging service users and carers

6.3   Education, training and workforce development

Nurses

Staff in primary care typically report they lack general mental health training. They also say they lack specific competencies. `Making a Difference' (Department of Health 1999) outlines how nurses can act as health promoters, provide information for patients, assess health risks and screen for early signs of health problems. This can be applied to mental health, just as in other areas of health care (Gournay 1999). However, only 2% of practice nurses have formal mental health training (Thomas 1993) and most believe they need more.

There is now good evidence that primary care staff without a core qualification in mental health can be trained to deliver brief, effective interventions. For example, health visitors can be trained to deliver brief treatment for women with postnatal depression. Work undertaken by the Institute of Applied Health and Social Policy and others shows members of the primary care team, such as practice nurses, can also enhance their skills through training in mental health care. Taken together, this indicates that basic awareness training, training in working safely, support to identify role boundaries, education about cultural issues, and information about local services are as important as specific skills training.

One example of good practice in the provision of multi-disciplinary education is the University of Birmingham's community mental health programme. This post-graduate course concentrates on psycho-social interventions using an inter-professional focus between nurses, occupational therapists, social workers, psychologists, psychiatrists and development workers. Positive effects have been demonstrated for a variety of learning outcomes, including partnerships with service users.

Counsellors

Access to effective psychological therapy and counselling services is commonly problematic, although up to one third of GPs in 1996 had direct access to such services. Some GPs employed counsellors directly and reclaimed their salaries through the GP reimbursement scheme. Others established service level agreements or contracts for direct services from local departments of psychology in the NHS and/or counsellors in the non-statutory sector.

Now, counsellors are now working in around half of all general medical practices nationally (Mellor-Clarke 2000). There is emerging evidence (King et al 2000) that, provided training and quality standards are met, they can be effective in helping patients with common mental disorders.

The Government has set out clear national standards in the National Service Framework for mental health for how to get quicker access to more effective treatment. Guidance on commissioning (see below) describes the arrangements being implemented in primary care which will ultimately mean that all the practices in a PCG have fair access to an appropriate range of counselling and psychological therapy services, commissioned on the basis of an assessment of local population need.

The guideline on treatment choice decisions in psychological therapies and counselling (Department of Health 2001) can help services know when and whom to refer and how to develop protocols for local referral.

General Medical Practitioners

General Medical Practitioners play a central role in the care and treatment of people with mental illness. However many lack confidence managing mental health issues and this is partly due to a lack of training (Turton et al 1995). Just under half of all GPs complete a mental health training placement as part of their vocational training, and this may be insufficient to prepare them for the mental health work they will undertake. In many cases, the placement also takes place in an acute rather than general or primary care setting.

There is a strong argument that post-qualification education and training for primary care staff is most effectively delivered to the whole team, rather than to individuals (Tylee 1999). This includes training for General Medical Practitioners. However, despite some examples of excellent practice, there is no agreed curriculum for a programme of training, there is no national accreditation, programmes are not available in all parts of the country, and staff report that access to funding for training is problematic.

By 2003/4, there is an intention to have established a national programme of locally focused, modular, accredited training for primary mental health care staff to strengthen their knowledge, competence and teamwork. In the meantime, it will be important for PCGs and PCTs to develop the local evidence base concerning needs for training, local resources and plans for their staff consistent with the guidance set out in `A Health Service of all the talents: developing the NHS workforce' (Department of Health 2000).

6.4   New staff and new ways of working

Staff should be organised in such ways that access to expertise and support from specialists is available. Several models currently exist. In Scarborough (Cohen 2000) a named link worker has been employed to work at the primary-secondary interface. In other places, specialists provide on site services in primary care. To date, relatively little formal evaluation of these models has been undertaken, but work is now being commissioned.

In the future, especially as other services and teams come on stream, it may be helpful to scope new roles for Community Mental Health Teams in relation to primary care. This could have advantages for service users in terms of improved care pathways. It could also have advantages for staff in terms of greater role clarity. However, it is important that change is managed carefully.

In addition, there is likely to be scope for delivering effective treatments in innovative ways. For example, the usual method of accessing brief psychological therapies, such as cognitive behaviour therapy (CBT) is via workers with a specialised training based in a clinic or office offering weekly sessions of approximately an hour. There is emerging evidence (Lovell, 2000) that more accessible, more cost-effective methods of delivery may also be possible. For example, research has examined the use of assisted bibliotherapy for moderate anxiety problems, and a number of CD-Rom based technologies are currently being developed. An appraisal of CD-Rom based CBT is currently being undertaken by the National Institute for Clinical Excellence.

New mental health workers

The proposals in the NHS Plan to develop new mental health workers in primary care and community mental health workers are part of the package of measures designed to modernise mental health care and improve access to services. New funding for 1000 new primary care mental health workers will be available from 2003/4. Preliminary plans are

being developed to elaborate roles and responsibilities. The graduate workers will fulfil new roles in primary care as members of the team. The purpose is not to substitute for existing staff, or replace the work they do but rather to:

- Support delivery of brief, evidence-based effective interventions and self-help for people with common mental disorders, including children.
- Strengthen information available for patients.
- Support development of practice-based information systems, audit, and outcome measurement.
- Improve satisfaction of service users with care.
- Improve knowledge about the mental health network.
- Support audit of pathways of care

Preliminary consultation on the roles and responsibilities of new primary care workers indicates that their work may be divided into three broad areas, although the balance of time given to specific activities will be a matter for local determination:

a) **Client work**- information, assessment, screening, and onward referral, where appropriate, and in partnership with other members of the primary care team for people with mental health problems. Brief, evidence-based techniques such as anxiety management and CBT for common mental disorders; self-help material for service users; health promotion; information for service users.

b) **Practice team work** – support for audit, routine measurement of outcomes, mental illness registers, support for implementation of referral protocols, team case reviews, support for integration of service users and carers into mental health service systems (including CAMHS and older peoples' services) and advocacy.

c) **Wider network** – In partnership with other members of the team, liaison with other statutory (such as housing, welfare and benefits) and non-statutory sector services (charitable and voluntary sector) and with specialised services in support of effective services for all those, including people with SMI, managed in primary care.

It will be apparent that none of these tasks is strictly `new' and many are already being undertaken in part by existing staff. It is also important to note that different service systems (such as CAMHS and services for older people) will dictate different working styles, and may not require the same type of input from the new workers as required for adults with mental health problems. However, this initiative offers an opportunity to achieve some changes in ways of working, as well as increase the overall resource available to primary care mental health. It will therefore be very important that new primary care

workers are well integrated with existing primary care teams and staff with expertise in mental health.

New funding for one year of full time training will be available. Issues of safety, risk management and evidence-based practice will be paramount. In addition, work on career pathways, and on the flexibility of systems to encourage retention is developing. Above all, it will be essential to ensure that local arrangements are in place to provide appropriate supervision and support.

Consultation on the scopeand direction of roles and responsibilities for the new primary care workers is currently taking place and further guidance will be issued to place in this guide.

`Gateway' workers

Most health and local authorities already use a number of gateways to specialised services in an emergency. They include:

- Accident and Emergency Departments
- Out of hours services (including Section 12 trained doctor and Approved Social Worker) or CMHT access out of hours.
- NHS Direct – walk in centres, helpline and NHS Direct online.
- Criminal Justice system (Police and Court Diversion schemes).

However, there are variations in the quantity, accessibility and acceptability of these systems, and only a very few authorities offer the full range of round-the-clock provision. New funding is therefore also available from 2003/4 to appoint 500 community workers. There are variations in the quantity, accessibility and acceptability of current systems providing access to specialised care. The purpose of providing 500 community mental health staff is to:

- Improve the `gateway' to specialist services
- Support provision of a `round the clock' co-ordinating service for access to specialised care
- Liaise with mental health teams (assertive outreach, home treatment, court diversion) A & E teams, NHS Direct and primary care staff
- Involve service users and carers more.

6.5   Conclusion

For all these initiatives, there is more work yet to do. All comments and questions are welcome. In the short term, publication of the Workforce Action Team report will help to elaborate the vision for improved primary care mental health and it will contain more detail of the basis for the proposals outlined herein.

6.6   Evidence for Further Reference

Cohen, A. (2000). `Working with primary care – the Scarborough initiative' The Mental Health Review.5:4.

`A Health Service of all the talents' (2000) Department of Health.

`Making a Difference' (1999) Department of Health. The Stationery Office.
`Treatment choice decisions in psychological therapies and counselling' (Feb 2001) Evidence based clinical practice guideline. Department of Health. Reference 23044 www.doh.gov.uk/mentalhealth/treatmentguideline.

Donaghue, J.M. and Tylee, A. (1996). `The treatment of depression. Prescribing patterns of antidepressants in primary care in the UK.' BJPsychiat. 168. 164-168.

Goldberg, D. & Huxley, P. (1992). `Common mental disorders: a biosocial model. London: Routledge.

Goldberg, D. `Filters to care: a model.' (1991). In Jenkins, R., Griffiths, S. (eds) `Indicators for mental health in the population.' HMSO. London.

Gournay, K. (1999) `Future role of the nurse in primary mental health care.' In Tansella, M and Thornicroft, G. (eds) Common Mental Disorders in Primary Care. London: Routledge.

King, M. et al (2000) `Randomised controlled trial on non-directive counselling, cognitive behaviour therapy and usual general practitioner care in the management of depression and mixed anxiety.' HTA 4: 19.

Lovall , K and Richards, D. (2000) `Multiple access points and levels of entry (MAPLE): Ensuring choice, accessibility ad equity for CBT services.' Behavioural and Cognitive Psychotherapy. 28.

Lepine, J P et al (1997) `Depression in the community: the first pan-European study DEPRES.' International Clinical Psychopharmacology. 12. 19-29.

Mellor-Clarke, J. (2000) `Counselling in Primary Care in the context of the NHS quality agenda.' BACP.

Meltzer, H., Gill, B., Pettigrew, M. and Hinds, K. (1995) `The prevalence of psychiatric morbidity among adults' HMSO. London.

Nazareth, I., King, M., and Tai, S. (1996)`Monitoring psychosis in general practice: a controlled trial.' British Journal of Psychiatry. 169. 475-482.

Thomas, R.V. et al (1993) `The role of the Practice Nurse in mental health: a survey.' Journal of Mental Health. 2: 65-72.

