Mental illness.

THE HEALTH OF THE NATION

Key Area Handbook

MENTAL ILLNESS

DEPARTMENT OF HEALTH

MENTAL ILLNESS

A 3½″ computer disk, prepared in WordPerfect 5.1., is included at the back of this handbook.

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PREFACE

This handbook forms part of a series of Health of the Nation Key Area handbooks. In The Health of the Nation White Paper published in July 1992, the Government said that the National Health Service Management Executive would commission handbooks on possible local approaches to each of the five Key Areas identified in the White Paper: Coronary Heart Disease and Stroke, Cancers, Mental Illness, Accidents, and HIV/AIDS and Sexual Health.

The aim of the handbooks is primarily to assist managers and directors in purchasing authorities (DHAs, FHSAs, purchasing consortia and, for mental illness, Local Authority Social Services Departments) to develop local strategies for reducing mortality and morbidity in each Key Area. The handbooks also aim to disseminate widely information about local initiatives to managers and directors in provider organisations and to group together other relevant information. The handbooks may also be of interest to organisations such as in the voluntary sector, which join together with the NHS and SSDs in alliances for health.

The information in the handbooks is illustrative rather than prescriptive and it is intended that they should be used as practical guides. NHS managers and others will wish to use the guides selectively and adapt them to suit local circumstances in the light of local priorities and available resources. The handbooks vary in length, structure and content as a result of the differences in subject matter, secondary audiences and the amount of prominence each Area has had in the past.

The handbook series is complemented by a range of other documents which the Department of Health has issued in order to help implement the Health of the Nation strategy. A supplement to the Public Health Common Data Set, which contains baseline data on the primary targets, was issued in October 1992. First Steps for the NHS, which sets out suggestions for management action for each Key Area grouped by type of contract or plan, was issued in

November 1992. A workshop on Alliances for Health was held in November 1992 and a report will be published in Spring 1993. In addition, a sub-group of the Minister's Wider Health Group has been established to produce a handbook with guidance on how to form healthy alliances. The Department of Health also plans to publish a discussion document to advance the process of setting local targets.

The production of the Key Area Handbooks has been the result of a joint working venture between the Department of Health, the NHS and other organisations. The handbooks could not have been published without the help and advice of colleagues from outside the Department and we are grateful to them for their valuable contribution.

The ultimate purpose of the Health of the Nation initiative is to bring about the further continuing improvement in health. The intention of the Key Area Handbooks is to contribute to that process.

Comments on this handbook are very welcome and should be sent to Dr Rachel Jenkins or Dr David Kingdon at the Department of Health, Wellington House, 133-155 Waterloo Road, London SE1 8UG.

The intention is to carry out an evaluation exercise later in the year based on feedback from users.

Further copies are available from:

BAPS,
Health Publications Unit,
Heywood Stores,
No. 2 Site, Manchester Road,
Heywood, Lancashire OL10 2PZ.

GLOSSARY

ASW	Approved Social Worker
CHC	Community Health Council
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DGH	District General Hospital
DH	Department of Health
DHA	District Health Authority
ECT	Electro-convulsive therapy
FHSA	Family Health Services Authority
GPFH	General Practitioner Fundholder
HEA	Health Education Authority
HAS	Health Advisory Service
IT	Information Technology
LA	Local Authority
LASS	Local Authority Social Services
LEA	Local Education Authority
MDT	Multi-disciplinary team
MRC	Medical Research Council
NHS	National Health Service
NHSME	National Health Service Management Executive
NSF	National Schizophrenia Fellowship
OPCS	Office of Population Censuses and Surveys
PACT	Placement, Assessment and Counselling
PHCT	Primary Health Care Team
R&D	Research and Development
RDP	Research and Development for Psychiatry
RCGP	Royal College of General Practitioners
RDRD	Regional Director of Research and Development
RMO	Responsible Medical Officer
RSU	Regional Secure Unit
SHA	Special Health Authority
SSD	Social Services Department
SSI	Social Services Inspectorate
TAPS	Team for the Assessment of Psychiatric Services

CHAPTER 1

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Introduction

1.1 The Health of the Nation identified mental illness as one of the five key areas in its health strategy. The three primary targets which the White Paper set are:

- To improve significantly the health and social functioning of mentally ill people
- To reduce the overall suicide rate by at least 15% by the year 2000 (from 11.0 per 100,000 population in 1990 to no more than 9.4)
- To reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (from the life-time estimate of 15% in 1990 to no more than 10%).

The significance of mental illness and suicide

1.2 Mental health problems are a leading cause of illness, distress and disability (see Appendix 1.1).

1.3 Mental illness (see Appendix 1.2 for a brief description) accounted for 18,286 recorded deaths in 1991. Within this, suicide is a significant cause of premature death[1]. There is now widespread evidence that suicide is preventable. Appendix 1.3 sets out important background information for managers which will put the measures outlined in this handbook to reduce suicide into context. Suicide:

- accounts for approximately 1% of all deaths annually – 5,567 deaths in 1991
- has risen by 75% in young men (aged 15-24) since 1982
- is the second most common cause of death in 15-34 year old males.

1.4 Mental health problems make significant demands on NHS, social services, employers and society generally, occurring in 50% or more of people on social workers' caseloads, whether generic, mental health or other specialist (eg elderly or children). Suicide accounts for about 8% of all working days lost through death (ie between ages 15-64) whilst mental illness accounts for approximately:

- 14% of NHS inpatient costs
- 14% of certificated sickness absence.

[1]Suicide and self inflicted injury (ICD E950-E959) and injury undetermined whether accidentally or purposely inflicted (ICD E980-E989). Coroners vary in their criteria for recording a suicide verdict. Including the category of undetermined deaths reduces the variation considerably. Most undetermined deaths are suicides.

1.5 These figures are likely to be underestimates because of:

- the failure to recognise some mental illness at community and primary health care level
- the failure to recognise psychiatric morbidity in general medical and surgical settings
- insufficient attention given to psychological distress associated with physical diseases, particularly those associated with long-term disablement, for both the patient and their carers
- the substantial effect of mental illness on other morbidity and mortality statistics. For example, Standardised Mortality Ratios for people with schizophrenia are 2.5, ie two-and-a-half times the average
- the under-reporting of mental illness due to stigma.

Developing comprehensive local services

1.6 Major advances have been made in the last decade both in the understanding and management of mental illness and the risk factors and circumstances in which suicide occurs. Significant opportunities now exist for the effective treatment and continuing care of people with acute and severe and enduring mental illness and the reduction of suicide rates. Developments include:

- **Changes in treatment methods** – particularly the development of psychotherapies, including cognitive, behavioural, interpersonal and family therapies and the improvements in physical interventions (see Chapter 6)
- **Changes in treatment settings** – with the move from institutions to comprehensive local services (14 old-style mental hospitals were replaced between 1985 and the end of 1992) (see Chapter 6)
- **Changes in working patterns** – the development of multi-disciplinary team work and greater involvement and influence of users and carers (see Chapter 10).

1.7 In spite of the opportunities provided by these developments, mental illness has remained a poor relation in NHS and LA management priorities. Services have been fragmented and poorly co-ordinated, resulting in poor information and

inappropriately targeted resources; alliances between health and social services have not been developed to their full potential.

1.8 NHS and SSD management has a key role to play in developing and encouraging change to ensure:

- the most effective treatment for each individual with a mental illness
- that changes in treatment and care setting take place in a systematic manner.

How to use this handbook to achieve the targets

1.9 In a situation where "need is limitless and resources finite", organisation of the available resources is critical to ensure that allocations are used as cost-effectively as possible in order to provide the maximum possible health benefits.

1.10 Due to the close co-operation required between health and social services in the delivery of the Mental Illness Key Area targets, this handbook is addressed jointly to the NHS and SSDs. It concentrates on providing practical advice to managers on the **implementation of change** necessary to achieve the targets in the mental illness key area. The handbook sets out a range of options which may be adapted to suit local circumstances. The ideas contained in the handbook are not comprehensive, but should act as stimuli for development and innovation at a local level.

1.11 Progress towards the primary targets will not be instantaneous. Managers at all levels of the health and social services will want to undertake an honest appraisal of the local situation and then to prioritise the action that they take. They will want to draw up a clear timescale for implementation, which fits local circumstances and needs, to help them break down the process of change into manageable stages. Managers – and practitioners – will then be able to identify milestones to set achievable but challenging targets against which progress can be monitored.

1.12 Principal themes for management action highlighted in the handbook are:

- working with other agencies to promote mental health and reduce the stigma attached to mental illness (Chapters 2 and 5)
- a systematic approach to needs assessment and review of current service provision (Chapter 3)

- consultation with all interested parties locally, in particular taking account of user and carer views, in the development of strategies and services to reduce mental illness and suicide (Chapter 4)
- the development of effective joint planning and purchasing between the NHS (including GP fundholders) and Social Services Departments (Chapters 5 and 12)
- ensuring a smooth transition from old-style institutions to community care, including the full, effective and speedy implementation of the Care Programme Approach (CPA) and care management (Chapters 6 and 9)
- facilitating and promoting staff development and multi-disciplinary working and the development of closer working between primary and secondary care sectors to increase the awareness, detection and treatment of mental illnesses (Chapter 10)
- the implementation of effective mental health information systems (Chapter 11)
- targeting a balance of prevention, treatment (including reducing dependence upon benzodiazepines), rehabilitation and continuing care effectively upon different user groups – children and adolescents, young adults, older adults, elderly people, women, people from black and other ethnic minorities, mentally disordered offenders etc
- the need for close and co-operative working between health and social service managers and staff delivering care.

The further development of primary mental health targets

1.13 The current scarcity of information on the epidemiology of mental illness and attempts to use process indicators, such as bed numbers, as proxies for outcome, have distorted service provision. We have therefore made our first target a real morbidity outcome target, for which we shall require outcome indicators. These are being developed and the target will be refined as more data becomes available. Further national targets will be set in the middle of the decade to focus more directly NHS and local authority efforts in this area.

Appendix 1.1

EPIDEMIOLOGICAL DATA ON MENTAL ILLNESS

1. The following estimates describe the disease prevalence and service contact a District/Purchasing Consortium or Local Authority can expect amongst its resident population. The figures are based upon a population of 500,000 including 70,000 over the age of 65.

2. The disease prevalence figures below are broad estimates. As local information gathering becomes better established, the quality of this epidemiological data should improve.

Disease prevalence	
1,000-2,500	with schizophrenia – between 33% and 50% only will be in contact with mental health services
500-2,500	with affective psychosis
10,000-25,000	with depressive disorder
8,000-30,000	with anxiety states
3,500	with dementia

3. Service contact figures reflect service use rather than the need for service provision.

Service contact	
10,000	seen annually by psychiatrists
1,350	on CPN caseload at any time
2,000-2,500	admitted to psychiatric ward annually
450-500	psychiatric inpatients at any time
30,000-40,000	seen annually in general practice with diagnosed mental illness

Appendix 1.2

MENTAL ILLNESSES – BRIEF DESCRIPTIONS

Schizophrenia

involves the most basic functions that give people a feeling of individuality, uniqueness and self-direction (creating their 'reality boundary'). It can cause them to hallucinate, develop feelings of bewilderment and fear, and to believe that their deepest thoughts, feelings and acts may be known to, or controlled by others.

Affective (mood) psychosis

causes profound changes in mood, either to severe depression with reduction in levels of activity, or elation with over activity.

Depressive disorder

is where symptoms such as depressed mood, loss of interest, reduced energy, suicidal ideas, sleep and appetite disturbance exceed normal mood fluctuation.

Anxiety states

includes phobias, panic and generalised anxiety disorders where anxiety symptoms, eg worry, tension, over breathing, giddiness, cause significant distress and/or disability.

Dementia

leads to decline in intellectual functioning and memory caused by diseases of the brain, such as Alzheimer's and Vascular (blood vessel) disease.