Turton, P., Tylee, A. and Kerry, S. (1995) `Mental health training needs in general practice.' Primary Care Psychiatry. 1:197-9.

Tylee, A., (1999) `Training the whole primary care team.' In Tansella and Thornicroft. Op cit.

7.   MENTAL HEALTH PROMOTION

7.1   Introduction

The inclusion of a mental health promotion standard in the National Service Framework represents an important milestone. For the first time, health and social services have a clear remit to promote mental health for all and to reduce the discrimination experienced by people with mental health problems. The publication of national guidance to support standard one (Making it Happen, April 2001), together with specific performance management targets (table 7a), means that mental health promotion is no longer optional. But delivery will still present a challenge. Above all, there will need to be a greater recognition of what mental health promotion can contribute, both to the improvement of services and the broader public health agenda. Local work to implement standard one is already raising some fundamental questions about the relevance of mental health promotion to those delivering services, and the kind of partnerships which will be necessary to deliver standard one effectively.

7.2   Performance management targets for standard one

The Department of Health is developing a revised performance assessment framework to monitor progress on implementation of all the NSF Standards and the NHS Plan as it relates to mental health. Table 8a below summarises the key performance targets for standard one. The NSF required services to develop a local mental health promotion strategy by April 2001. In recognition of the publication of *Making it Happen* in March 2001, a revised performance target of March 2002 has been set for services to develop and agree an evidence-based mental health promotion strategy based on local needs assessment.

Table 7a

NSF Standard One: Performance Targets For Local Services

By March 2002, develop & agree evidence-based mental health promotion strategy based on local needs assessment

By March 2002, build into local mental health promotion strategy action to promote mental health in specific settings, based on local needs

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By March 2002, build into local mental health promotion strategy action to reduce discrimination

By March 2002, the written care plan for those on enhanced Care Programme Approach (CPA) must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits.

By March 2002, implement strategy to promote employment of people with mental health problems within health & social services.

7.3   What is mental health promotion?

Mental health promotion involves any action to enhance the mental well-being of individuals, families, organisations or communities.

Mental health promotion is essentially concerned with:

- how individuals, families, organisations and communities think and feel
- the factors which influence how we think and feel, individually and collectively
- the impact that this has on overall health and well-being.

The requirement in the National Service Framework to 'promote mental health for all' provides an opportunity to transform the terms of the debate about mental health and to consider the 'public mental health'. (Friedli 1999) 'Public mental health' takes a broader view of mental health and provides a framework for talking openly about the mental health needs of the whole community.

Mental health promotion does have a role in preventing mental health problems, notably anxiety, depression, drug and alcohol dependence and behavioural disorders. But mental health promotion also has a wider range of health and social benefits. These include improved physical health, increased emotional resilience, greater social inclusion and participation and higher productivity.

Interventions to reduce stress in the workplace, to tackle bullying in schools, to increase access to green, open spaces and to reduce fear of crime all contribute to health gain through improving mental well-being, in addition to any impact they may have on preventing mental disorders.

Mental health promotion can also contribute significantly to health improvement for people living with mental health problems and has a key role to play in challenging discrimination and increasing understanding of mental health issues.

Mental health promotion works at three levels: and at each level, is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems.

- Strengthening individuals - or increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- Strengthening communities – this involves increasing social inclusion and participation, improving neighbourhood environments, developing health and social services which support mental health, anti-bullying strategies at school, workplace health, community safety, childcare and self-help networks.
- Reducing structural barriers to mental health - through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing services, and support for those who are vulnerable.

At each level, interventions may focus on strengthening factors known to protect mental health, (e.g. social support, job control) or to reduce factors known to increase risk, (e.g. unemployment, violence).

Risk factors for mental health problems include bereavement, a family history of psychiatric disorder, violence, childhood neglect, financial strain, family breakdown, long term caring and unemployment. These can be reduced by strengthening factors known to protect mental well-being. The strength of evidence for protective and risk factors varies, but is particularly robust in relation to the impact of early childhood experiences, notably the importance of socio-economic circumstances which support warm, affectionate parenting. However, many risk factors for mental health problems are difficult to address, especially by the health sector alone, for example, gender roles, long term economic problems and the growing gap between rich and poor.

A mental health promotion strategy needs to address ways of strengthening protective factors and working to reduce risk factors at an individual, community and structural or policy level.

7.4 Benefits of mental health promotion

Mental health promotion can:

- improve physical health and well-being
- prevent or reduce the risk of some mental health problems, notably behavioural disorders, depression and anxiety, substance misuse
- assist recovery from mental health problems
- improve mental health services and the quality of life for people experiencing mental health problems
- strengthen the capacity of communities to support social inclusion, tolerance and participation and reduce vulnerability to socio-economic stressors
- increase the 'mental health literacy' of individuals, organisations and communities
- improve health at work, increasing productivity and reducing sickness absence.

7.5 Mental well-being and physical health

There is a growing body of research (see table 8b below) that demonstrates the impact of mental health on physical health. Much of the research in this area is concerned with how the social environment acts on biology to cause disease. (Marmot & Wilkinson 1999) What has been called 'stress biology' looks at the relationship between chronic stress and the nervous system, the cardio-vascular and the immune systems, influencing cholesterol levels, blood pressure, blood clotting, immunity, and growth in childhood.

"We are now beginning to recognise that people's social and psychological circumstances can seriously damage their health in the long term. Chronic anxiety, insecurity, low self esteem, social isolation and lack of control over work appear to undermine mental and physical health."

(Brunner and Marmot 1999).

Table 7b

The impact of mental health on physical health

- In a cross sectional study based on data from 39 states in the USA, Kawachi et al found lower levels of social trust were associated with higher rates of most major causes of death, including coronary heart disease, malignant neoplasms, cerebrovascular disease, unintentional injury and suicide. (Kawachi et al 1997)

- Depression increases the risk of heart disease fourfold, even when other risk factors such as smoking are controlled for. (Hippisley-Cox et al 1998)

- Lack of control at work is associated with increased risk of cardiovascular disease. (Bosma et al 1997; Marmot et al 1991)

- Sustained stress or trauma increases susceptibility to viral infection and physical illness by damaging the immune system. (Stewart-Brown 1998)

- Emotional well-being is a strong predictor of physical health. Men and women who scored highest in a survey on emotional health were twice as likely to be alive by the study's end. The link between subjective feelings of happiness and good health held even after controlling for chronic disease, smoking, drinking habits, weight, sex and education. (Goodwin et al 2000)

- Depression is a risk factor for stroke. (Jonas and Mussolino 2000)

- Depression has a significant impact on health outcomes for a wide range of chronic physical illnesses, including asthma, arthritis and diabetes (Turner and Kelly 2000)

It is widely understood, in relation to physical health, that anyone can experience physical ill-health, and that while not all physical ill-health can be prevented, people can take steps to improve their physical health and to reduce their risk of physical health problems. This is reinforced by a wide range of policies in schools, in the workplace and in communities, to promote physical well-being and reduce the risk of physical health problems. Achieving the same policies in relation to mental health is part of the underlying rationale for mental health promotion. For this to be successful, there will have to be a greater understanding of the links between mental well-being and physical health by policy makers and practitioners.

7.6   Mental health promotion and mental health services

Mental health promotion and the delivery of mental health services are often seen as separate tasks, in competition for scarce resources. This view may be based on the belief that mental health promotion is not relevant to people with long term mental health problems. However, just as a diagnosis is only one part of a person's life, so medical treatment is only one part of the support they need – to cope, to recover and to avoid relapse. The other support – by far the largest part – will come from family, friends, schools, employers, faith communities, neighbourhoods – and from opportunities to enjoy the same range of services and facilities within the community as everyone else.

There is growing evidence that addressing these wider issues improves physical and mental health and promotes recovery. The importance of engaging with issues like friendship, social networks and employment has been central to the success of early intervention programmes, which aim to reach young people experiencing a first episode of psychosis (see also section 5 of this guide). These and other initiatives provide an opportunity for mental health promotion and mental health services to identify shared goals and work towards a common agenda, at the heart of which is recognition of the needs of the whole person.

These issues are part of a broader social inclusion agenda which must include a clear strategy to tackle the discrimination experienced by service users, notably in relation to employment. Examples of interventions to reduce social exclusion include:

- Supported employment in a real working environment
- Increasing compliance with the Disability Discrimination Act and extending this to include people who have had psychiatric treatment for less than 12 months
- Including personal experience of mental health problems in person specifications
- Media training for service users

- Primary care referrals to voluntary, service user and self-help groups
- Initiatives to increase access to mainstream services – education, leisure, transport

Lack of control and lack of influence are independent risk factors for stress (Rainford et al 2000). This suggests that indicators of participation, inclusion, access and influence need to be built into clinical indicators of effectiveness. In other words, the way in which a service is delivered may have an impact on health, over and above the clinical effectiveness of the treatment provided.

The importance of meaningful public participation in the delivery of services is a central feature of both the National Service Framework and the NHS Plan. Service user and carer involvement should now be a key feature of the way in which mental health services are planned and implemented. However, participation in, and influence over, health care may have intrinsic health benefits.

7.7 Developing an evidence-based mental health promotion strategy

A meta analysis of different programmes shows that mental health promotion is most effective when it:

- intervenes at a range of different times in the life cycle, e.g. infancy and adolescence
- is integrated within different settings, e.g. schools and primary care
- is planned at different levels, e.g. local/regional/national (Hosman et al, 1994).

Also when it:

- targets a combination of factors (e.g. coping skills and access to employment)
- involves the social networks of those targeted
- intervenes at different times/levels
- uses a combination of methods.

The following principles also appear to be underlying features of effective approaches for individuals, families, organisations and communities:

- Reducing anxiety
- Enhancing control
- Facilitating participation
- Promoting social inclusion.

A strategic approach to mental health promotion should aim to include a balance of:

- Developing coping/life skills e.g. parenting, communication, negotiation
- Promoting social support and networks e.g. tackling bullying, supporting bereaved families, facilitating self-help groups, increasing access to information and opportunities to participate
- Addressing structural barriers to mental health in areas like education, employment, housing and income policy.

Developing a mental health promotion strategy is a complex task. It will need to engage stakeholders across many different settings and sectors, with competing and often opposing perspectives, in a shared vision. For this reason it can be more helpful to focus on strategies for solving problems, rather than trying to achieve consensus on labels and definitions. A settings approach, like the one adopted by the West Midlands Region, focussing on schools, neighbourhoods, prisons, workplace, media and primary care, can make the task more manageable.

7.8 Key stages in developing a local mental health promotion strategy

The checklist (at table 7c below) outlines the key stages in developing a strategy. For each stage of the strategy, it is helpful to consider:

- **Levels** e.g. individuals, community, structural/policy
- **Settings** e.g. schools, workplaces, prisons, mental health services, home/early years, primary care, residential homes, acute services and A&E, media, neighbourhoods
- **At risk and vulnerable groups** e.g. people sleeping rough, people in prison, victims of abuse or domestic violence, refugees, people with drug and alcohol problems, looked after children, black and minority ethnic groups, low income and excluded groups.

Table 7c

Key stages in developing a strategy

1. Agreeing a vision and setting aims and objectives
2. Mapping existing initiatives
3. Identifying key settings and target groups
4. Making the links with policy initiatives with supporting goals
5. Identifying key stakeholders – consultation and gaining commitment
6. Selecting interventions
7. Finding the evidence to support the approach taken
8. Identifying the staffing and resource implications
9. Establishing indicators of progress
10. Building in evaluation

7.9   Working across professional and sector boundaries

Many of the factors which influence mental health lie outside health and social care. Effective mental health promotion depends on expertise, resources and partnerships across all sectors and disciplines. Mental health promotion is also relevant to the implementation of a wide range of policy initiatives including social inclusion, neighbourhood renewal and health at work. The new agenda for service delivery, including the modernisation of the NHS, outlined in the NHS Plan, and the improvement of mental health services, will also benefit from applying the principles of mental health promotion. Mental health agencies will also wish to promote the mental health of their employees.

Mental health promotion initiatives to support and engage local communities and mental health promotion policies in schools and the workplace have a significant impact on the physical and mental health of people with mental health problems, as well as the wider population. A key priority for Government is tackling social exclusion. On almost any indicator, people with long term or intermittent mental health problems are among the most excluded. Conversely, social exclusion is a key risk factor for a range of mental health problems. It is therefore crucial that mental health services engage with the broader public health agenda, and that there are opportunities to look beyond service delivery goals, important though these are.

Social inclusion, social capital, neighbourhood renewal and community development describe processes that aim to strengthen social networks and structures to support local communities. Policy initiatives that address regeneration are concerned with reducing

health inequalities, raising educational standards, improving health, tackling social exclusion and developing sustainable work and independence. Mental health promotion can make a real contribution to these areas of concern, and in turn the initiatives undertaken will help promote mental health.   An integrated local mental health strategy will have to work to develop a shared understanding of the processes involved in working towards these goals.

The three main regeneration policies using an Action Zone approach (HAZ, EducAZ, EmpAZ) aim to intervene at an individual level (Employment), a community or organisational level (Education) and a service or strategic level (Health). The New Deal for Communities includes many of the aims of the specific Action Zones and will deliver improvements at a neighbourhood level. This is directly comparable with a mental health promotion strategy that promotes public mental health at all levels in society.

7.10   Using the evidence base

The NSF grades evidence as shown below:

Table 7d

Types of evidence in the National Service Framework

I	at least one good systematic review, including at least one randomised controlled trial (RCT)
II	at least one good RCT
III	at least one well-designed intervention study without randomisation
IV	at least one well-designed observational study
V	expert opinion, including the opinion of service users/carers

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All grades of evidence have strengths and weaknesses. It is therefore helpful to identify the kind of evidence on which a planned intervention is based and to be clear about limitations. While RCTs are useful for assessing the impact of a single intervention on clearly defined symptoms, they are much less successful at dealing with complex interventions. Expert opinion, drawn from service users, is particularly important evidence in addressing quality of life issues, as well as informing service delivery and clinical priorities. For example, people with mental health problems consistently report that negative and sensationalised media coverage damages their health.

The following example, drawn from a local strategy, brings together a small number of initiatives supported by different grades of evidence:

- Increasing public awareness and improving knowledge, attitudes and awareness e.g. World Mental Health Day, working with local media, service user led programmes in schools and communities (V)

- Influencing employers through programmes to increase employment of people with mental health problems and to develop understanding of the importance of mental health promotion in the workplace for all employees (I)

- Supporting parents e.g. parenting skills, emotional support for young mothers, community mother programmes, pre-school education (I)

- Mental health promotion in schools, through healthy schools initiatives, anti-bullying strategies, student councils, peer education (III) (IV)

- Strengthening self-help and support networks and ensuring better links between primary health care and sources of information and support in the community (I-IV).

Table 7e

Summary of Interventions supported by the evidence base

Employment: what works to improve prospects, increase health at work and reduce impact of unemployment?
- Pre-school day care
- Supported employment in real work place
- Organisation-wide approaches to stress
- Social support/problem solving/cognitive therapy

Alcohol and drug misuse
- Brief interventions in primary care (alcohol)
- Pre-school education (drugs)
- Health promoting schools approach

At risk groups:
Pregnant Women
- Home based professional or lay support
- Informal social support

Children experiencing adverse life event
- Cognitive behavioural skills/social support

Disadvantaged children
- Parent skills training
- Support visits
- School-based interventions
- Pre-school education

School-based programmes
- Multi-faceted whole school approach involving staff, community, environment and school culture
- Development of social competencies
- Group counselling
- Peer led programmes
- Anti-bullying policies

Older People
- Volunteering
- Peer Support/counselling

Whole Population:
- Regular Exercise
- Access to green open spaces
- Opportunities for arts and creativity
- Social support, diversity of networks, participation and inclusion

7.11 Making it Happen

Making it Happen: a guide to delivering mental health promotion will be published in April 2001 by the Department of Health. This detailed guide:

- Defines mental health and mental health promotion
- Makes the case for investing in mental health promotion
- Shows how mental health promotion fits in with other policy initiatives
- Provides a framework for developing local strategies
- Describes the types of evidence and their strengths and weaknesses
- Gives examples of effective interventions
- Describes how to apply the evidence
- Gives information on evaluation.

The guidance is intended to be helpful rather than prescriptive. It was developed in extensive consultation with a wide variety of stakeholders from the field.

7.12 National Support for Standard One

A Mental Health Promotion Project has been established within the Department of Health, led by Richard Berry, to take forward policy development and implementation around mental health promotion and suicide prevention. The aim of the project is to promote mental well-being in the general population and empower people with mental health problems to participate in society to their fullest possible extent. Contact details for the project team are given below. In addition, a Project Group has been appointed, bringing together service users, voluntary organisations, researchers, clinicians, health promotion specialists and others, to provide the expertise required to support the development of mental health promotion.

The Mental Health Promotion Project has seven objectives, each of which is being taken forward through a series of initiatives, some of them providing support to local services or direct action in pursuit of project objectives, and others influencing and working with other stakeholders:

- support implementation of NSF Standard One
- take steps to reduce the death rate from suicide and undetermined injury by at least one fifth by 2010

- raise awareness of mental health issues with a view to reducing discrimination against people with mental health problems
- promote greater opportunities for people with mental health problems to access suitable employment, housing, education, welfare benefits, leisure and financial services
- promote mental health for specific groups of people
- promote mental health in specific settings
- encourage and support international co-operation in sharing good practice in mental health promotion.

A national group has been established to bring together representatives from each of the regional offices with a lead interest in mental health promotion with a view to promoting shared learning and development across regional boundaries. Through the regional offices, the project team has also mapped local NSF standard one leads with a view to stimulating the development of a mental health promotion community to facilitate the identification and dissemination of good practice.

7.13 References for further Evidence

Bosma, H., Marmot, M. G., Hemmingway, H. (1997) Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) study *British Medical Journal* 314:558

Brunner E and Marmot M (1999) Social organisation, stress and health in Marmot MG and Wilkinson RG eds *The social determinants of health* Oxford University Press, Oxford

Contributors to the Cochrane Collaboration and the Campbell Collaboration (2000) *Evidence from systematic reviews of research relevant to implementing the wider public health agenda* NHS Centre for Reviews and Dissemination

Friedli, L. (1999) From the margins to the mainstream: the public health potential of mental health promotion *International Journal for Mental Health Promotion* I (2) 30-36

Goodwin, J.S. (2000) Glass half full attitude promotes health in old age *Journal of the American Geriatrics Society* **48**: 473-478

Hippisley-Cox, J., Fielding, K., Pringle, M. (1998) Depression as a risk factor for ischaemic heart disease in men: population based case control study *British Medical Journal* **316**: 1714-9

Hosman, C., Veltman, N. (1994) *Prevention in Mental Health: a review of the effectiveness of health education and promotion* Utrecht

Jonas BS and Mussolino ME (2000) Symptoms of Depression as a Prospective Risk Factor for Stroke *Psychosomatic Medicine* 62(4) 463-472

Kawachi, I., Kennedy, B., et al (1997) Social Capital, Income Inequality and Mortality *American Journal of Public Health* **87**:491-498

Lister-Sharp D, Chapman S, Stewart-Brown S, Sowden A (1999) *Health Promoting schools and health promotion in schools: two systematic reviews* Health Technology Assessment

Marmot M & Wilkinson R (1999) *Social determinants of health* Oxford: Oxford University Press

Marmot M., Davey-Smith, G., Stansfield, S., Patel, C., et al (1991) 'Health Inequalities among British Civil Servants: the Whitehall II study' *The Lancet* **337** 1387-1393

Rainford, L, Mason, V, Hickman M & Morgan A (2000) *Health in England 1998: investigating the links between social inequalities and health* London: the Stationary Office

Stewart-Brown, S. (1998) Emotional well-being and its relation to health *British Medical Journal* **317**: 1608-1609

Turner J & Kelly B (2000) Emotional dimensions of chronic disease *British Medical Journal* **172**: 124-128

8.   TAILORING SERVICES TO LOCAL NEEDS

Planning and implementing system change at the local level

8.1   Background

Local mental health communities will have:

* developed Local Implementation Plans to achieve the National Service Framework for Mental Health standards and NHS Plan targets;
* reviewed these plans through a self assessment in Autumn 2000;
* drawn up plans for 2001/02 through both NHS and LA planning processes.