Eating disorders

include anorexia nervosa, where severe weight loss occurs, and bulimia nervosa which both involve fear of fatness with under and over eating.

Personality disorders

involve deeply ingrained and enduring behaviour patterns, showing themselves as inflexible responses to a broad range of personal and social situations. They may be associated with distress and problems in social functioning.

Appendix 1.3

SUICIDE

"'If they want to do it, they will do it anyway' is *not* the case."

1. Much is known about suicide, its risk factors and the circumstances in which it occurs. A basic knowledge of the factors involved will help guide managers in ensuring that action is taken to achieve the targets.

2. Suicide is rarely a choice made unclouded by depression. Of the people who commit suicide:

   90% have some form of mental disorder

   66% have consulted their GP in the previous month

   40% have consulted their GP in the previous week

   33% have expressed clear suicidal intent

   25% are psychiatric outpatients.

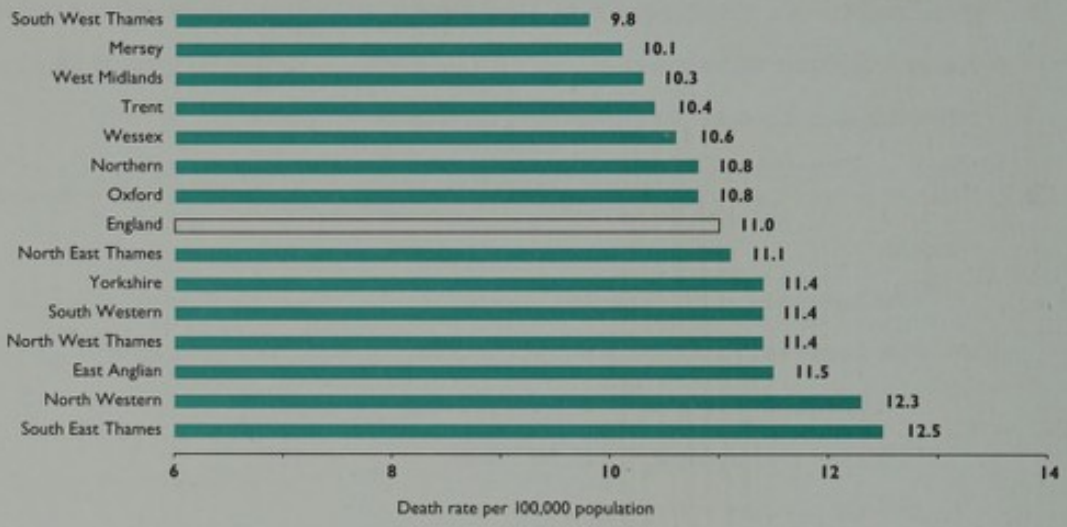
3. People who have attempted suicide in the past are at increased risk – approximately 100 times in the year after an attempt.

Factors influencing suicide rates

4. The causes of suicide can be many and various, but are fundamentally the inter-action of life events, psychological state, lack of effective treatment and social support and access to the means to commit suicide. International comparisons, as well as variations within England between Regional Health Authorities, show that social and cultural factors as well as access to means influence suicide rate. Addressing all these issues will help reduce the incidence of suicide.

5. The graph on the next page shows Regional variations in suicide rates within the UK.

Death Rates* for Suicide and Undetermined Injury
by RHA Persons All Ages 1989-1991



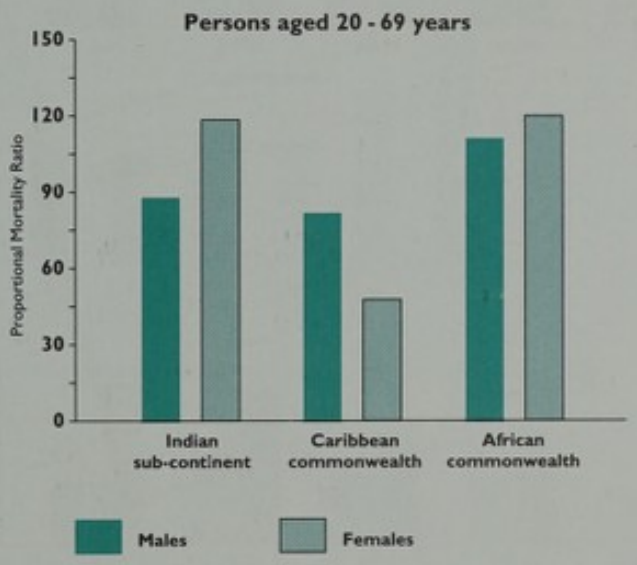
***Rates calculated using the European Standard Population**

Source: Public Health Common Data Set 1992, The Health of the Nation Baseline Data (ICD E950-E959, E980-E989)

Sex and age

6. Rates of suicide are twice as high in men as in women and the difference is increasing. Although motherhood does not protect against depression, mothers of young children are less likely to commit suicide. However, as the following graph shows, rates of suicide amongst immigrant populations are higher amongst females than males.

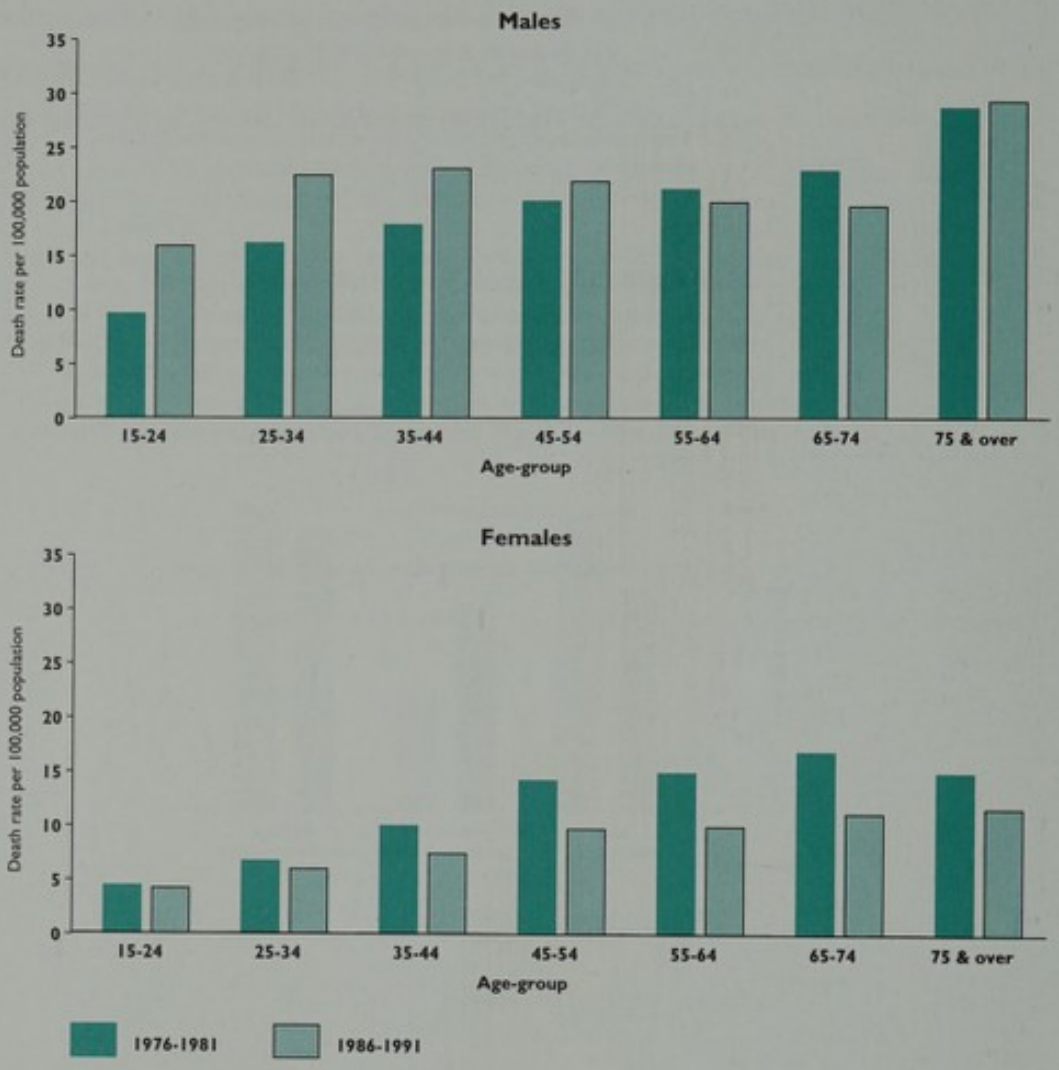
Suicide and Undetermined Injury
by Sex and Country of Birth
England & Wales 1970-78



Source: OPCS Immigrant Mortality

7. Since the early 1970s, suicide rates for men under the age of 45 have risen and are now higher than those of older men, apart from men aged 75 and over. In contrast, rates for women remain lower in women aged 45 and under. The graphs on the next page highlight recent trends in suicide rates by sex and age.

Death Rates for Suicide and Undetermined Injury
by Sex and Age England

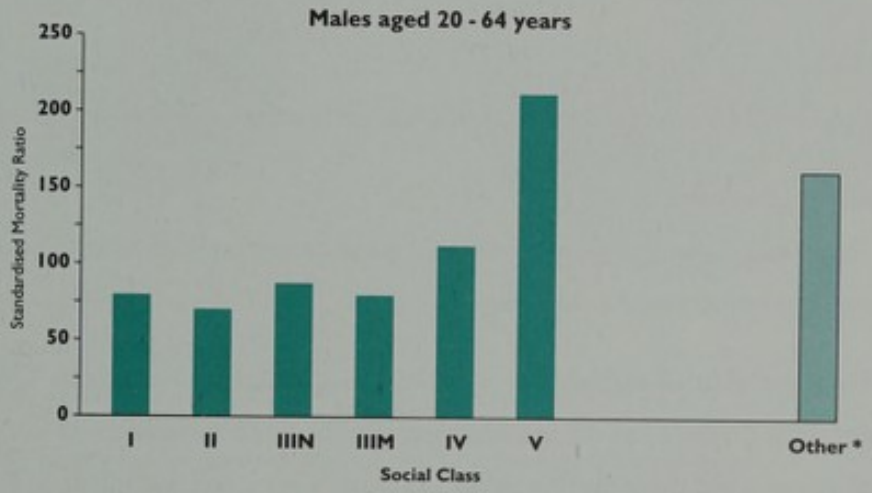


Source: OPCS (ICD E950-E959 + E980-E989)

Social Class

8. The following graph shows that suicide rates are highest in social class V (unskilled workers).

Suicide and Undetermined Injury
by Social Class England and Wales
1979-80, 1982-83



*Armed forces and unoccupied, inadequately described

Source: OPCS Occupational Mortality

Employment status

9. Suicide rates are higher amongst the unemployed, although the relationship is complex.

Family status

10. The ending of marriages or partnerships – whether by divorce or death – has a direct impact on suicide rates. It may also have a delayed effect on children whose parents separate, leading to mental illness or suicide in later life.