The NHS Plan Implementation Programme details how local mental health communities (NHS organisations and local councils) must carry out a modernisation audit and prepare 3 to 5 year service plans as part of their Health Improvement Programmes. In this way the Local Implementation Plan becomes a core component of the Health Improvement Programme. To ensure that future service developments are co-ordinated and relate to local need, local mental health communities will need to demonstrate that they have comprehensively reviewed services. The Local Implementation Plan Stage 3 report must be agreed with NHS and social care Regional Offices by the end of November 2001. It will form the basis for detailed planning activity for implementation in 2002/2003 and beyond.

The whole system approach to mental health modernisation planning will require a cultural change for both managers and staff. The issue of culture has been consistently highlighted as the main determinant for the successful implementation of any developments within an organisation. Culture - the beliefs, values and customs of the organisation - affects every part and function of the organisation.

Changes in organisational and care culture that are required to achieve the modernisation agenda include:

* ✓ Increased partnerships and reduced hierarchy
* ✓ Increased choice and autonomy for service users and carers
* ✓ Increased transparency-both for service planning and clinical care
* ✓ Increased value on evidence based services
* ✓ Increased focus on outcomes, as opposed to inputs and outputs
* ✓ Increase in integrated and mainstream services, and reduced specialisation and service insularity
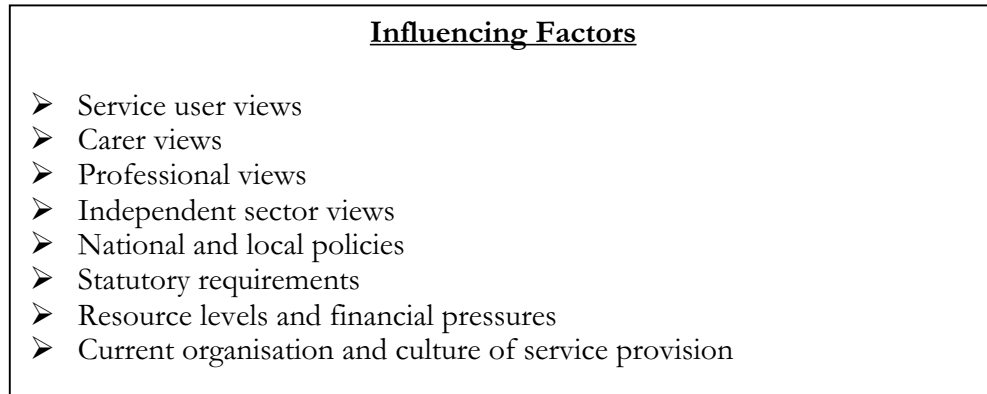
- ✓ Increased value on information systems
- ✓ Increased attention to supporting the workforce, both clinical and management
- ✓ Increased value placed on non-professional and volunteer staff
- ✓ Increased opportunities for involvement of staff groups in major re-developments
- ✓ Increased meaningful service user and carer involvement and inclusion in service planning

Accomplishing this change in culture will require clear and strong leadership within the mental health sector and across the broader health and social care systems. The leaders need to communicate a vision of the future system, engage key stakeholders across that system, and manage the organisational and structural changes required to reach the vision.

A comprehensive review must be more than just ticking boxes stating that service elements and underpinning supports are in place or planned to be in place. Table 8a provides an overview of the mental health service review process. It is important to recognise that a review is an interaction of the Influencing Factors, such as resource levels, and the assessment of local need.

Mental health communities will also have to take care that they do not think about service elements in isolation. All elements have to interact as a system, so that the service user experiences continuity during their pathway through care, with each element offering added value.

The rest of this section provides practical guidance for mental health communities in reviewing their services. The comprehensive review is an overview of the functioning of the mental health system. It will be important for mental health communities to identify priorities following the proposed process.

Table 8a Comprehensive review process

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Influencing Factors

➤ Service user views
➤ Carer views
➤ Professional views
➤ Independent sector views
➤ National and local policies
➤ Statutory requirements
➤ Resource levels and financial pressures
➤ Current organisation and culture of service provision

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Review of Local Service Provision

- all elements in place/planned to be in place?
- sufficient service, staff and financial capacity?
- co-ordinated pathway for the service user and carer?
- quality?
  - accessibility
  - effective use of contemporary interventions
  - service user and carer experience
  - achieving desired outcome
  - efficient use of resources

Needs
Assessment

Aggregated
Individual

Population
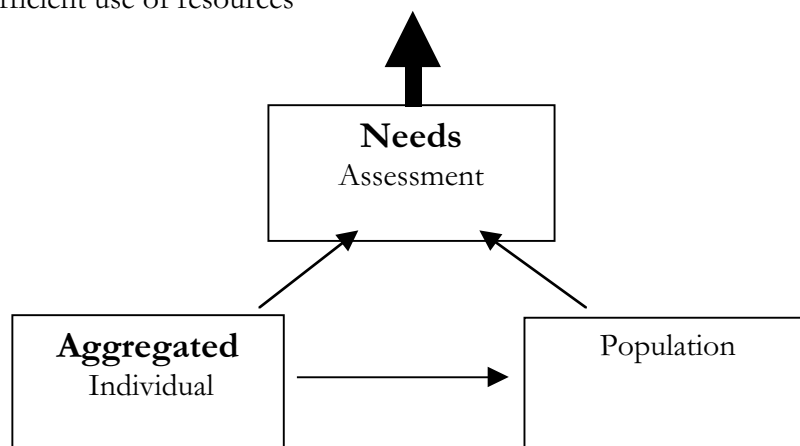
8.2   Make use of existing information first

Mental health review teams should be able to make use of a range of information that is already available:

*   Mental Health Service Mapping – local compared to regional/national picture
*   public health department – local need and population
*   local authority planning department – local need and population
*   local service user and carer surveys
*   clinical governance reports
*   Best Value reports
*   Reports of local inquiries
*   Mental Health Act Commission visit reports
*   Finance departments (HA/LA/NHS Trust)
*   Information departments on activity and performance indicators
*   Human resource departments
*   LIP self-assessment
*   Benchmarking clubs (e.g. Inner Cities and Rural)
*   Other available local reports

Resources

Mental Health Service Mapping 2001 - University of Durham, Di Barnes - 0191 374 7241
LIP Self Assessment and Benchmarking - Mental Health Strategies - 0161 727 9419

8.3   Assessing Need

Introduction

There is no such thing as an agreed and definitive statement of need. Needs assessment will always pose a compromise between comprehensiveness and practicality.

If needs-based planning is to be practised routinely by social services and health authorities, there are four challenges to be faced:

- The questions they are asked to address must be appropriate to the audience, commissioner, participants and service users and carers
- Methods have to be capable of delivering relevant information that is timely and within the resources of the authorities
- The information has to be reliable and credible to all those concerned with the planning decisions
- Methods have to strike a balance between ease of use and validity.

Cooper and Singh (2000) in an editorial reviewing methodological problems of psychiatric epidemiology note that the **complementary** roles of population-based studies, key-informant surveys and general practice data can be used to gain better insight into local need.

They suggest that a needs assessment approach in which the need for specific care packages can be specified may provide a basis for service planning. Aggregated individual needs assessment and population estimates based on epidemiological studies can be used in complementary ways.

Aggregated Individual Needs Assessments

The NSF has placed considerable emphasis on individual needs assessments (Standards 2 and 4).

Government policy also advocates that service developments be based on the needs of the whole local population. This has been emphasised by *Our Healthier Nation* (Department of Health, 1999):

'Health Authorities will have a key role in leading local alliances to develop Health Improvement Programmes, which will identify local needs and translate the national contract [partnership between Government, local communities and individuals] *into local action.'*

Aggregated individual needs assessment can integrate the two requirements for individual and population needs assessment. This can assist local services in further developing their Local Implementation Plans for the NSF.

As individual needs assessments are based on people using mental health services, and in particular those using mental health services most frequently, there are difficulties in estimating the absolute level of need in the population. These limitations can be overcome to some extent by attempting to survey the needs of people with severe mental illness not using mental health services. For example, there may be people using homeless persons' services with severe mental illness, high levels of risk behaviour and substance misuse, but who are not in contact with specialist mental health services.

A simple method and toolkit have been developed by The Department of Health with the Sainsbury Centre and Institute of Psychiatry (Needs Based Planning, 2000). These will be disseminated through regions to LITs as part of the comprehensive review exercise. In time the Mental Health Minimum Data Set will provide even better information. This method can quantify need. For example, how many people using mental health services are unemployed? It should also be possible to use existing activity-based computer systems to identify who uses various combinations of services. How many people have been inpatients and received assertive outreach services? Conversely, how many people have been inpatients and not received assertive outreach services or any other form of community follow-up? These simple sets of information can help to establish how much of each service element is required and how much overlap there is in usage. Local assessment of need should include an audit of access to mental health services for people aged 14-35 experiencing the first onset of psychosis (see Chapter 5 for further details).

Population Needs Assessment

At present the best two indicators for mental health needs are *The York Psychiatric Index (YPI)* (Smith, Sheldon & Martin, 1996) and the *Mental Health Needs Index (MINI)* (Glover, Rubin et al, 1998). These methods are based on utilisation data, and so do not effectively distinguish between demand and supply. Further, they are limited in scope in that all are based on health data; neither involves the use of social care or primary care data.

A national collection of surveys of sufficient scale and quality, the ONS Psychiatric Morbidity Surveys (e.g. Jenkins *et al,* 1997), is now available to provide a link between mental health and a range of socio-demographic factors at a local level (from the Census and related sources). Prediction formulae for levels of psychiatric problems have demonstrated the significance of gender, age, household structure, employment status, tenure and rurality (Jenkins, 1998).

Review teams can make use of the Mental Health Foundation's *The Fundamental Facts* (Bird, 1999). This resource details the importance of considering the age structure of the

population, gender and race. It also documents the relationship between mental health problems and suicide, self-harm, homelessness, substance misuse and offending.

Resources

The Fundamental Facts…all the latest facts and figures on mental illness. Lisa Bird, 1999. The Mental Health Foundation. Tel 020 7535 7400 e-mail mhf@mentalhealth.org.uk website http://www.mentalhealth.org.uk

Needs Based Planning Toolkit (Sainsbury Centre for Mental Health/Institute of Psychiatry, 2000). Tel 020 7403 8790 (Graham Durcan) http://www.scmh.org.uk (all parts of the toolkit are downloadable from the 'analysis' section of the web site.

Bebbington, A.C., Turvey, K., Janzon, K. (1996) "Needs-based planning for community care" University of Kent: PSSRU DP 1206/2.

Cooper and Singh (2000), 'Population research and mental health policy' *British Journal of Psychiatry* 176,407 – 411

Glover, G.R, Robin, E., Emami, J., Arabscheibani, G.R. (1998) "A needs index for mental health care". Soc Psych Epidemiol 33, 89-96.

Jenkins, R., Bebbington, P., Brugha, T.S., Farrell, M., Lewis, G., Meltzer, H. (1997) "The national psychiatric morbidity surveys of Great Britain – strategy and methods" Psychological Medicine 27, 765-774.

Jenkins, R., Bebbington, P., Brugha, T.S., Farrell, M., Lewis, G., Meltzer, H. (1998) "British psychiatric morbidity survey" B.J.Psych 173, 4-7.

Smith, P., Sheldon, T.A., Martin, S. (1996) "An index of need for psychiatric services based on in-patient utilization". B.J.Psych 169, 308-316.

8.4   Cultural Sensitivity

Introduction

The specific mental health needs and concerns of black and minority ethnic communities in England are often unrecognised and poorly responded to (Audit Commission 1994). For example, suicide rates are higher for Asian women and young black men, and schizophrenia diagnosis rates are higher for African and Caribbean men (especially second generation).
Black and minority ethnic groups are more likely to live in London and other large cities, mostly in deprived inner-city areas. Towns and cities, particularly in the south east of England, have recently seen an influx of refugees fleeing political unrest abroad. All these groups, whether black British or newly arrived asylum seekers, may have specific (but very different) mental health needs. Service providers need to ensure that care is equitable and culturally sensitive or risk having services that are inappropriate or discriminatory.

'The government recognises that the social causes of ill health and the inequalities which stem from them must be acknowledged and acted on.' (DH, 1998)

The NHS Plan notes that people in minority ethnic communities are less likely to receive the health services they need. The NSF emphasises existing services' insensitivity to people of African and Caribbean ethnicity and notes that assessment procedures are inadequate for Asian communities. The NSF also stresses that minority ethnic groups (including refugees) suffer from social exclusion that compounds their mental health problems.

The Local Context : Who Constitutes Your Population?

A review of the local population needs to be carried out. This can be quite basic, but should include:

*   ethnic breakdown of general population,
*   community languages spoken,
*   religious diversity,
*   housing types (including homelessness),
*   unemployment
*   any vulnerable groups.

Most of this information can be collected from local government offices, libraries or health authority public health departments.

The Local Context : What Constitutes Your Service?

Collecting local data is a first step towards meeting government requirements for ethnic monitoring and ensuring that services are appropriate for local people. For example, if there are refugees in your locality, interpreting facilities may be required, and there may be particular religious or other cultural needs and expectations to be met, as well as mental health problems specific to the traumas of being uprooted and encountering prejudice or danger, and adjusting to live in a new environment.

Another important move is looking at the ethnic breakdown of staff throughout the organisation, with the aim of creating a workforce that is representative of the population it serves (NHS Executive1998).

The sorts of ethnic data you need to gather are:

- ethnic, linguistic, religious, age and gender breakdown of service users
- linguistic, religious, age and gender breakdown of staff (at all levels). It has been found that staff from minority ethnic groups are over-represented in lower grades and under-represented in higher grades.
- your organisation's policies on racial equality, ethnically equitable services, etc and results of any measures/audits of the policies (including breaches and numbers trained in policy)
- representation of ethnic groups on (executive and non-executive) committees and boards within the organisation
- availability of interpreting services and their range of languages (the training received by interpreters and by health staff in how to work with interpreters in mental health settings should also be available for scrutiny)
- data from any previous audits or evaluations on cultural sensitivity.

Other issues to look at include whether there are multi-faith places of worship in hospitals. Spiritual aspects of care are rarely considered routinely. But insufficient attention to, for example, some religious groups' daily routines and requirements may compound the isolation and stigma of mentally disordered service users.

Are there single sex units? Single sex areas offer more safety and comfort to women who may by distressed on a disturbed acute psychiatric ward. (Mixed wards should be phased out as a matter of national policy, but it is worth noting that some ethnic minority or religious groups require separate areas for men and women).

Are there crèche facilities? Black and minority ethnic groups are relatively young in age profile.

The Local Context : Voluntary and Independent Specialist Service Providers

The voluntary sector is critical to the success of our mental health system. Independent providers often bridge the gap between statutory services and public needs and expectations. Statutory services should acquaint themselves with any local groups for black or other minority ethnic groups, and work together to identify gaps in services, duplication and ways of working in partnership to provide appropriate services. These organisations may need support to survive, especially at times of growth.

Audit

An audit can provide performance indicators to show evidence that, for example, people from minority ethnic groups have been properly assessed and cared for, and that assessment and care are improving. Audit can be considered as a process by which a 'learning organisation':

* monitors its own activities and
* implements a strategy to modify practice.

This assumes that:

* internal audit is acceptable to all stakeholders
* the organisation is able to reflect critically on existing practice, recognise its shortfalls and support changes.

The advantage of internal audit is that the organisation itself implements and takes responsibility for individual clinical and organisational performance. However, there may be a lack of expertise in conducting an effective culturally sensitive audit. It could be argued that self-audit is less objective and is at risk of excluding diverse stakeholders. Minority ethnic communities, service users, voluntary organisations, primary and secondary care may all have important perspectives to contribute. It is worth considering setting up an audit team comprising members from both within and outside the organisation.

The following elements should be looked at when developing a strategic approach to problems identified by an audit:

- human resources strategy, including promoting best practice in recruiting and retaining staff from minority ethnic groups across the range of disciplines
- anti-discriminatory policy and monitoring
- partnerships with voluntary and independent providers
- interpreting and good practice guidelines to address linguistic diversity
- staff training needs
- shortfalls in organisational procedures and practice
- service user-staff matching, including matching staff mix to local population diversity
- service user views of the cultural and religious aspects of service
- a service user-staff-voluntary sector forum (feeding directly into the Trust board)
- advocacy services for people from minority ethnic groups.

Resources

http://www.mailbase.ac.uk/lists/minority-ethnic-health/ **minority-ethnic-health**
This list is aimed at professionals working in the academic, NHS and local government sectors who continually strive to improve the health of minority ethnic communities in the UK via a multi-disciplinary approach.

Audit Commission (1994) *Finding a Place: A Review of Mental Health Services for Adults.* London: Audit Commission

Commission for Racial Equality http://www.cre.gov.uk

London Region good practice sites: http://www.virtuall.org/sup_you/minority/prac.html

Cultural Sensitivity Audit Tool (Sainsbury Centre for Mental Health, 2001). Tel 020 7403 8790 http://www.scmh.org.uk.

Department of Health (1998) *A First Class Service: Quality in the new NHS*.

Department of Health (2000) *The Race Equality Agenda of the Department of Health.* London: DOH

Jennings, S. Creating solutions: developing alternatives in black mental health. (King's Fund, 1996)

Nazroo, J. Ethnicity and mental health: findings from a national community survey. Policy Studies Institute 1997

National Visit 2: Improving Care for Detained Patients from Black and Minority Ethnic Communities (Sainsbury Centre for Mental Health 2000) includes an appendix with contact names and addresses for good practice examples in the areas of recording and monitoring ethnicity, dealing with racial harassment, training in cultural sensitivity and the use of interpreters.

NHS Executive (1998) *Working Together*. London: NHS Executive

NHS Executive (1999) *Addressing black and minority ethnic health in London – a review and recommendations*. London: NHS Executive

8.5 Gender Sensitivity

The NHS Plan recognises that mental health services are not always sensitive to the needs of women. Women live longer than men: but they have more mental health problems, particularly anxiety, depression and eating disorders.

Domestic violence affects one in four women aged 16-59. The stresses and anxiety, which many people experience in abusive relationships, can be reflected in a range of emotional and psychiatric problems.

Post-natal depression affects 10-15 per cent of mothers. A smaller proportion of women develop post-natal psychosis. However, in the first month after childbirth a woman is 20 times more likely to be admitted to hospital for treatment for a severe mental illness than in the 24 months before delivery.

There is a commitment in the NHS Plan that by 2004, services will be redesigned to ensure there are women-only day services in every health authority. At present the community day centre services that women value are found in the voluntary sector. Statutory authorities will need to ensure that in developing local women-sensitive services that they identify these services and include them in service development planning and funding.

Services for women should also be sensitive to their cultural and ethnic backgrounds. The review of populations needs and the audit system outlined in the previous section on cultural sensitivity can also be used to analyse issues around gender. The Equality Impact Assessment Tool at Annex A provides a methodology for looking at equality issues across the board.

Resources

The Vital Connection: An Equalities Framework for the NHS: NHSE
Equal Opportunities and Monitoring in NHS Trusts: HSC 1998/148
NHS Equality Awards www.doh.gov.uk/nhsequality
National Women's Mental Health Network [contact details awaited]
Domestic Violence: A Resource Manual for Health Care Professionals (DH: 2000)
Women and Mental Health: Edited by Dora Kohen (2000)

8.6   Involving and Supporting Service Users and Carers

`[Service users] provide a uniquely valuable perspective on services and it is impossible to get the best from a change process without actively involving them.' *(DH, 1998)*

Community Interaction

The process of enhanced service user and carer participation in services aims to ensure that the needs of the community as a whole are met - including those members whose needs are a priority but which are inadequately met by current provision. Enabling wider public comment on and contribution to the planning and development process is therefore important.

In many localities the basics will already be in place. These could include current / past client surveys by questionnaire or interview, techniques as simple as suggestion boxes on all sites and having an advertised single point of contact for comments and responses to proposals. Although the complaints system can also be a valuable source of information on client satisfaction, it is important that people wishing simply to comment on services should have a distinct route to do so without having their input labelled as a complaint. Proposals and plans should be widely publicised at an early stage, including in non- mental health environments, and plans should be available in all significant community languages and in audio-visual form where appropriate.

Is there an effective service user/carer group or groups already in existence?

Whether a group can be considered effective depends on factors such as its current membership - primarily in terms of how people are recruited (through open advertising, word of mouth or other means?) and whether the membership is large and inclusive enough to be representative of - and actually reflects - the social, cultural and gender mix of the local area. In some areas there will be good reasons for attempting to facilitate groups to represent service users with particular interests, for example gay and lesbian people or people from ethnic minorities. An additional factor will be whether the group or groups (and their meetings) are accessible from all parts of the geographical area covered, which may be a particular difficulty in rural areas.