Mental disorder

11. Serious mental disorder and alcohol abuse have a marked effect on lifetime suicide rates. They are estimated at:

schizophrenia	10%
affective disorder	15%
personality disorder	15%
alcohol dependence	15%

Season

12. Suicide rates are highest in the spring and early summer, notably April, May and June.

Access to means

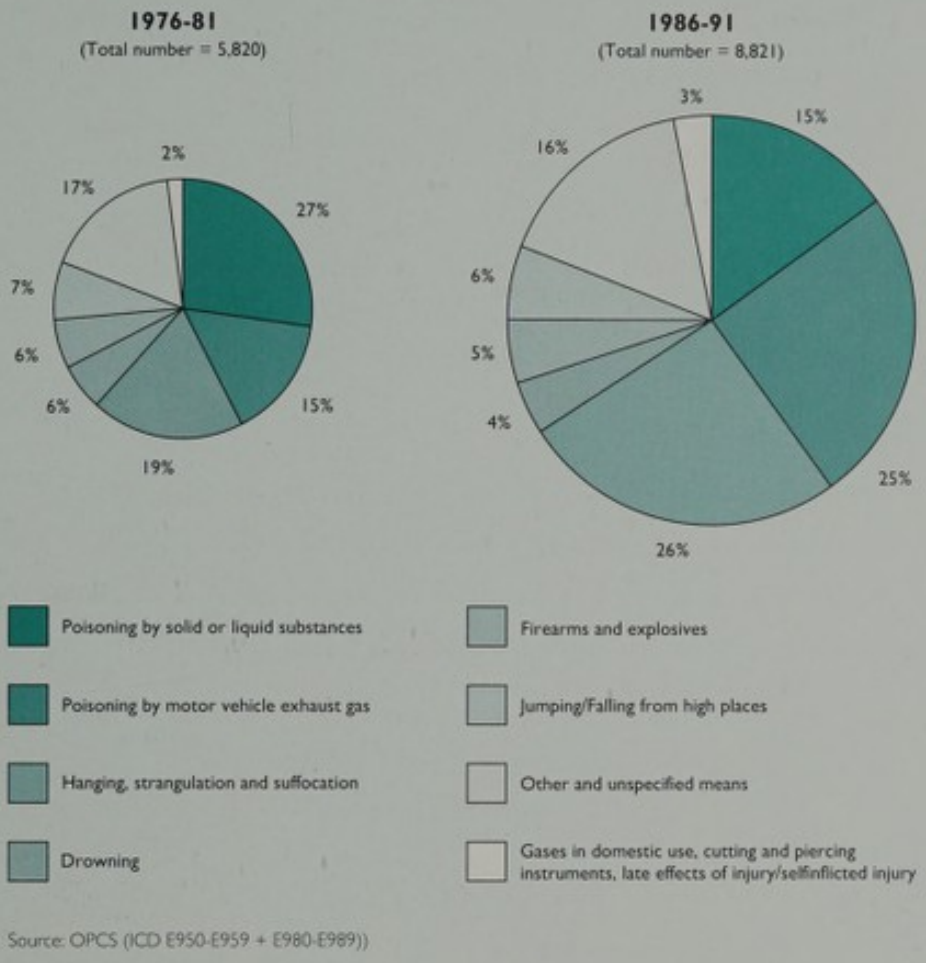
13. The availability of easy and relatively painless methods of suicide is an important factor in influencing suicide rates.

14. The inhalation of car exhaust fumes causes 33% of male suicides. Tighter exhaust emission controls and the introduction of catalytic converters could have as dramatic an effect as did the reduction of the proportion of carbon monoxide in household gas in the 1960s.

15. Self-poisoning has declined with reduced prescriptions for barbiturates, but still accounts for 66% of suicides amongst women, paracetamol being commonly used.

16. The pie charts on the next page show the incidence of suicide by method.

Deaths from Suicide and Undetermined Injury
by Method Males aged 15-34 England and Wales



Source: OPCS (ICD E950-E959 + E980-E989))

Local suicide rates

17. Although there will be considerable variations geographically and over time for reasons outside a GP's or team's control, on average the annual suicide rates shown in the table on the next page can be expected.

Location	*Suicides/annum*
GP practice (list size 6,000)	1
Mental Health team (sector 50 to 100,000)	6-12 in sector
	2-5 amongst patients
DHA/Purchasing consortium	
(500,000 population)	50-60
Region	400

Measures to reduce suicide

18. Suicide rates **can** be reduced. The measures described in this handbook will all help in reducing the risk and incidence – in particular, developing well managed and responsive local services providing early intervention in the treatment of mental illness. Particular interventions are described in Chapter 6.

CHAPTER 2

MENTAL HEALTH PROMOTION

MENTAL HEALTH PROMOTION

Action summary

All NHS and SSD Managers

- Develop good practice to improve mental health in the NHS and LA workplace.
- Build alliances for health promotion outside the NHS and local authority social services.
- Co-ordinate local strategies with the Health Education Authority.

Promoting mental health and preventing mental illness

2.1 Mental illness more than many other illnesses has been the subject of immense stigma and discrimination. Health promotion can do much to improve this situation and to create a health care system which promotes the health of the nation as well as treating existing mental illness. In developing its overall strategy towards Health of the Nation targets, the NHS and SSD's will want to find the appropriate local balance in resource allocation between current service provision and the health promotion aspects of its work.

2.2 Unlike treatment measures which can be immediate in their effect, health promotion is a longer-term strategy. Increasing awareness about mental illness, changing public attitudes and developing strategies to prevent illness will:

- reduce the incidence of mental illness and suicide, by for example, improving coping abilities in stressful situations
- counter the fear, ignorance and stigma which still surround mental illness and create a more positive social climate in which it becomes more acceptable to talk about feelings, emotions and problems and to seek help without fear of labelling or feeling a failure
- prevent the deterioration of an existing mental illness
- improve the quality of life of people with long-standing, recurrent or acute mental health problems, their family and friends
- maintain and improve social functioning.

NHS and SSDs direct action

2.3 The NHS and social services have a direct role in promoting mental health and preventing mental illness. Each will benefit from effective co-operation with the other in its mental health promotion work.

2.4 Different mental health problems will be more prevalent in different parts of the local population – for example, stress related disorders in mothers with young children; living through bereavement for the elderly; coping with work and lack of work etc. Health and social service authorities should therefore consider the priority groups for health promotion in their locality and how best to target promotional work at different age groups – children and adolescents, adults and the elderly – and at women and people from black and other ethnic minorities.

Primary prevention

2.5 Primary prevention centres on procedures to avoid the occurrence of illness or disability. A major area of direct health promotion work is the detection of at risk groups and the provision of advice and counselling, for example in connection with:

- disemployment – redundancy and retirement
- family formation – genetic risk and environmental hazards to foetal development and the avoidance of drugs, nicotine and alcohol during pregnancy
- family circumstance – bereavement, single parenting. Befriending schemes for young mothers are one approach successfully established by Homestart and Newpin
- social isolation – from friends, family and other support structures
- living conditions – homelessness or inadequate housing
- sensory or physical impairment – to reduce the additional risk of disabling depression
- child abuse – the early detection and management of emotional and physical abuse
- awareness of mental health – increasing people's ability to recognise their own stress and look after themselves.

Secondary prevention

2.6 This focuses on early diagnosis and treatment to shorten episodes of illness, and to

limit disability arising from illness. By preventing the knock on consequences of mental illness for spouses, children, carers, colleagues, secondary prevention also has a primary preventive effect. It can also reduce rates of hospitalisation and the need for costly ongoing care. Measures include:

- the early detection and effective management of depression in primary care
- the early detection and treatment of people with psychoses
- developing personal coping strategies to minimise the effects of conditions, for example, hearing voices.

Tertiary prevention

2.7 This focuses on measures to limit disability and handicap due to impairment or illness which is not fully curable. Measures can include:

- countering discrimination in health provision to people with a history of mental illness
- developing coping strategies with carers and people with long-term physical or mental illness
- providing respite care for people with chronic mental illness and support for carers.

Opportunistic advice

2.8 Health and social care professionals, particularly primary care workers, have many opportunities in their contacts with service users to identify mental illness and give advice to promote mental health, for example:

- during GP health checks of elderly people. The diagnosis of depression in old age is often missed and can be just as effectively treated as in youth or middle age
- during health visitors contacts with children and elderly people
- during regular consultations in general practice
- in accident and emergency departments
- in social work settings.

The NHS and SSD workplace

2.9 The stresses of NHS and local authority social services work can be severe. The costs to the NHS and SSDs of mental illness can be high in terms of time off work and reduced effectiveness whilst at work. The suicide rate for doctors is twice the national

average; women doctors' suicide rate is seven times the equivalent rate for other women professionals. As a major employer and participant in the Health at Work initiative, the NHS has taken on a commitment to promote the mental health of its workforce. Departmental initiatives to support this include:

- setting the mental health of the NHS workforce as one of the six National research priorities in mental health for the NHS Research and Development programme
- the Chief Executive's systematic review within the NHS, to test some concrete ideas for organising work at hospital level.

Building Alliances

2.10 Mental health promotion, particularly primary prevention, needs to take place in a much broader arena than that set by health and social service provision. The NHS and SSDs have a leading role to play in ensuring that mental health promotion is widely supported and integrated into different settings and will want to consider how it can build alliances for mental health promotion with a variety of organisations, including:

- voluntary organisations
- housing departments and housing associations
- education services
- youth groups
- employers and trades unions
- local media.

Some suggested areas of joint working with these and other organisations are described in Chapter 5.

References

HEALTH EDUCATION AUTHORITY (1992) *Health at work in the NHS.* London: Department of Health.

JENKINS, R. (1990) Towards a system of mental health outcome indicators. *British Journal of Psychiatry,* **157**, 500-514.

JENKINS, R. (1992) *Preventing Mental Ill Health at Work.* London: HMSO.

LAKE, B., BURGESS, J.M. (1989) Mental health and mental illness: educating sixth-formers. *British Journal of Occupational Therapy,* **52, 8,** 301-4.

MIND (1992) Action Pack on Employment and Mental Health. London: MIND.

NEWTON, J. (1992) *Preventing mental illness in practice.* London: Routledge & Kegan Paul.

NEWTON, J. (1988) *Preventing mental illness.* London: Routledge & Kegan Paul.

PARDES, H., *et al* (1989) Prevention and the field of mental health. *Annual Review of Public Health,* **10**, 403-422.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Report on Prevention and Mental Health.* London: RCPsych.

TOMES, K, *et al* (1990) *Health Education: effectiveness and efficiency.* Chapman and Hall.

TRUTE, *et al* (1989) Social rejection of the mentally ill: a replication study of public attitude. *Social Psychiatry and Psychiatric Epidemiology,* **24**, 69-76.

WEST MIDLANDS REGIONAL HEALTH AUTHORITY (1992) The Promotion of Mental Health. Birmingham: WMRHA.

WHITEHEAD, Margaret (1989) *Swimming Upstream.* King's Fund Institute.

CHAPTER 3

SKETCHING THE LOCAL PICTURE

SKETCHING THE LOCAL PICTURE

Action summary

DHAs (with GPFHs), FHSAs and Directors of SSDs

- Develop a local population profile and build up a **composite** picture of mental health needs.
- Organise information on suicide incidence.
- Identify local initiatives and opportunities and profile current initiatives and service provision and assess the extent to which needs are being met.
- Compare mental health of resident population and suicide rates across the Region and country.

PROVIDERS

Use brief standardised assessment procedures of symptom state, social disability and quality of life.

Encourage staff to co-operate with the Confidential Inquiry into Homicides and Suicides by Mentally Ill People.

Sketching the local picture

3.1 In order to meet the targets set out in the Health of the Nation, a more detailed and coherent local picture is necessary in:

- drawing up a population profile
- assessing the needs of people with mental illness
- identifying initiatives and service availability.

Developing a population profile

3.2 The relationship between socio-demographic characteristics and use of services, particularly admission rate, is well established. Purchasing authorities will therefore

want to establish a profile of the local population to identify indicators for targeting particular measures to prevent mental illness and suicide, including:

- pockets of high unemployment, particularly amongst young men
- alcohol consumption and drug abuse
- proportion and location of people from black and other ethnic minorities, including refugees and whether established in or new to UK
- areas of poor housing, overcrowding and lack of amenities
- numbers of people who are elderly and very elderly
- number of single parents and children in single parent families.

Additional information that could be included in drawing up a socio-demographic profile of the population is given in Appendix 3.1. OPCS census data can provide much locally useful information.

3.3 It is important that GPFHs collaborate with DHAs in developing a local population profile and in needs assessment exercises. In particular, GPFHs will want to:

- obtain from the DHA/FHSA details of the population profile and results of needs assessment exercises for their catchment population, with particular reference to the factors identified in 3.2 above
- consider action in co-ordination with the mental health team working with the practice and the providers from whom they purchase services.