What is the established role of the service user/carer group(s)?

Service user/carer groups fulfil many different purposes, from providing social or peer support, through providing developmental input and feedback, to directly running services. Some service user groups work with mental health service users specifically, others include users of health or (more often) social services generally. Again, some will be targeted at particular groups within the community. Some will be affiliated or linked to national organisations such as MindLink or UKAN. These points need to be taken into consideration when a service user group is invited to participate in tasks such as service planning or development which may not be its primary objective.

What resources are available?

Are the local group(s) funded by health and social services and is this funding earmarked for a specific purpose? Service user and carer groups (and individual service users and carers) participating in the planning process have resource needs if they are to fulfil their role effectively such as access to an office, photocopying facilities, telephones and stationery. Groups should be able to access training and should have a budget to allow members to attend relevant conferences and similar events. Payment to members for the tasks they undertake on behalf of the group and of local services is also desirable, as well as payment of all out of pocket expenses including travel, childcare and subsistence.

Service User/Carer Representation

Are service users and carers represented on relevant planning or review bodies? Representatives can have a role in all areas of policy making from Trust or Social Services Board level through planning and development groups to areas such as clinical audit, quality assurance or complaints handling. A forum where local service users and carers (jointly or separately, as they wish) can regularly meet with managers and senior clinicians can also be helpful. Are they able to influence the agenda of meetings or is their role merely reactive or even simply observational? Many people taking on this role are relatively inexperienced in meetings and training should be provided. It may be useful to have a range of people involved. It is not uncommon to have very few individuals occupied in a wide range of meetings and this has obvious implications for true representation. Also, in many cases service user representatives may be asked to comment on areas outside their direct experience (e.g. forensic services). In others the `user reps' have been in the role for so long that it is difficult to see what relevance their previous experience may have to

current provision. A consideration in this regard is how accessible or accountable service user representatives are to users of services, whether or not they are active in local groups. Publicising who the representatives are, and their role, and providing an easy mechanism for people to contact them - for instance by a private mailbox at a Trust or Social Services office - can be useful in some circumstances.

Making Representation Effective

Simply allowing service users and carers to attend relevant meetings will not ensure adequate service user/carer representation. To be effective, representatives will require information, support and the space to make a genuine contribution. Having more than one service user and carer representative on any particular development group is desirable (to allow peer support and enhance accountability). Even where services are particularly well intentioned perhaps the commonest reasons why service user and carer representatives fail to impact on planning and development include:

- Lack of access to background or strategic policy information, combined with the lack of resources to research alternative or additional information.
- Lack of knowledge of the legal and fiscal constraints under which services operate, often as result of a defensive attitude on the part of those services (and sometimes due to a paternalistic attitude as well).
- Lack of clarity - or candour - as to what is available for discussion and what has already been decided.
- Unfamiliarity with the terminology (and jargon) employed in internal papers as well as government guidance and briefings.
- Nervousness about speaking up in meetings due to always being in a minority, perhaps being seen (or even treated) as token presences, and being unused to formal meeting structures and, again, the language employed.
- Inability to set the agenda, so that service user representatives are always in the position of responding to service proposals. Alternatively, lack of resources to develop proactive positional papers of their own.
- Lack of support outside of meetings, such as to provide reassurance and reinforcement but also to provide an effective mandate.
- Lack of clarity in the planning process and in particular a failure of services to keep service user representatives informed of progress (or the lack of it) in the developments of proposals and the likely time scales involved.

These issues need to be addressed in local planning arrangements.

Advocacy and Quality Monitoring

The number of advocacy groups has grown very substantially in the UK in the last ten years. The United Kingdom Advocacy Network (UKAN) now has a membership of over 350 groups. Some of these groups are very strong, advocating for service user/survivor rights at a local as well as an individual level. Mind's service user network MindLink has a group membership and tends to include more campaigning work along the lines discussed in this paper. The Mental Health Foundation (Strategies for Living) and the Sainsbury Centre for Mental Health (User-Focused Monitoring) have developed approaches to research and quality monitoring which have service users at their centre. The Carers' National Association is a carer led organisation which empowers carers by raising the status of carers and by increasing their awareness of the role and contribution they make to the community.

Resources

United Kingdom Advocacy Network (UKAN)
MindLink
Strategies for Living, The Mental Health Foundation. Tel 020 7535 7400 e-mail
mhf@mentalhealth.org.uk website http://www.mentalhealth.org.uk
User Focused Monitoring, Sainsbury Centre for Mental Health. Tel 020 7403 8790
http://www.scmh.org.uk
Taking your partners: Using opportunities for inter-agency partnership in mental health.
Sainsbury Centre for Mental Health 2000.
Department of Health (1998) *A First Class Service: Quality in the new NHS*.
Carers National Association. Tel 020 7490 8818
Department of Health Carers' Website: http://www.carers.gov.uk
National Black Carers Network: nbcwn@lycos.co.uk
Giving Users a Voice – West Midlands NHS Executive/MIND Tel.0721 224 4743
Guide to Payment for Service Users- West Midlands Partnership for Mental Health Tel. 0121 224 4743

8.7   Workforce Needs Assessment

Restructuring the mental health system and adding new resources to the mental health sector will not achieve the intended results without a sufficient workforce with the right skills and motivation. While there are many skilled and valuable workers already in the system, the service model described in the NSF and NHS Plan will place new demands upon the workforce. Managers and clinical staff will need additional training and support to meet these. In addition, the expansion in capacity of the system made possible by new resources will increase the demand for new workers.

The Workforce Action Team, set up by the Department of Health, will report in Spring 2001. It will address numbers of staff and their capabilities, and strategies to assist recruitment and retention.

Health and social care agencies are expected (NSF Milestone) to undertake a full review of their existing mental health workforce as part of their service review. This must address the need for their future service system to have both the required workforce capacity (i.e. numbers) and the capabilities (i.e. changes in skill/knowledge/attitudes and changes in professional/non-professional mix). It will be essential to engage human resource professionals in the local review process.

Resources

Improving Working Lives Toolkit (DH) 0541 5554555
Finding and Keeping (The Sainsbury Centre for Mental Health) 0207 403 8790

8.8   Analysis and Action

A needs assessment should be compiled for the whole LIT area and for each service locality. A locality may be the same geographical area as a Primary Care Group/Trust. Needs should be quantified and based on both aggregated individual data and the local implications from published epidemiological evidence.

Specifically for each services:

- *Purpose and Role*: What is the purpose/function of this service?
- *Description:* What does it do and how?
- *Service User Carer Information*: Whom does it serve?
- *Organisational Context*: How does it relate to other services (care pathways)?
- *Management of the Service*: What are its operational procedures, arrangements for access and discharge, hours of operation
- *Staffing*: How is it staffed, minimum numbers and skills required?
- *Quality*: Is there evidence of effectiveness, utility and service user satisfaction?
- *Potential*: What potential is there for this service to change or extend its functions or provide alternative services?

In summary, three main questions have to be addressed:

- Are all the service elements required by the NSF/NHS Plan in place or planned to be in place by set deadlines?
- Do these elements work together as a system to meet identified need?
- Are the underpinning human and financial resources and information systems in place or planned to be in place?

The LIP should include a clear action plan including objectives, targets and responsibilities. This action plan should recognise that the comprehensive review comprises the whole mental health service system and not elements in isolation. The action plan should include future plans for more detailed reviews of need, resource disposition and achieved outcomes. This action plan should be signed off by NHS Trusts and Health Authority Chief Executives, and also by Director(s) of Social Services.

DH Department
o Health

9.   ACHIEVING AND SECURING PROGRESS

9.1   Context

Delivering the whole system changes detailed in this guide will require sustained national and local action. Services are not however embarking upon this from a stationary start. A significant amount of work is already in progress, and much nears completion as a result of work in implementing the underpinning programmes of the NSF.

This section outlines national progress on key underpinning strategies together with action which each local health and social care community must take in order to achieve the whole systems change detailed in this guide. It also highlights where help and guidance is available.

9.2   Clinical Governance

There is a statutory requirement on NHS organisations to improve the quality of care as set out in guidance issued in March 1999 (HSC 99/065). This requires organisations to produce clinical governance development plans and annual reports on what they are doing to improve and maintain clinical quality.

The Commission for Health Improvement was established in 1999 with responsibility for conducting clinical governance reviews of every NHS trust, health authority and primary care group/trust at least every 4 years looking at the organisation's clinical governance arrangements.

Clinical governance provides a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical care will flourish. Clinical governance is part of the overall programme of performance management of NSF and NHS Plan implementation. The Local Implementation Plan (LIP) Self Assessment Framework includes indicators on governance to ascertain whether there are effective joint structured systems for monitoring, safeguarding and developing the quality of service provided, with access to regular service user based outcome information. Only 1 in 10 LITs thought that this would be in place by April 2001.

Local Action

LITs must ensure that appropriate clinical governance arrangements are in place.

9.3   Workforce Development

A Workforce Action Team (WAT) was established in late 1999 and has as its aim "to enable mental health services to ensure that their workforce is sufficient and skilled, well led and supported to deliver high quality mental health care, including secure mental health care".

The WAT programme of work is designed to look at the "big picture", setting out the national perspective on workforce, education and training issues. However, it needs to take account of what is happening at a variety of levels nationally, regionally and locally.

The original remit of exploring the short and longer-term solutions necessary to deliver the NSF now also incorporates the NHS Plan.

Key Work Areas

The programme drawn up by the WAT covers ten key work areas as set out below:

- Determination of a single agreed set of competencies required to deliver each of the NSF standards
- Mapping of all current education and training provision
- A programme of engagement with the professional and regulatory bodies to discuss the outcome of the mapping exercise in relation to pre-qualifying training and Continuing Professional Development
- Development of a range of models for assessing the potential numbers and mix of staff required to deliver the NSF and the NHS Plan
- Development of National Occupational Standards
- Tackling stigma which attaches to working in mental health services
- Recruitment of more professionally non-affiliated people into the mental health workforce
- Employing skill mix solutions to provide an adequate workforce
- Addressing primary mental health care workforce issues
- Improving the recruitment and retention of staff.

Current Position

The WAT published its Interim report in September 2000 and this is being supplemented by a series of monthly Newsletters with the intention of keeping the health and social care communities informed of developments and contact points.

Work is now taking place to prepare a final report to Ministers with publication scheduled for later in the spring of 2001. The aim is to set out the work of the WAT and to put this into the context of other developments that are happening in mental health as well as the wider issues around workforce, education and training. The intention is to provide a report which not only describes the issues but sets out the future position and how services might get there. It will be a practical document aiming to provide managers, practitioners, staff, and service users with some of the answers to what is a complex and often long-standing set of challenges.

The WAT final report will be supplemented by a Department of Health Implementation Plan to be published simultaneously. The Department of Health will have to consult on the plan but essentially it will provide the basis for taking this challenging agenda forward across all agencies and disciplines in the context of both the NSF and the NHS Plan. The aim is to give effect to the work of the WAT and to provide a framework for action for local health and social care communities.

Further help and guidance is available from John Allcock, room 316, Wellington House, 133-155 Waterloo Road, LONDON SE1 8UG, 020-7972-4224, john.allcock@doh.gsi.gov.uk. Further details can also be found in the WAT Newsletters which are on the NSF web-site at www.doh.uk/nsf/mentalhealth.htm.

Local Action

LITs must ensure that comprehensive and integrated workforce plans are prepared for their services, drawing on the guidance available from the WAT.

9.4   Better Information for Better Services

The need for better information for better services spans all of health and social care. 'Information for Health' (Sept. 1999) and its update 'Building an Information Core' (Jan. 2000) detail actions for the NHS. 'Information for Social Care', soon to be published, will be the corresponding document for Social Services.

Modern, integrated services need modern integrated information and systems to deliver this. Tackling the legacy of poor and variable mental health information was highlighted as an urgent priority within the NSF.

The Mental Health Information Strategy (March 2001) details the vision and the actions necessary to deliver improved mental health information. The strategy focuses on the delivery of five integrated goals across health and social care:

- integrated service user information
- local service and access information
- widely accessible consumer information
- an accessible evidence base for all, and
- quality and management information to aid continuous service improvement.

Delivery of the strategy requires a common language connecting these goals so all those accessing information can be sure of consistency with respect to terms and vocabulary employed. Also fundamental to strategy implementation is developing an information culture.

The strategy details a series of timed national and local actions. A Mental Health Information Group will ensure the national co-ordination and implementation of initiatives. It will report directly to the Mental Health Taskforce. A National Implementation Team will provide guidance and assistance to local health and social care communities during implementation.

Local Action

Nationally over £1 billion is available for information, communication and technology over the next three years LITs must ensure that the opportunity to develop the information infrastructure resulting from the MHIS is taken.

LITs and their local Information Strategy (LIS) colleagues must draw-up local action plans by August 2001 to implement their mental health information strategies. This will then be incorporated into revised LIS plans and the Autumn 2001 LIP framework.

Further guidance and information can be obtained from Dr Susan Knight who is chairing the national Health Information Group.

9.5   Performance Management

Measuring change and managing performance is central to government objectives. Health Circular 1998/074 states:

'National Service Frameworks will set national standards and define service models for a defined service or care group; put in place strategies to support implementation; and establish performance measures against which progress within an agreed timescale will be measured.'

The Mental Health Performance Management Project

A Mental Health Performance Management Project and a Performance Monitoring Steering Group have been established to co-ordinate and develop national performance monitoring initiatives. They are managing and overseeing the development and implementation of a programme of monitoring of the mental health service objectives set out in the MHNSF and the NHS Plan. This will show how each health authority, trust and local authority performs, whether performance has improved or worsened and how it compares with other HAs, Trusts and LAs. The overall aim is to determine whether finance is getting to people, whether people are getting the services they need, and whether change is taking place. The objective of performance monitoring in each case will be to evaluate performance and progress in terms of whether the services provided are of sufficient quantity (ie enough) and quality (ie good enough); whether they are good value for money; and, where they have not met these criteria, whether they are getting better.

Mental Health Performance Management Arrangements

Establishing 'Local Implementation Teams' was a requirement of the MHNSF. The NSF states that 'local health and social care communities must translate the national standards and service models into local delivery plans', and take 'ultimate responsibility for ensuring [their] implementation' (p.83-84). There are 126 LITs which vary in size from region to region. Regardless of size, LITs constitute boundaries which are discreet and mutually exclusive, thereby enabling enumeration of services for defined populations, and the

involvement of all those commissioning and providing services within the boundaries of each LIT area.

The MHNSF, with its standards and service models, is the overarching policy document. The NHS Plan sets out 'new arrangements for monitoring and reporting the performance of local health services' based on the NHS Performance Assessment Framework (PAF). The NHS Plan included extra annual investment to fast-forward the implementation of the NSF, setting new timescales and specific objectives. The Mental Health Taskforce Board has been established to oversee the implementation of the NSF and the NHS Plan, and Taskforce Projects set up to undertake this implementation.

NHS Plan implementation involves setting targets for the NHS to deliver in the year ahead in the form of Service and Financial Frameworks (SaFFs) which translate the targets into milestones with data items that will indicate whether the targets are being met. The SaFF process is supported by Local Action Plans (LAPs) giving details about how these targets will be achieved, the resources required and the risks involved. The mental health targets in the NHS Plan Implementation Plan for 2001-2002 are set out in Annex A.

Outcome Measurement

A Mental Health Performance Assessment Framework (MHPAF) – attached at Annex B - has been developed which joins all of this together. At the top are mental health outcomes defined in terms of:

- Mortality (suicide rate reductions)
- Morbidity (reduction in mental illness/mental health improvement)
- Quality of Life for Service Users and Carers
- Service User and Carer Satisfaction

Under these are the domains of the NHS PAF and the Personal Social Services (PSS) PAF. At the next level are the aims specified in the MHNSF standards and underpinning programmes, and the service provisions contained in the NHS Plan. The MH PAF includes 'milestones defined as targets with dates' for the NHS Plan objectives. There are also targets and milestones for each of the NSF standards. Performance indicators, defined as 'specific, quantifiable measures of progress against each objective', are being developed for all of the Taskforce Project objectives.

Local Implementation Plans

The first national monitoring exercise (LIP 1) took place in spring 2000. This required LITs to prepare and submit narrative plans setting out their approach to implementing the NSF, alongside Joint Investment Plans detailing current and proposed expenditure. The documents were given an overall 'traffic light' rating by each of the health and social care regional offices. The second phase of national monitoring (LIP 2) took place in autumn 2000. For this, LITs were required to undertake a self assessment of progress, in a traffic light format, against a total of 35 indicators of the quality of current services, planned services and the planning process. This Self Assessment Framework concentrated in particular on the underpinning strategy areas: workforce, information, governance, finance, and planning and management processes. Progress against key service objectives, such as assertive outreach, crisis resolution and the provision of secure accommodation, was also monitored.

For each of the 35 indicators, a statement described the corresponding traffic light positions, and each LIT was asked to indicate whether red, amber or green most nearly matched the situation in their locality. Broadly, achievement of a 'green' rating was set at a challenging level, requiring very substantial progress to have been made against an indicator. A 'red' rating demonstrated little or no progress against an indicator. 'Amber' was the intermediate or default rating, and deliberately broad in scope, so as to ensure a clear highlight of areas of promise or problem.

Following completion of the Framework, LIT members met regional health and social care mental health leads to discuss their initial ratings and their implications. This validation process resulted in some ratings being amended. This produced no systematic tendency for ratings to be made better or worse. The final report was based on the validated ratings agreed by LITs with regional offices. The LIP Self Assessment Framework has been widely welcomed. It will be continued and extended. Its main elements will remain constant in order to track progress on key areas over time. A LIP3 Self Assessment will be undertaken in autumn 2001 with a particular focus on financial monitoring.

Service Mapping

A comprehensive mapping of all health and social care mental health services was undertaken in autumn 2000. The purpose of the mapping was to produce a national picture of the services available to help people with mental health problems and their carers. Moreover, the mapping was needed to provide the baseline against which change could be measured and progress monitored as implementation of the NSF progresses over the next ten years, and the NHS Plan over the next three years. Contributions to the mapping from

health authorities, trusts, local authorities and the voluntary sector were co-ordinated by LIT leads and signed off by Chief Executives of trusts and health authorities, and by Directors of social services.

The mapping covered thirteen categories of services. These were: community mental health teams, access and crisis services, services for mentally disordered offenders, clinical services, local low and medium secure services, psychological therapies, home support, day services, support services, services for carers, accommodation, mental health promotion and direct payments. Data provided for each service included, where relevant: availability, target groups (eg minority ethnic communities, dual diagnosis), sector of providers, staffing, capacity, and catchment area.

The mapping data will be used in the comprehensive service review process, and will be updated in autumn 2001 in the form of a database. The findings of the first and subsequent mapping exercises will be published in the form of an Atlas, with maps and tables showing, for example, levels of service provided by population weighted for indices of deprivation and other demographic factors.

Benchmarking

The NSF required all NHS providers to be in a 'benchmarking club' by December 2000. Whilst some progress has taken place, for example, around disseminating the LIP Self Assessment Framework, overall benchmarking progress has been patchy. Although no single model is currently in use, the framework developed and being extended by the Inner Cities Mental Health Group is robust. This has been taken on board and modified in Trent Region and to a certain extent in South East Region, and is being evaluated in Northern and Yorkshire Region. It is now intended to give the work a national emphasis.

Further advice and guidance available from the Joint Leads on Mental Health Performance, Information and Finance Dr. Cathy Borowy (020 7972 4241) and Dr. Susan Knight (01132 545 216).

ANNEX A

Policy Making for Equality Impact Assessment

Step One: Define Issues and Goals

1. Identify the goals and objectives, and analyse the problems and concerns so that main factors affecting women and men, people from black and minority ethnic groups and disabled people are taken into account. Make sure the outcomes enable these groups to make an equal contribution to the economy and to society. **Ask:**

- what is the policy trying to achieve?

- does the policy affect women and men, people from black and minority ethnic groups and disabled people differently?

- has previous work thrown up gender/race/disability considerations for this policy?

- is the policy meant to overcome inequalities or eliminate barriers, if so should there be an equality objective or objectives?

- what these groups, including representative organisations, say about the goals and issues?

Step Two: Collect Data

1. Consider what information is required to inform the policy-making process or to develop policy options. Request information from national and community-based organisations and consult representative groups, who may have information and persepectives that are new. Build in time to allow them to consult internally, as they may have limited funds and resources and probably work through volunteers. Consult research and statistical sources, they can help with the design and analysis of data collection, with consultation and interpreting the facts and findings from an equality perspective. **Ask:**

   - what is the gender/race/disability profile of the people affected by the policy?
   - how can data be broken down by gender/race/disability?
   - what other information apart from statistics is needed to understand the issues/perspectives?