3.4 Building up an accurate picture of mental health will establish a baseline against which:

- local targets can be set
- action initiated
- progress monitored.

Local needs assessment

3.5 The use of mental health services is often more the reflection of historic circumstance, local service availability and provider priorities than a reflection of need. The process of health needs assessment is now becoming well established. Its

application to mental illness is being developed. Assessment should take account of both health and social care needs. Methods include:

- surveys of users and the local catchment population
- focus groups and depth interviews
- process information such as GP referral patterns, GP morbidity survey (currently available every 10 years), GP and IP data by diagnosis. Comparisons will also help identify training needs. In isolation, information from this source will always provide significant underestimates of actual need.

3.6 As well as establishing the general mental health needs of the population, purchasing authorities will want to identify the particular needs of different groups of service users. Needs assessment processes should be sensitive to differences of age, gender, social class and ethnicity as well as to general care needs associated with specific mental illnesses. Particular attention should be paid to the needs of:

People from black and other ethnic minorities

3.7 Differences in service provision for people of different cultures and religions should be accounted for. In particular purchasers should assess needs of access to:

- professionals from similar cultural backgrounds
- interpreting services
- special dietary arrangements and other culturally specific requirements.

Women

3.8 58% of mental health service in-patient admissions are women. Women's particular concerns may include:

- access to child care facilities at day centres or outpatient clinics etc
- the choice of a female professional including a female keyworker
- the choice of a single sex ward (or area within a ward).

Mentally disordered offenders

3.9 Research has shown that many purchasers have failed to address the needs of mentally disordered offenders in purchasing plans. The Final Report of the Joint Department of Health/Home Office Review of Services for Mentally Disordered Offenders – which makes a large number of important recommendations – highlights

the need for **local** assessment of the service needs of mentally disordered offenders to take account of need for:

- local and medium secure hospital provision at all levels
- non-secure provision.

Elderly people

3.10 In assessing need, age determined cut off should be sensitively applied. For example, an existing patient with schizophrenia who reaches the age of 65 might have their needs better met by remaining within existing service provision.

3.11 Particular issues for people who are elderly will include the need for:

- continuing and terminal care beds for people with dementia
- respite care
- practical advice and support for carers in dealing with, for example, behavioural problems, incontinence or immobility.

Children and adolescents

3.12 The needs of children and adolescents are different from those of adults. Psychosocial factors which affect parents can also have distinct and separate effects on their children. In assessing needs, purchasers and providers will need to consider the child *and* the family, the school or college *and* the child's general social network.

3.13 Some particular issues to consider when assessing the need for services for children and adolescents are:

- the rate and effect of changes in family circumstance such as separation, divorce or death of a parent
- the level of homelessness and poor living conditions
- drug addiction and alcohol misuse in both children/adolescents and their parents.

Other groups

3.14 The particular needs of other groups who may have difficulty in accessing services and who may feel disenfranchised or alienated should also be identified, including:

- people who are homeless
- carers of people with mental illness

- people with both physical and mental illness
- people with learning disabilities and mental illness – in line with HSG(92)42
- lesbians and gay men.

3.15 People with mental illness will often have needs which should be met by both health and social service providers of care. Local authorities have a statutory duty to assess the community care needs of people with a mental illness. Establishing joint needs assessment between the NHS and SSDs can:

- ensure the needs of the individual at the interface of health and social care are assessed
- maximise resource utilisation
- facilitate the most effective delivery of care.

3.16 The Department has commissioned a national psychiatric survey to be carried out by the OPCS to establish the prevalence of mental illness. The results of this survey should be available to the service from 1994/5 and will provide a comparator between local needs and the national context. Details of the survey are at Appendix 3.2.

3.17 The Research Unit of the Royal College of Psychiatrists is leading work to develop appropriate instruments to assess symptom state, social disability and quality of life. These brief standardised assessment procedures will enable all patients within the mental health care system to have their health, social disability and quality of life routinely measured, enabling health outcome targets to be set and patient outcomes to be monitored both nationally and locally.

3.18 Providers should incorporate these measures and undertake regular assessments, initially on a sample basis at specified intervals. The brief standardised assessment procedures will be available to the NHS and SSDs in final form in 1994/5. Further information is at Appendix 3.3.

Organising information on suicides

3.19 In order to assess appropriate action to reduce suicide rates, it is necessary to develop a more comprehensive local picture of the incidence of and factors related to suicide.

3.20 It is also necessary to identify the number of people with a severe mental illness to measure reductions in suicide rates amongst this group. This will initially need to be collected from:

- people in contact with the social and psychiatric services
- surveys of GPs and community agencies
- hospital settings, particularly A&E departments.

3.21 RHAs, DHAs and LAs will want to establish annual suicide figures. Due to the likelihood of random fluctuations at local level, health and social service authorities will find it more useful to use rolling averages to establish an initial baseline and an ongoing measure of changes in suicide rates:

- Regions should consider adopting a three year rolling average, using 1988-90 as their baseline data;
- Districts and local authorities should consider using a five year rolling average, using 1986-90 for their baseline data.

3.22 Authorities will want to correlate suicide figures to a wide range of indicators – including socio-demographic background, ethnicity, age and sex (see para 3.2 and Appendix 3.2). This information should be incorporated in mental health information systems (see Chapter 11).

3.23 Suicide figures can be obtained from the OPCS, the Public Health Common Data Set and through the local coroner's office. Establishing links with pathology departments will enable access to a great deal of information about suicides contained in pathology reports. Local information on suicides should also contribute to and benefit from reports of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People. Further information is at Appendix 3.4.

3.24 Multi-disciplinary review and audit in mental health services and primary care will provide valuable information about the circumstances in which people commit suicide – as well as identifying the needs of relatives and staff for support and counselling following a bereavement. Close liaison with the coroner's office will help identify cases of suicide for audit. Identifying useful information may be assisted by:

- inviting a clinician from another team to chair the audit
- inviting management to participate in relevant aspects of the mental health team audit.

Identifying local initiatives

3.25 A local profile should help DHAs, FHSAs, and SSDs identify possible sources of help and existing initiatives aimed at promoting the mental health of the local population, including:

- health education across age groups in formal and informal settings (see Chapter 5)
- media coverage of mental health issues (see Chapter 5)
- training opportunities for professionals and lay people – eg teachers, carers, youth workers etc (See Chapter 10)
- information on mental health and mental illness available to the general public and service users (see Chapters 4 and 13)
- job creation schemes and activities for the unemployed
- support projects for single parents
- local suicide support services
- community and leisure facilities.

Profiling service provision

3.26 A wide range of service settings and treatments may be available to both health and social services for people with mental illness (see Chapter 6). Sketching local service provision will assist in:

- identifying gaps in service provision and potentially redundant facilities
- evaluating different methods of service delivery
- achieving an appropriate balance between prevention, treatment, continuing care and rehabilitation
- identifying numbers of staff required, the appropriate balance in staff mix and staff training and education needs.

3.27 Particular attention should be paid to the identifying current provision of services dedicated to the needs of:

- mentally disordered offenders in both secure and non-secure settings
- patients in need of continuing care
- children and adolescents.

3.28 An example of a service profile for over 16s excluding services for people with dementia and mentally disordered offenders is given in Appendix 3.1. Similar service profiles can be drawn up for children, people who are elderly and mentally disordered offenders.

3.29 Establishing common formats for information collection will assist regional identification of areas needing particular attention. Much information can be extracted from purchasing plans.

References

General

NHSME (1991) *Assessing health care needs. A DHA project discussion paper.* London: Department of Health.

STEVENS, A. & GABBAY, J. (1991) Needs assessment needs assessment ... *Health Trends* **23,** 20-3.

Mental Health Specific

BARKER, I. (Oct 1991) Purchasing for people. *Health Services Management,* 212-4.

GOLDBERG, D. & GATER, R. (1991) Estimates of need. *Psychiatric Bulletin,* **15,** 593-5.

GOLDBERG, D. & HUXLEY, P. (1992) *Common Mental Disorders. A bio-social model.* London: Routledge.

GRIFFITHS, S., WILEY, I. & JENKINS, R. [Eds] (1992) *Creating a common profile.* London: HMSO.

JARMAN, B., HIRSCH, S., WHITE, P. & DRISCOLL, R. (1992) Predicting psychiatric admission rates. *British Medical Journal,* **304,** 1146-51.

JENKINS, R. & GRIFFITHS, S. [Eds] (1991) *Indicators for mental health in the population.* London: HMSO.

THORNICROFT, G., BREWIN, C., & WING, J. (1992) *Measuring mental health needs.* London: Gaskell.

WING, J.K. (1992) *Epidemiologically-based Mental Health Needs Assessments. A Review on Psychiatric Disorders (ICD-10, F2-F6)* London: NHSME.

Black and other ethnic minorities

CONFEDERATION OF INDIAN ORGANISATIONS (1992) *A cry for change.* London: CIO.

FERNANDO, S. (1988) *Race and Culture in Psychiatry.* London: Routledge.

FRANCIS, E., *et al.* (1989) Black people and psychiatry in the UK: an alternative to institutional care. *Psychiatric Bulletin,* **13,** 482-5.

LOWE, F. (27 August 1992) Cut off from care. *Community Care.* 21.

MOODLEY, P. (1987) The Fanon Project: a day centre in Brixton. *Bulletin of the Royal College of Psychiatrists,* **11,** 417-418.

MOODLEY, P. (1990) Blacks and Psychiatry: a framework for understanding access to psychiatric services. *Psychiatric Bulletin,* **14,** 538-40.

Women

MIND. (1992) *Policy on women and mental health.* London: MIND Publications.

WOMEN AND MENTAL HEALTH INTERNATIONAL CONFERENCE COMMITTEE (1991) Women and Mental Health. *British Journal of Psychiatry,* **158** (supplement 10).

Children and Adolescents

QUINTON, D. & RUTTER, M. (1984) Parents with children in care. *Psychology and Psychiatry,* **25,** 211-229.

Mentally Disordered Offenders

NHS MANAGEMENT EXECUTIVE (1992) *Executive Letters (92)6 and (92)24.*

JONES, D. & DEAN, N. (1992) Assignment of need for services for mentally disordered offenders and patients with similar needs. *Health Trends,* **24,** 48.

DEPARTMENT OF HEALTH/HOME OFFICE (1992) *Review of health and social services for mentally disordered offenders and others requiring similar services: Final Summary Report (Cm 2088).* London: HMSO.

Suicides

CHARLTON, J., *et al.* (1992) Trends in suicide deaths in England and Wales. *Population Trends,* **69,** 10-16.

CHARLTON, J., *et al.* Suicide deaths in England and Wales – Trends in factors associated with suicide deaths. *Population Trends,* (In Press).

Further references are on p.74.

Appendix 3.1

ASSESSING SERVICE NEED AND PROVISION

Establishing a Socio-Demographic Profile

1. The following outlines information that can be used in drawing up a socio-demographic profile. It will need to be supplemented by other population groups of local relevance, for example refugees:

POPULATION BY AGE GROUP:

- 0-14 years
- (15-17 years)
- 15-64 years
- 65-79 years
- 80 and above
- Total

SOCIAL CLASS

- A-E

UNEMPLOYMENT RATES:

- Correlated to:
- age
- ethnicity
- sex

JARMAN INDEX

POPULATION DENSITY:

- Urban
- Semi-rural
- Rural

ETHNIC GROUPS:

- White – UK born
- White – Irish
- White – Other
- Black – Caribbean
- Black – African
- Black – other
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Other
- Total

HOMELESSNESS:

- Homeless – bed and breakfast
- Homeless – sleeping rough
- Homeless – other
- etc

Establishing current services

2. The table on the next page gives an example of some of the information that may be useful in drawing up a profile of current services.

Residential Accommodation	Places/ 100,000 popn.	Day Care	No. places	
Current availability: Special hospital[2] Medium secure: NHS Private Local secure units				Court diversion scheme Available: Y/N
Acute unit: In mental hospital In general hospital In other location		Day hospital: in-patients out-patients		Sufficient staff to allow for special (1:1) observation policies on acute wards when required Y/N
24 hour NHS accommodation		Day care: rehabilitation/ continuing support	NHS LA Vol	Sector teams – including intensive domiciliary support capability Available Y/N
Mental nursing homes		Employment schemes: Dept. Employment Other NHS/ LASS/Vol		No. of care managers (wte)
Residential care homes		Support groups/ drop-in centres		
Unstaffed group homes				
Adult placement scheme				No. of GP practice-based clinics/week

[2]ie number/100,000 population of District residents currently in such accommodation.

Appendix 3.2

NATIONAL SURVEY OF PSYCHIATRIC MORBIDITY

1. The Department of Health has commissioned a national survey of psychiatric morbidity. This will supplement local needs assessment surveys and will provide information to DHAs and SSDs to assist in needs assessment exercises. A pilot study was carried out in Summer 1992 in five geographic centres in England and produced an excellent response rate.

2. The aims of the national survey are:
   - to estimate the prevalence of psychiatric morbidity according to diagnostic category among adults in England
   - to identify the nature and extent of social disabilities as a result of mental illness
   - to examine the varying use of services and the receipt of care in relation to mental illness and the resulting social disabilities
   - to investigate the risk factors which are associated with mental illness.

3. The survey seeks to cover all sectors of the population by including adults living in communal establishments – hospitals, homes and hostels – as well as those living in private households. It is being carried out in three stages:
   - a screening questionnaire
   - a diagnostic schedule
   - a questionnaire covering services, care, social disabilities and risk factors.

4. The results of the national survey should be available to the NHS and SSDs from 1994/5 to supplement local needs assessment processes.

Appendix 3.3

BRIEF STANDARDISED ASSESSMENT MEASURES

1. The Research Unit of the Royal College of Psychiatrists has been commissioned to develop appropriate instruments in collaboration with users, carers, and the major professional groups – social work, nursing, psychiatry, occupational therapy and psychology – to assess symptom state, social disability and quality of life. This will build upon experience already developed in this area.

2. Such instruments will enable all patients within the mental health care system to have their health, social disability and quality of life routinely measured, thus enabling health outcome targets to be set and patient outcomes to be monitored both nationally and locally.

3. The Research Unit are considering a preliminary list of areas for measurement which includes:

• mental health problems	symptoms, diagnosis
• challenging behaviours	eg over activity, aggression
• negative behaviours	eg communication problems, retardation
• problems in self-care	eg personal, domestic
• social problems	eg family, housing, finances, employment
• physical health	illness, disability
• behaviour in relation to care – compliance	eg medication, appointments
• quality of life	choice, autonomy, use of amenities, quality of environment.

4. The measures will:
   - provide relevant information to feed classification (eg mental health developments of Read coding) and mental health information systems
   - establish a *minimum* data set which can be supplemented to meet local circumstances
   - need to be made available in collated form to those collecting it to ensure its reliability and to inform their own clinical practice.

5. The minimum data set will be collected nationally from 1995/6. The full timescale for the development of standard measures is:

1992/3	identify sites for piloting
1993/4	piloting of standardised assessment measures
1994/5	availability of measures for use in training nationally
1995/6	use nationally for minimum data collection.

Contact:	Professor J Wing
Address:	Research Unit, Royal College of Psychiatrists
	17 Belgrave Square
	London SW1X 8PG

Appendix 3.4

CONFIDENTIAL INQUIRY INTO HOMICIDES AND SUICIDES BY MENTALLY ILL PEOPLE

1. The Department of Health has established a Confidential Inquiry into Homicides and Suicides by Mentally Ill People with the purpose of eliciting avoidable causes of death and determine best practice by detailed examination of the circumstances surrounding such events. A multi-disciplinary Steering Committee, including management, nursing, psychiatric and social worker representation, has been formed. The inquiry is being led by the Royal College of Psychiatrists supported by relevant professional organisations.

2. When a suicide is identified:
   - health care professionals involved in the care or treatment of the deceased will be sent a questionnaire
   - information will be collected from professional staff on a confidential and **voluntary** basis, collated and anonymised
   - the information will be examined so as to draw lessons from the specific and cumulative events.

3. A pilot collection of data commenced in July 1992 to investigate events occurring on the rare occasions where a homicide is committed by a mentally ill person.

4. The inquiry will be extended in 1993 to include suicides of people in contact with or recently discharged from psychiatric care.

5. The first report detailing conclusions and presenting statistical data is expected to be published in 1995.

Contact: Unit Office, PO Box 1515, LONDON SW1X 8PL
Fax/Answerphone: 071 823 1031/1035

CHAPTER 4

SEEKING LOCAL VIEWS

SEEKING LOCAL VIEWS

Action summary

DHAs (with GPFHs), FHSAs, SSDs and service providers

- Consult all interested parties locally on needs assessment and service delivery on an ongoing basis.
- Provide practical support for user involvement in consultation exercises, including provision of resources where appropriate and supporting the work of independent advocacy services.
- Maximise user involvement in developing health and social care plans.

Seeking local views

4.1 Effective local consultation by purchasers is a vital element in the needs assessment process. Both purchasers and providers will also benefit from consulting users of services to inform the qualitative aspects of service provision. By ensuring that the most appropriate services are being delivered, health and social outcomes will be improved and the Health of the Nation Targets more easily met.

4.2 Purchasers and providers each want to seek local opinion for their particular interests. Local consultation will provide important information on, amongst other things:

- local views and preferences about the range of services and treatments available and the method of delivery (for example, on issues such as mixed wards or the choice of a key worker)
- access to services
- information about services
- the quality and appropriateness of care.

Whom to consult

4.3 Purchasers and providers should consult as widely as possible, including amongst:

- Service users – especially women and people from black and other ethnic minorities, both individually and through user groups and Patient Councils

- Patient advocates
- National and local voluntary sector eg MIND, NSF, CRUSE, Samaritans, Council of Voluntary Services
- Community Health Councils
- Carers – individually and through carer groups
- Health and social service professionals – especially GPs and other primary health care team members, community psychiatric nurses, and social workers
- Housing, education and police authorities
- Duty and local solicitors.

4.4 Consultation should be undertaken in a co-ordinated way to ensure that time is not wasted either for the organisations and individuals approached or for the health and social services.

Involving Service Users

4.5 Involving service users is particularly important in mental health services. Users will not only have views about the food on a ward, but about the quality and appropriateness of care they are receiving either in a hospital, residential home or the community. Users and carers have, for example, consistently expressed preferences for community-based services. User groups can be a powerful means of enabling users to have the confidence to express their views.

4.6 LAs have a duty to consult fully with users and their carers in the drawing up and monitoring of community care plans. NHS purchasers and providers, including GPs, have a similar responsibility.

4.7 Involving users with the most severe mental illnesses and the most long-standing health and social problems may pose particular problems. Enabling them to be involved in the planning and provision of services will help increase their self-esteem and is central to the creation of appropriate and responsive services.

4.8 Asking people for their opinions will raise expectations that those views will be acted upon. This may not always be possible – due for example to financial constraints or because differing viewpoints are offered (perhaps between service users and carers).

A clear explanation of the constraints on action should therefore be given when people's views are sought.

4.9 Effective consultation means:

- Providing full information in an easily accessible form
- Using a wide range of techniques to facilitate participation – for example, surveys, focus groups, depth interviews and speaking to user only groups
- Listening to the views of local people and involving them in discussions and the decision making process
- Acting upon views
- Reporting back to those who were consulted, explaining how decisions were reached.

4.10 Practical assistance will often need to be offered to service users to facilitate their involvement, for example through:

- paying expenses for travel and administration etc
- ensuring the support of an independent advocate
- making information available in appropriate languages, with interpreters for people whose main language is not English
- facilitating the development of user led groups.

Involving users in their own health care

Information

4.11 Providers will need to ensure that service users are enabled to define their own health and social care to their maximum ability. An essential building block is ensuring that information is made available as a matter of course to service users. This will include appropriate information on:

- rights – including welfare rights and those set out in the Patient's Charter
- services – including standards
- treatments, medication (including side effects) and coping strategies
- complaints and redress procedures
- the Mental Health Act (where appropriate).

4.12 Providers will need to ensure that information is:

- available at the time and place of need
- appropriate
- accessible – using an appropriate level of language
- available in different media – written, oral and visual.

Supporting advocacy services

4.13 Managers will need to consider the most appropriate mechanisms for enabling users to utilise that information to define their treatment in consultation with the specialists involved in their care. One particular method is by establishing advocacy services.

4.14 Advocacy is about giving the individual user a voice and getting the NHS and SSDs to listen to that voice and take account of its needs and preferences. In order to ensure that there is no conflict of interest in the representation of users' views, advocacy therefore needs to be independent of service provision.

4.15 Purchasers can support advocacy projects by:

- commissioning the provision of independent advocacy by a third party within the service provider setting
- incorporating appropriate clauses within the contract with the provider unit to guarantee the advocate a voice.

4.16 Purchasers and providers can additionally support advocacy projects by establishing mechanisms whereby the advocate can influence the decision making process – through, for example, a Steering Group and direct access to senior management.

Resources

Regional Health Information Services – contactable via the RHA.
National Disability Information Project, Policy Studies Institute, 100 Park Village East, London NW1 3SR. Tel: 071 387 2171

References

General

NHSME (January 1992). *Local voices: the views of local people in purchasing for health.* EL(92)1 London: NHSME.

SHROPSHIRE HEALTH AUTHORITY (1992) *Getting to the Core: A practical guide to understanding users' experience in the health service.* Shropshire Health Authority in conjunction with University of Birmingham.

Mental health specific

Barker, I. & PECK, E. [Eds] (1987) *Power in strange places: user empowerment in mental health services.* Good Practices in Mental Health.

BASSETT, T. *et al* (1988) *Involving service users in community mental health services.* In the GPMH and IAMHW information pack Community Mental Health Teams/Centres. Good Practices in Mental Health.
BEEFORTH, M., CONLAN, E., FIELD, V., HOSAER, B. & SAYCE, L. (1990) *Whose service is it anyway? Users views on coordinating community care.* Research and Development for Psychiatry, 134-138 Borough High Street, London SE1 1LB.
GOOD PRACTICES IN MENTAL HEALTH (1990) *Advocacy information pack.* Good Practices in Mental Health, 380-384 Harrow Road, London W9 2HU.
JOWELL, T. & RITCHIE, J. (1988) Listening to their needs. *Social Work Today,* **19, 38,** 18.
LINDOW, V. (1991) Towards user power. *Health Service Journal,* **101, 5266,** 18.
MCIVER, S. (1991) *Obtaining the views of users of mental health services.* London: King's Fund Centre.
MENTAL HEALTH MEDIA COUNCIL (1992) *From Anger to Action.* Video.
MIND (1991) *User involvement policy.* London: MIND.
NSF (1992) *How to involve users and carers.* London.
READ, J. & WALLCRAFT, J. (1992) *Guidelines for empowering users of mental health services.* London: COHSE/MIND.
SMITH, H. (1988) *Collaboration for change: partnership between service users, planners and managers of mental health services.* London: King's Fund Centre.
TOOK, M. & EVANS, T. (1990) *Provision of community services for mentally ill people and their carers: a survey for the Department of Health into the view of the NSF on community services.* London: National Schizophrenia Fellowship.