Step Three: Develop Options

2. Use the results of the research and data collection to help develop the policy recommendation or policy options. Present the recommendation or options in terms of impacts and implications for giving women and men, people from black and minority ethnic groups and disabled people equal access to policy benefits. **Ask:**

   - how does the recommendation or each option disadvantage or benefit women or men, people from black and minority ethnic groups and disabled people?
   - does the recommendation or any of the options reinforce or challenge traditional or stereotyped perceptions of these groups?
   - which option gives each of these groups real choice and an opportunity to achieve their full potential in society?
   - is there a need to consider mitigation where there will be a negative impact, and

     what action can be taken to reduce the impact or to create a more equality balanced

     policy?

Step Four: Communicate

3. The strategy used to communicate the policies can play a significant role in acceptance and implementation. Timing, choice of media, language, and public involvement are important to ensure that policy intent and the impacts of the policy, programme and legislation are understood. **Ask:**

- how does the policy reflect your organisation's commitment to equality?
- are separate approaches necessary for communication to be effective for women and men, people from black and minority ethnic groups and disabled people?

have gender, race and disability-inclusive language, symbols and examples been used in the materials communicating the policy?

Step Five: Monitor

4. Monitoring is the continuous process of scrutiny and examination of the impact of the policy on equality issues. It helps determine how well programmes are meeting their goals and provides opportunities for improvements. **Ask:**
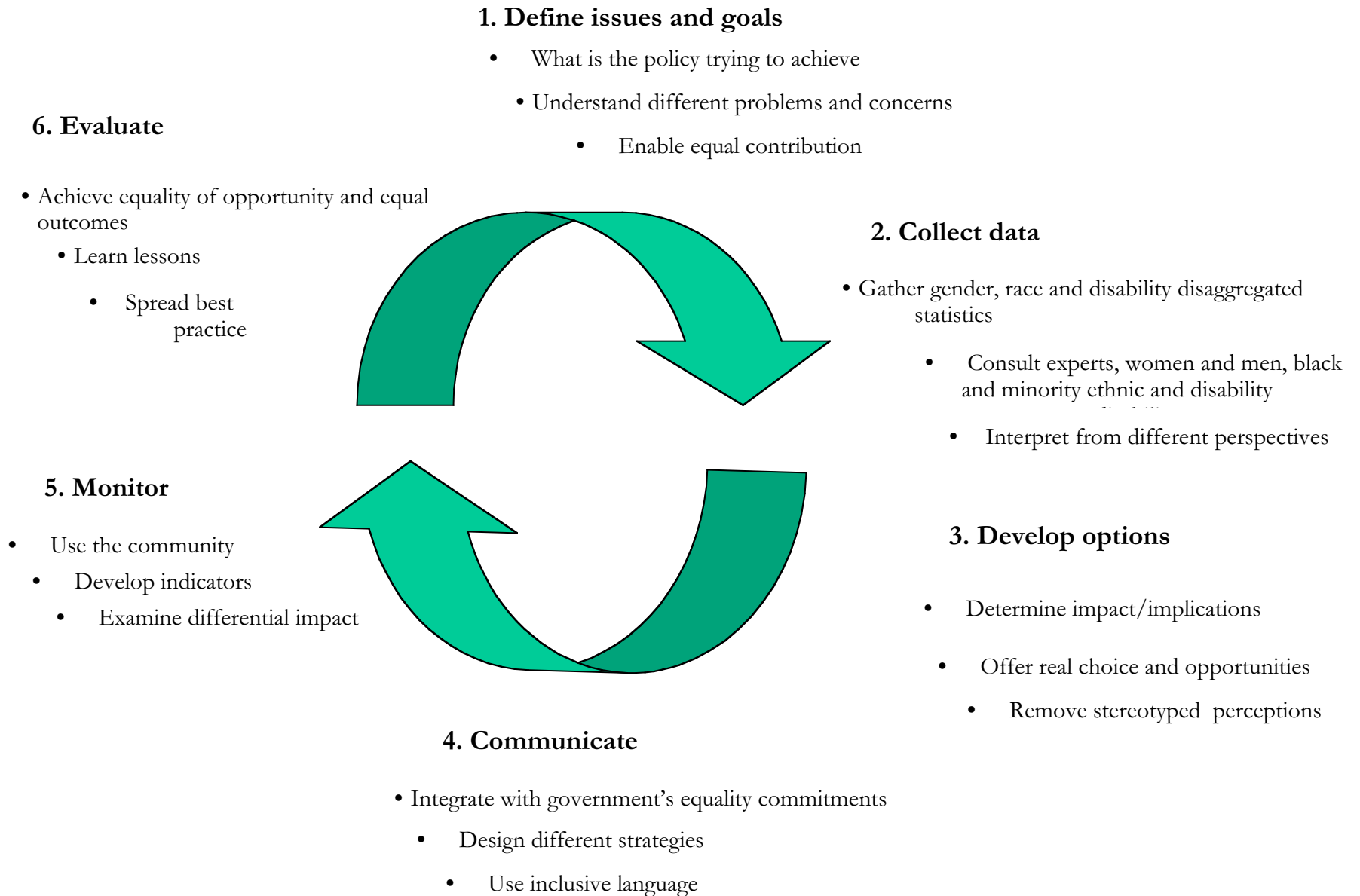
- do plans for monitoring include a measure for gender, race and disability impact?
- how can representative groups in the community help in monitoring the outputs and outcomes?
- do indicators and targets incorporate equality objectives?
- are there measures in place to initiate an investigation or to change the policy if it is not delivering the equality objective defined at the outset of the project?

Step Six: Evaluate

5. To be effective, policy-making must be a learning process that involves finding out what works and what does not, and making sure others can learn from it too. This means lessons learned from evaluation must be available and accessible to other policy-makers. **Ask:**

- is the policy delivering equality of opportunity for all groups?
- has the policy achieved equal outcomes?
- what lessons are there for improving future equality impact assessments, who needs to be informed and how is the information to be presented?

Aide-Mémoire for Equality Impact Assessment

1. Define issues and goals

- What is the policy trying to achieve
- Understand different problems and concerns
- Enable equal contribution

6. Evaluate

- Achieve equality of opportunity and equal outcomes
- Learn lessons
- Spread best practice

2. Collect data

- Gather gender, race and disability disaggregated statistics
- Consult experts, women and men, black and minority ethnic and disability
- Interpret from different perspectives

5. Monitor

- Use the community
- Develop indicators
- Examine differential impact

3. Develop options

- Determine impact/implications
- Offer real choice and opportunities
- Remove stereotyped perceptions

4. Communicate

- Integrate with government's equality commitments
- Design different strategies
- Use inclusive language

ANNEX B

Extract from NHS Plan Implementation Programme December 2000

Mental Health Services:

The NHS Plan builds upon the investment of the last two years in secure beds, 24 hour staffed beds, extra assertive outreach teams and improving access to services 24 hours a day, 7 days a week. The NHS Plan and the Mental Health NSF set out a radical shift towards new service models for mental health.

To deliver these services local health and social care communities will have to prepare effectively during 2001/2002, and plan for full-scale implementation of the new models in 2002/2003 and 2003/2004, using the increased funding in the 2001-02 Mental Health Grant. Developing a robust plan will require a comprehensive review of community mental health provisions to ensure that new services are delivered in a co-ordinated way. Mental Health Local Implementation Teams (LITs) will take the lead in this process, and the local mental health implementation plan remains the key document for consolidating investment and service development, and for delivering NHS Plan and MHNSF requirements.

However, whilst the planning process is going on, it is important that there is continuing improvement in mental health services during 2001-02. Mental health services should already be working towards delivery of key NSF milestones including the implementation of the MHIS, the MHMDS, clinical decision support systems, and the Workforce Action Team requirements.

Targets:

- By November 2001, each Local Implementation Team will have signed-off by the relevant NHS and Social Care Regional Office, their Stage 3 plan for implementing the MHNSF, and the mental health targets in the NHS Plan. Each health authority must reflect the LIT plans in their planning for 2002/03 and beyond.

- By March 2002, each health authority must have identified all clients who require the assertive outreach approach, and prepared plans for a further 50 assertive outreach teams to ensure that all clients who need this approach will be in receipt of such services by 2003. Also, the national psychiatric re-admission rate must be reduced to 12.3% by end March 2002.

- By March 2001, all specialist mental health service users on enhanced CPA should have a written care plan, available to staff providing care, and to users, at the time and place required to provide appropriate and effective care, which includes: the action to be taken in a crisis by the service user, the carer and the care co-ordinator; advises the GP of the response required if the service user needs additional help; is regularly reviewed by the care co-ordinator; and informs the service user how to access services 24 hours a day, 365 days a year. By March 2002, this should be extended to cover all service users on CPA, and all patients discharged from inpatient care should have a written care plan at the time of discharge. By March 2002, the written care plan for those people on enhanced CPA must show plans to secure suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits, and all regular carers of people on enhanced CPA, including children with caring responsibilities, should have their own written care plan which addresses their caring, physical and own mental health needs.

- By end March 2001, all health authorities should have in place protocols agreed and implemented between primary care and specialist mental health services for the management of: depression and post-natal depression; anxiety disorders; schizophrenia; those requiring psychological therapies; and drug and alcohol dependence. By end March 2002, all health authorities should have reviewed the operation of these protocols to ensure they are being used and operating effectively. In addition, health authorities will need to ensure that information about treatment and services are available for all people (regardless of age) presenting in primary care with mental health problems, including information about access to local self-help groups and support services such as housing and employment.

Planning milestones:

- To help prevent suicides amongst high risk groups, by March 2002 all patients with a current or recent history of severe mental illness and/or deliberate self-harm, and in particular those who at some time during their admission were detained under the Mental Health Act because of a high risk of suicide, must be followed up by a face to face contact with a mental health professional within 7 days of discharge from inpatient hospital care. Also, every health authority and local council must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others.

- By end March 2002, 60 staff will be recruited to provide prison in-reach services at selected prisons and 40 new secure beds will be provided to transfer those people no longer requiring the conditions of high security. These schemes will be discussed and agreed with Regional Offices.