Information for users & carers

GRIMSHAW, C. (1992) *A-Z of Welfare Benefits for People with a Mental Illness.* London: MIND.
MHF. *Schizophrenia and the family.*
MIND. *Understanding – mental illness; bereavement; caring; talking treatments; phobias & obsessions; anxiety.*
NSF. *Schizophrenia.*
ROYAL COLLEGE OF PSYCHIATRISTS. *Depression; Anxiety and Phobias; Anorexia and Bulimia; Bereavement; Surviving Adolescence; Fact sheets.*
SANE. *Schizophrenia; Anxiety, phobias & obsessions; Depressive illness.*

CHAPTER 5

DEVELOPING LOCAL ALLIANCES

DEVELOPING LOCAL ALLIANCES

Action summary

All NHS and SSD Managers

- Develop better co-operative working between primary and secondary health care and between health and social services.
- Develop alliances with a wide range of other local and national organisations to develop mental health initiatives.

The need for alliances

5.1 The Health of the Nation targets for mental illness cannot be achieved by the NHS and SSDs alone. Much can be done to prevent suicide and prevent and deal with mental illness outside the NHS setting. Collaborative approaches, involving the whole range of relevant agencies, provide the most effective way forward to alleviate mental illness and reduce suicide.

5.2 Building alliances will take time, effort and understanding. The benefits should include:

- more comprehensive collection and sharing of information on the local health picture
- other agencies setting their own targets for mental health
- co-ordinating action to maximise the effective use of resources – for example, community care programmes in health promotion campaigns
- a better understanding of mental illness and the contribution of social factors and alcohol and drug abuse to mental illness and suicide rates
- a better range of services for mentally disordered offenders, helping to avoid unnecessary imprisonment with the consequent risk of suicide or self-harm.

Key alliances

Primary and secondary care

5.3 Integrating primary and secondary care services is fundamentally important in the provision of continuity of care for people with mental illness. The development of

community services increases the need for co-operative working. FHSAs and DHAs should consider ways of greater integration of care through:

- involving FHSAs, GPFHs and other primary care providers in defining DHA purchasing plans and joint purchasing arrangements with SSDs
- joint training of staff and increased team working
- developing joint mental health promotion initiatives
- developing locality based commissioning focused on local authority wards
- supporting the development of guidelines and protocols.

5.4 Locality based commissioning, or sectorisation – which makes a mental health team responsible for a geographically defined population of between 50 and 100,000 – has developed rapidly in the NHS with 80% of DHAs sectorising their services. Effective management is necessary if locality based commissioning is to work in the best interests of the service user. Purchasers should ensure that:

- choice of consultant or other mental health worker within sectors (eg female or male) is available
- GPs are encouraged to refer to local sector services, but where a GP considers that referral outside of the sector is necessary, for example to access specialist skills, referral is unrestricted to secondary care services and social workers across sector boundaries
- closer working relationships between primary care and secondary or community services are effectively developed and the potential for conflict of responsibility and neglect of those with severe mental illness is reduced.

5.5 From April 1993, all GP Fundholders will be responsible for purchasing community mental health services for their patients in addition to their current responsibilities for outpatient mental health services. DHAs, SSDs and GPFHs will need to liaise closely in their needs assessment and service planning arrangements.

NHS and Local Authority Social Service Departments

5.6 Although the line between health and social care for people with mental illness is difficult to draw, it is important for the NHS and SSDs to agree means of identifying those patients properly the responsibility of the NHS so as to ensure that such patients receive health and social care services free of charge. The implementation of

Care Management and the Care Programme Approach (see Chapter 9) make effective co-operation between these two quarters a prerequisite to the effective delivery of care to people with mental illness.

5.7 The Mental Illness Specific Grant has greatly improved joint planning between health and social services. Joint planning and working can help at all points of service provision, including:

- needs assessment
- purchasing
- service delivery
- monitoring and evaluation.

5.8 The differentiation between purchasing and providing services in the NHS and SSDs can facilitate a more systematic approach to joint planning, commissioning and purchasing of services in response to assessed need (see Chapter 12).

Voluntary sector organisations

5.9 The voluntary sector is a source of expertise and can provide opportunities to reach people with mental illness. In its independent role, the voluntary sector acts both to monitor policy and provision and as a catalyst to change. This independence of view should be protected in any contractual arrangements between the NHS/SSDs and the voluntary sector.

5.10 The voluntary sector can be effective in:

- working to de-stigmatise social attitudes towards mental illness
- monitoring services and evaluating their effectiveness
- providing specialised advice to reduce and counter social stress, eg Citizen's Advice Bureaux, Family Welfare Associations
- directly providing a range of comprehensive local services.

5.11 Support for voluntary organisations, such as the Samaritans and SANE, which have access to people at high risk of depression and suicide can be particularly important. Self-help groups can also be especially helpful in providing support for individuals with mental illness and their families.

5.12 The precariousness of much voluntary sector funding should be recognised. The NHS/SSDs can provide direct financial support for projects and administration and should seek to ensure that the likely level of funding is indicated well in advance. In addition, managers can:

- support regional offices of larger voluntary organisations (particularly RHAs)
- involve voluntary organisations in their advisory framework
- make available resources such as the use of premises for meetings, other facilities and management support.

5.13 In addition to local branches of national organisations, unaffiliated groups may exist in your area. The National Council for Voluntary Organisations and your Regional Health Information Service should hold addresses and contacts for these. A list of national voluntary organisations in mental health is at Appendix 5.1.

Other major alliances

Local Authorities

5.14 Local authorities can have a broad influence on mental health. In addition to the direct involvement of social services and their involvement in education and housing discussed below, local authorities can promote mental health by ensuring:

- accessible and affordable recreational facilities
- safe environments for children to play in
- the early detection of physical and emotional abuse in children
- community facilities for the unemployed, women at home, older people, people with chronic sickness etc.

5.15 Many suicides also occur on property under local authority jurisdiction. Joint working may lead to initiatives to reduce suicides at these points – for example, with fencing off high points such as cliffs and bridges and locating telephone boxes displaying helpline numbers at high risk spots.

Education and youth services

5.16 Effective collaboration to meet the assessment and treatment needs of children and adolescents is particularly essential between health, social and education services to meet the assessment and treatment needs of children and adolescents. Education and

informal youth settings also provide important opportunities for mental health promotion. The NHS and SSDs can liaise with LEAs, school governing bodies and head teachers in public and private education provision to:

- promote the implementation of an integrated health education in schools. Psychological aspects of health, family life education and substance misuse are included in National Curriculum Guidance
- identify complementary activity outside the school setting such as youth clubs and community groups.

The housing sector

5.17 Alliances with the housing sector – particularly local authority housing departments and local housing associations – can be mutually beneficial, for example:

- in the better determination of housing priority for people with mental illness
- rapid response by mental health teams to requests for assistance where complaints or difficulties arise in relation to people who are thought or known to have mental health problems
- the development of cluster flat schemes where a small number of patients – no more than four or five – live together in flats in a block or maisonette
- increasing utilisation of warden assisted accommodation for people with mental illness
- reducing the number of people, particularly those with mental illness, in bed and breakfast accommodation and on the streets
- alleviating the threat of eviction, which costs housing organisations time and trouble. Evicted residents may well be lost to mental health services
- ensuring that people with mental illness are fairly represented in the housing special needs quota.

Criminal justice system

5.18 Alliances at both purchaser and provider level between health and social services can be developed with:

- police services
- probation services
- prison services

- court services
- Crown Prosecution Service
- duty solicitors and local Law Societies
- local law centres.

5.19 This will contribute to:

- better understanding by criminal justice officials of the Mental Health Act and the needs of mentally disordered offenders and increased access to psychiatric and social work personnel for assessments
- efficient development of court diversion schemes and the transfer of mentally disordered offenders to community support or hospitals
- the development of links between area (Woolf) committees for the criminal justice system and health and social services.

5.20 Each prison establishment has a Suicide Prevention Management Group, which is responsible for reviewing incidents, maintaining staff awareness, ensuring good communication between staff and outside agencies and developing local prevention policy.

Employers and trades unions

5.21 The workplace can be a major cause of stress affecting mental health, smoking and alcohol consumption as well as work performance. Eighty million days sick leave – four days for each worker – are certified as due to mental illness. This figure understates time off from work due to mental ill health because it takes no account of absence wrongly attributed to physical illness, or of uncertified absence. It also leads to reduced work performance, including poor decision making and personnel management. It affects all employers. Health Promotion Departments can work with local employers and workers to develop strategies for mental health in the workplace.

5.22 The report of the Department of Health and Confederation of British Industry sponsored conference on mental health sets out examples of good practice. The Health and Safety Executive have formed a broadly based working committee to advise on good practice in the workplace. Recommendations included:

- reducing stress in the workplace environment

- prompt detection and management of depression and anxiety in occupational settings, with good systems of referral as appropriate and access to confidential counselling services
- careful rehabilitation back to work after episodes of illness severe enough to have necessitated a period off work
- pre-retirement education and training.

5.23 Some DHAs currently offer occupational mental health services within employment settings. DHAs will wish to develop and expand the availability of these schemes, working closely with employers to ensure appropriate targeting of such services and the most effective use of NHS expertise.

5.24 The reduction of suicides occurring on commercial property – such as jumping from multi-storey car parks – can also be a focus of joint working.

Employment services

5.25 Enabling people with mental illness to return to work or find employment for the first time is an important element in their rehabilitation. An advocacy role with employers is often needed to combat prejudice and stigma. Local Placement, Assessment and Counselling Teams, run by the employment services and accessed through job centres, provide a route to Ability Development Centres, which are replacing traditional Employment Rehabilitation Centres and are repositories of expertise and advice.

Local media

5.26 The NHS and SSDs can collaborate with the media to improve understanding of mental health issues through:

- non-stigmatising reporting of mental health issues in press, radio and TV
- encouraging the inclusion of a regular health column in local press where this does not already exist and the specific inclusion of mental health issues
- promoting radio counselling programmes
- encouraging publicity for independent help and advice, including children's advice centres.

5.27 Health Promotion Departments can also take paid advertising space where necessary.

References

Education

NATIONAL CURRICULUM COUNCIL (1990) *Curriculum Guidance 5.* London: Department of Education.

Primary Care

BENNETT, C. (1989) General Practitioner assessment of the Worcester Development Project. *Journal of the Royal College of General Practitioners,* **39,** 106-9.

JENKINS, R., FIELD, V., & YOUNG, R [Eds] (1992) *The primary care of schizophrenia.* London: HMSO.

JENKINS, R., NEWTON, J. & YOUNG, R. [Eds] (1992) *Prevention of depression and anxiety in General Practice: the role of the primary care team.* London: HMSO.

NHSME (1992) *Guidance on the extension of the Hospital and Community Health Services elements of the GP Fund-holding scheme from 1 April 1993. (EL(92)48).* London: NHSME, Portland Court.

Housing departments

SONE, K. (8 June 1992) Raise the roof. *Community Care* 14-15.

Criminal Justice System

HOME OFFICE (1990). *Provision for mentally disordered offenders.* (Circular 66/90). London: Home Office.

JAMES, D.V. & HAMILTON, L.W. (1991) The Clerkenwell scheme. Assessing efficacy and cost of a psychiatric liaison service to a magistrates court. *British Medical Journal,* **303,** 282-285.

JONES, D. & DEAN, N. (1992) Assessment of need for services for mentally disordered offenders and patients with similar needs. *Health Trends,* **24,** 48.

JOSEPH, P.L. & Potter, M. (1990) Mentally disordered homeless offenders – diversion from custody. *Health Trends,* **22, 2,** 51-3.

Employment

HEALTH EDUCATION AUTHORITY (1992) *Health at work in the NHS.* London: Department of Health.

JEE, M. & REASON, L. (1988) *Action on Stress at Work.* London: Health Education Authority.

MENTAL HEALTH MEDIA COUNCIL (1992). *Working Life: an employers guide to mental health issues and recruitment.* Video.

MIND (1992) *Action Pack on Employment and Mental Health.* London: MIND.

STUART, M. (1990) *MIND Guide to Employment Projects.* London: MIND.

Appendix 5.1

NATIONAL VOLUNTARY ORGANISATIONS

Afro-Caribbean Mental Health Association.

35-37 Electric Avenue, London SW9 8JP [071 737 3603]

Alzheimer's Disease Society.

Gordon House, 10 Greencoat Place, London SW1P 1PH [071 306 0606]

Association for post-natal illness.

c/o Claire Delpech, 7 Gowan Avenue, London SW6 6RH [071 731 4867]

CRUSE – Bereavement Care.

Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR [081 940 4818]

Depressives Anonymous.

36 Chestnut Avenue, Beverley, Humberside HU17 9QU [0482 860619]

Good Practices in Mental Health.

380-384 Harrow Road, London W9 2HU [071 289 2034]

Guidepost Trust.

Two Rivers, Station Lane, Witney, OXON OX8 6BH [0993 772886] (Provides supported housing).

Homestart.

2 Salisbury Road, Leicester LE1 7QR [0533 554988]

Making Space.

46 Allen Street, Warrington, Cheshire WA2 7JB [0925 571680] (Serves mainly Yorkshire and the North West of England.)

Manic Depression Fellowship.

13 Rosslyn Road, Twickenham TW1 2AR [081 892 2811]

Mental After-Care Association.

25 Bedford Square, London WC1B 3HW [071 436 6194]

Mental Health Foundation.

8 Hallam Street, London W1N 6DH [071 580 0145]

(Supports research and innovative projects in the independent sector.)

MIND.

22 Harley Street, London W1N 2ED [071 637 0741]

NEWPIN.

St Margaret House, 21 Old Fort Road, London E2 9PL [081 980 3639]

National Black Mental Health Association.

Macro House, 182 Soho Hill, Handsworth, Birmingham, B19 1AF

National Schizophrenia Fellowship.

28 Castle Street, Kingston upon Thames, Surrey KT1 1SS [081 547 3937]

Phobic Action.

Claybury Grounds, Manor Road, Woodford Green, Essex IG8 8PR [081 559 2551]

RELATE.

Herbert Grey College, Little Church St, Rugby CV21 3AP [0788 573241]

Research and Development for Psychiatry.

134-138 Borough High Street, London SE1 1LB [071 403 8790]

Richmond Fellowship for Community Mental Health.

8 Addison Road, Kensington, London W14 8DL [071 603 6373]

(Operates nationally, provides services and educational programmes.)

SANE.

2nd Floor, 199-205 Old Marylebone Road, London NW7 5QD [071 724 6520]

Samaritans.

17 Uxbridge Road, Slough SL1 1SN [0753 32713]

Survivors speak out.

33 Lichfield Road, Cricklewood, London NW2

Turning Point.

101 Backchurch Lane, London E1 1LU [071 702 2300]

United Kingdom Advocacy Network.

The Paddocks, Haggonsfields, Rhodesia, Worksop, Notts S80 3HW

The National Council of Voluntary Organisations (NCVO).

Regent's Wharf, 8 All Saints Street, London N7 9RL [071 713 6161] (can provide information about local activity)

CHAPTER 6

IDENTIFYING AND ASSESSING AVAILABLE INTERVENTIONS

IDENTIFYING AND ASSESSING AVAILABLE INTERVENTIONS

Action summary

NHS Purchasers and Directors of SSDs

- Identify the range of service delivery options.
- Assess the appropriateness of different service options to the needs of the resident population.

Service providers

- Ensure the provision of appropriate service interventions in mental health and general medical and surgical settings.

Options in mental health care

6.1 A wide range of interventions exist for the care, treatment and rehabilitation of people with mental illness and much research has been carried out nationally on their effectiveness for particular service user groups. However, levels of care provision around the country have varied such that many managers and professionals may be unaware of the options available or their particular value in different conditions, for example, the use of cognitive and interpersonal therapies in the treatment of depression and eating disorders; and family therapy and early intervention in treatment of schizophrenia.

6.2 Purchasers will need to identify the range of options to ensure that purchasing plans are fully developed to meet assessed needs. They should be forward looking in introducing new care arrangements. They will also want to review the research and to supplement it with local analysis into the most cost-effective delivery of care to meet assessed needs within their District (see Chapter 7).

6.3 Purchasers will want to ensure that they identify appropriate services to meet the needs of particular groups of service users (see Chapter 3). For example, the high levels of psychiatric morbidity in homeless people and their difficulties in accessing services may require specific attention – such as developed through the Inner London Homeless Mentally Ill Initiative and the Nottingham homeless.

6.4 This chapter sets out some basic information for managers on the available options to enable them to develop a local range of comprehensive services and treatments.

- different service settings
- different treatment methods
- specific interventions to reduce suicide.

Service settings

6.5 Care outside the institutionalised setting of large mental hospitals can improve health outcomes. It has been shown, for example, in studies over a 15 year period that the establishment of good rehabilitation facilities can lead to a significant improvement in schizophrenic patients who seemed irredeemably institutionalised.

6.6 It is imperative to put in place a comprehensive range of day, residential and domiciliary services before a large mental hospital is closed to ensure appropriate replacement facilities are available for discharged patients.

6.7 Comprehensive purchasing guidance in relation to children and adolescents has been developed by Action for Sick Children in association with South West Thames RHA and the National Association of Health Authorities and Trusts. These include:

- a range of services to meet the range of needs, including protected in-patient and day patient facilities
- the improvement by specialist services of the mental health skills of those involved in primary care.

6.8 The following table sets out a range of service settings for adults.

	Acute/emergency care	**Rehabilitation/continuing care**
Home-based	Intensive home support Emergency duty teams Sector teams	Domiciliary services Key workers Care management
Day care	Day hospitals	Drop-in centres Support groups Employment schemes Day care
Residential support	Crisis accommodation Acute units Local secure units	Ordinary housing Unstaffed group homes Adult placement schemes Residential care homes Mental nursing homes 24 hour NHS accommodation Medium secure units High security units

6.9 Within these options, purchasers will want to identify and evaluate the appropriate balance in delivering acute and continuing care for their locality. A fuller description of these service settings highlighting key issues is given at Appendix 6.1 to assist purchasers in this process. Some research information supporting the effectiveness of different service settings is at Appendix 6.2.

Treatment methods

6.10 A wide range of interventions are available to supplement traditional uses of psychiatry. Controlled evaluation of many psychosocial treatments, particularly cognitive and behavioural psychotherapies and family intervention strategies, have demonstrated their effectiveness in treating mental illness, complementing pharmacological interventions. Comprehensive reviews are readily available of the

increasing range of treatments and their appropriate applications. Some examples are given in Appendix 6.3, particularly of:

- psychotherapies
- drug treatments
- ECT.

6.11 Drug treatment with benzodiazepines can be effective in relieving anxiety in the short term, however:

- their effectiveness decreases over time
- long-term use can lead to dependency
- they can mask the underlying symptoms of depression which may then remain untreated.

6.12 A managed move to effective treatments such as anxiety management techniques, relaxation training and psychotherapies needs to be undertaken, particularly in primary health care settings.

Mental illness in general medical and surgical settings

6.13 The incidence of mental health problems is considerably raised amongst people referred to general medical and surgical services. Mental health services can relieve suffering and reduce disability (see Appendix 6.4). There is also evidence that the costs of providing high quality liaison psychiatry services is more than matched by the savings made in the reduction of inappropriate investigations and length of stay.

Interventions to reduce suicides

6.14 Suicide is preventable. Lives can be saved. There is a growing body of research on effective interventions which can reduce suicide rates, some of which are highlighted in Appendix 6.5.

Early intervention

6.15 Identifying mental illness in its early stages can have a significant effect on hospitalisation and suicide rates. Early identification and management of depression in primary and social care settings – and in particular improved management of depression in general practice – have been shown to be effective in reducing suicide rates. The Defeat Depression campaign, being run by the Royal Colleges of General

Practitioners and Psychiatrists, should have a significant impact. FHSAs can support the dissemination of materials and its implementation at practice level. Reassessment of services for those who have attempted suicide or parasuicide might usefully be considered in accordance with HC(84)25.

Appropriately targeted local services

6.16 Evidence suggests an association of lower suicide rates amongst the severely mentally ill with services provided locally by DGHs compared with large mental hospitals. In addition early research also suggests that the introduction of community based services can reduce suicide levels. Research has highlighted the hitherto unrecognised frequency of suicide in traditional services. Co-ordinated and appropriate discharge policies are essential (see Chapter 9).

Effective supervision

6.17 The term supervision is one users may be suspicious of, suggesting surveillance and interference with independence and civil liberties. Attention will need to be paid in minimising intrusion whilst making care available. The ready availability of admission facilities is important where the risk of suicide is high. Within these facilities, there should be clearly defined policies for managing suicidal patients, including defined observation policies.

6.18 The importance of appropriate, co-ordinated discharge planning can hardly be overstressed in this context.

6.19 Provider units will also wish to ensure improved assessment and management of suicide risk in A&E departments, medical and surgical wards. (People who have attemped suicide in the past are at increased risk – approximately 100 times in the year after an attempt.)

Social support through life events

6.20 Including, for example, bereavement counselling or social service support for single parent families.

Reducing the availability and access to methods of suicide

6.21 Reductions in access to easy means of lethal injury have been shown to have a

marked effect on reducing suicides not compensated for by substitution of other methods. Changes in car exhaust emission standards in 1992 and the requirement that all new cars are fitted with catalytic converters from January 1993 should have a similar effect, as seen in other countries where changes have already taken place. Further improvements in emission standards on old cars should help. Addressing issues of labelling, for example on paracetamol bottles to warn of toxicity, is an issue the NHS can more directly address, as is the issue of storage and availability of over the counter medicines which are poisonous.

References

Children and adolescents

KUTZ, Z. (Ed) (1992) *With Health in mind: mental health care for children and young people.* London: Action for Sick Children.

Elderly people

HEALTH ADVISORY SERVICE (1982) *The Rising Tide. Developing services for mental illness in old age.* Surbiton: HAS.

Specialist services

ACCESS TO HEALTH (1992) *Purchasing and providing services for homeless people.* London: Access to Health.

MAYOU, R. *et al* (1990) The present state of consultation and liaison psychiatry. *Psychiatric Bulletin,* **14,** 321-5.

PARRY, G. (1992) Improving psychotherapy services: applications of research, audit and evaluation. *British Journal of Clinical Psychology,* **31,** 3-19.

ROYAL COLLEGE OF PSYCHIATRISTS (1992) *Report on Puerperal Mental Illness Services.* London: RCPsych.

ROYAL COLLEGE OF PSYCHIATRISTS (1992) *Eating Disorders.* London: RCPsych.

Suicide

APPLEBY, L. (1992) Suicide in psychiatric patients: risk and prevention. *British Journal of Psychiatry,* **161,** 749-758.

BLACKER, C.V.R. *et al* (1992). Assessment of deliberate self harm on medical wards. *Psychiatric Bulletin,* **16,** 262-263.

HAWTON, K. (1987) Assessment of suicide risk. *British Journal of Psychiatry,* **150,** 145-153.

MORGAN, H.G. (1992) Suicide prevention. Hazards on the fast lane to community care. *British Journal of Psychiatry,* **160,** 149-153

MORGAN, H.G. & OWEN, J.H. (1990) *Persons at risk of suicide. Guidelines on good clinical practice.* Nottingham: Boots.

MORGAN, H.G. & PRIEST, P. (1991) Suicide and other unexpected deaths among psychiatric in-patients. The Bristol confidential inquiry. *British Journal of Psychiatry,* **158,** 368-374.

ROSSITER, J.C. (1989) Suicidal patients – effect on staff. *Psychiatric Bulletin,* **13,** 495-6.

ROSSITER, J.C. (1991) Suicide. *Psychiatric Bulletin,* **15,** 674-5.

Appendix 6.1

SERVICE SETTINGS FOR THE DELIVERY OF MENTAL HEALTH CARE

User's homes

1. Most patients can be supported in their homes during periods of crisis, and this is generally their preference. Home care is unsuitable for those at significant risk to themselves or others and people who live in markedly adverse social circumstances. Individual assessment at home can also be a cost-effective measure.

Day hospitals

2. These provide alternatives to hospitalisation for even quite psychotic patients and are suitable settings for group therapies and more intensive support for out-patients. Most patients attend for short periods of up to three months.

Crisis accommodation

3. This can be sited in various settings such as mental health centres, hostels or ordinary housing. It is extremely popular with users.

Acute Units

4. Where patients are disturbed or suicidal, a ward's protective environment assists in stabilisation, treatment and re-establishment in the community. Acute units can also be places of sanctuary for vulnerable patients and provide respite for relatives. Many beds are inappropriately occupied, for example by people with severe mental illness awaiting supported accommodation in the community, leaving shortages for appropriate use.

5. Alternatives to location on District General Hospital sites – which may have poor access, be excessively large and in design more suited to general medicine or surgery – can be developed offering a more user-friendly design. Local acute units exist, for example, at Cosham in Portsmouth and The Grange, Long Benton in Newcastle.

Day centres

6. These provide rehabilitation and continuing support. They should be provided in separate locations to day hospital services, but with close links between them, and integrated with community services as far as possible.

Drop in centres

7. Drop in facilities can allow social contact to be gradually increased and engagement with services commenced.

Community Mental Health/Resource Centres

8. These can provide team bases including, where appropriate, interview facilities and day care.

Unstaffed group homes/flatlets

9. Group homes with communal living are an option for some patients who have good relationships with each other. Care managers/key-workers need to ensure that monitoring of the support provided, such as by domiciliary home care workers, occurs on a regular basis.

Adult placement schemes

10. Such schemes have provided alternative care for a small well-selected group of patients. The importance of selection of carers and patients, training and continuing support, particularly in emergencies, is crucial to the success of such schemes.

11. If private board and lodging houses are used for accommodation, purchasers should ensure that:
    - it is close to friends, family or the user's previous residence (eg the hospital where they were living)
    - quality standards are monitored on an ongoing basis by the key worker or care manager.

Residential care homes

12. Small groups of patients will need the support of group homes with staff present in the homes for extended periods of the day or giving 24 hour cover. In the latter case, sleeping in staff provide the least restrictive, whilst appropriately supportive, option for a significant number of patients.

13. Some schemes have developed on a core and cluster model with staff from the more highly staffed hostels also supporting those which are more independent.

14. Care homes should be local to friends and families, or to the user's previous residence. Voluntary sector organisations – including Turning Point, Making Space, the Guidepost Trust, Mental After Care Association, and the Richmond Fellowship – have particular experience in this area.

Mental nursing homes

15. These provide asylum or sanctuary care for extended periods. Care should be provided in as domestic a setting as possible. The smaller Registered Mental Nursing Homes may be suitable.

24 hour NHS residences

16. Hospital hostels may be suitable for younger age groups and other NHS accommodation will be needed for continuing health care for the elderly. 24 hour residences tend to be more cost effective than long-stay wards and are more appropriate than 'revolving' users in and out of acute wards.

Local Secure Unit

17. Sites need to be available for the minority of people with mental illness who present aggressive or otherwise dangerous behaviour. Such provision is in short supply and should be a priority for purchasers.

Medium Secure Units

18. Mainly provided in the 21 Regional secure units and intended for the assessment, the care and the treatment of patients with mental disorder who require conditions of security. Patients can be referred by special hospitals, courts, prisons or local services.

High security units

19. Each purchaser needs to be aware of their residents in Special Hospitals and ensure that mental health teams are involved in care planning for those returning *prior* to discharge. A working group on High Security and related Psychiatric provision has been established by the Department of Health and will report during 1993.

References

Domiciliary management

BARTLETT, N. (1990) Stepping into the breach. *Community Care*, **797**, 14-15.

DEAN, C. & GADD, E. (1989) An inner city home treatment service for acute psychiatric patients. *Psychiatric Bulletin*, **13**, 667-9.

GOOD PRACTICES IN MENTAL HEALTH *Crisis Services Information Pack.* London: GPMH.
JONES, S.J., TURNER, R.J. & GRANT, J.E. (1987) Assessing patients in their homes. *Bulletin of the Royal College of Psychiatrists,* **11,** 117-9.

Crisis accommodation

TURKINGTON, D., *et al.* (1991) The use of an unstaffed flat for crisis intervention and rehabilitation. *Psychiatric Bulletin,* **15,** 13-14.

Acute units

MEDICAL ARCHITECTURE RESEARCH UNIT (1991) *Building for mental health.* London: PNL Press.
DEPARTMENT OF HEALTH NHS ESTATES DIVISION (1993) *Design Guide. Accommodation for adults with acute mental illness – options for the 90's.* London: HMSO.
PECK, E. & SCOTT, J. (1990) Myth and Reality. *Health Services Journal,* **100,** 365.

Local secure unit

BLUMENTHAL, S. & WESSLEY, S. (June 1992) *The Extent of Local Arrangements for the Diversion of the Mentally Abnormal Offender from Custody. A Report to the Department of Health.*
HAYES, G. & SOLIMAN, A. (1991) The development of a district based forensic service. *Psychiatric Bulletin,* **15,** 149-150.
O'GRADY, J.C. (1990) The complementary role of regional and local secure provision for psychiatric patients: three years experience in Leeds. *Health Trends,* **22,** 14-16.

Case management

CHALLIS, D., CHESTERMAN, J., TRASKE, K. & VON ABENDORFF, R. (1987) Assessment and case management: some cost implications. *Social Work and Social Sciences Review,* **1, 3,** 147-162.
HUXLEY, P.H. (August 10 1990) Community mental health: a way of meeting the challenge. *Community Psychiatric Nursing,* **4,** 13-19.
LAMB, H.R. (1980) Therapist case-managers: more than brokers of services. *Hospital and Community Psychiatry,* **31,** 14-18.
ONYETT, S. (1982) *Case management in mental health.* London: Chapman & Hall

Day care

ECHLIN, R. (1990) *Day Care Information Pack.* London: Good Practices in Mental Health.
VAUGHAN, P.J. & PRECHNER, M. (June 1985) Occupation or therapy in psychiatric day care? *Occupational Therapy,* 169-171 UNSTAFFED GROUP HOMES.
KINGDON, D.G. *et al.* (1989) Befriending: cost-effective community care. *Psychiatric Bulletin,* **13,** 350-351.
PYM, B. (6 April 1989) Run it your own way. *Community Care,* 17-19.

Residential accommodation

ANSTEE, B.H. (1985) An alternative form of community care for the mentally ill: supported lodging schemes...a personal view. *Health Trends,* **17,** 39-40.
HAMMOND, T & WALLACE, P. (1991) *Housing for people who are severely mentally ill.* London: National Schizophrenia Fellowship.
MIND (1992) *Housing with support: a quality action guide.* London: MIND.
RESEARCH AND DEVELOPMENT FOR PSYCHIATRY (1992) *Who does what?* London: RDP.
SHERLOCK, J. (1991) *At home in the community.* London: Good Practices in Mental Health.
DEPARTMENT OF HEALTH SOCIAL SERVICES INSPECTORATE (1991) *All change.* London: DH SSI.
DEPARTMENT OF HEALTH SOCIAL SERVICES INSPECTORATE (1992) *Standards for specialist residential care for people with mental health problems.* London: HMSO.
WING, J.K. & FURLONG, R. (1986) A haven for the severely disabled within the context of a comprehensive psychiatric service. *British Journal of Psychiatry,* **149,** 449-457.
YOUNG, R. (Ed) (1992) *Residential needs for severely disabled psychiatric patients.* London: HMSO.

Appendix 6.2

EVALUATION OF DIFFERENT SERVICE SETTINGS FOR THE TREATMENT OF PEOPLE WITH MENTAL ILLNESS

This appendix gives references and brief descriptions of examples of evaluative assessment of different service settings. They lend broad support to the benefits of locally focused, comprehensive community services.

Comparison of services

1. GRAD, J. & SAINSBURY, P. (1963) Evaluating a community care service. *Trends in the Mental Health Services* (Ed Freeman & Farndale J.) London: Pergamon.

   This comparison of an early community service with a more traditional one concluded that hospital admissions were reduced in number in the former. However whilst this markedly increased burden on families, admissions were more likely to be appropriately responding to social pressures and the domestic problems of patients' families who generally preferred the community services.

2. BEISER, M., SHORE, J.H., PETERS, R. & TATUM, E. (1985) Does community care for the mentally ill make a difference? A tale of two cities. *American Journal of Psychiatry,* **142,** 1047-52.

   Matched groups of schizophrenic patients were assessed over a period of one year following discharge in two cities, one with and one without 'model' community services. The former experienced fewer admissions, were more likely to be employed, and reported a higher level of well-being.

3. HAFNER, H. & KLUG, P. (1982) Effectiveness and cost of community care for schizophrenic patients. *Hospital and Community Psychiatry,* **40,** 59-63.

   Changes in utilisation of psychiatric services, following a change from a hospital-centred to an integrated community-based structure, were found to cover needs previously unmet, particularly alcohol-related disorders and depression, at similar cost.

Components of services

4. JONES, R., GOLDBERG, D. & HUGHES. (1980) A comparison of two different services treating schizophrenia: a cost benefit approach. *Psychological Medicine,* **10,** 493-505.

Comparisons were made over a four year period between patients admitted with schizophrenia to a teaching District General Hospital unit and to an Area Mental Hospital with modern rehabilitation facilities. Clinical outcome was broadly similar but the former imposed less of a strain on relatives and was associated with less unmet need. Duration of stay was also significantly shorter and, despite higher unit costs, the DGH(T) was economically superior to the Area Mental Hospital.

5. TYRER, P. *et al* (1989) Integrated hospital and community psychiatric services and use of inpatient beds. *British Medical Journal,* **299,** 298-300.

Introducing community services with specific geographical boundaries in Nottingham led to a significant reduction in admissions and overall use of inpatient beds. It was concluded that such 'sectorisation' was a viable and economic way of improving psychiatric services.

6. KNAPP, M. *et al* (1990) The TAPS project 3: Predicting the community costs of closing psychiatric hospitals. *British Journal of Psychiatry,* **157,** 661-70.

The team for the assessment of psychiatric services was established in 1985 to monitor closure of Friern and Claybury Hospitals in North East Thames and a series of publications have resulted. Community costs for replacement services have been found to be lower than hospital costs, not just for the first cohorts of leavers, but is predicted to be so for the full populations of the two hospitals and users generally prefer them.

7. YOUNG, R. [Ed] (1991) *Residential needs for severely disabled psychiatric patients: the case for hospital hostels.* London: HMSO.

HYDE, C., BRIDGES, D., GOLDBERG, D. *et al* (1987) The evaluation of a hostel ward. *British Journal of Psychiatry,* **151,** 805-12.

These studies demonstrate that domestic accommodation with 24 hour nurse staffing (hospital hostels) can provide alternative residential provision for those with severe mental illness who were previously accommodated in 'long-stay wards'. Costs tend to be less. They can provide more appropriate placement than 'revolving' in and out of acute wards as has been seen in many districts, particularly in London.

8. CREED, F. *et al* (1990) Randomised controlled trial of day patient versus inpatient psychiatric treatment. *British Medical Journal,* **300,** 1033-7.

DICK, P. *et al* (1985) Day and full-time psychiatric treatment: a controlled comparison. *British Journal of Psychiatry,* **47,** 246-50.

Day hospital care is an effective alternative to admission for most neurotic and personality disordered patients and many psychotic ones. Length of stay in day hospitals has tended to be longer off-setting some of the cost-savings made.

9. BURTON, A., WEISBROD, A., TEST, M.A. & STEIN, L.I. (1980) Alternative to mental hospital III: economic cost-benefit analysis. *Archives of General Psychiatry,* **37,** 400-5

HOULT, J. & REYNOLDS, I. (1984) Schizophrenia: a comparative trial of community orientated and hospital orientated psychiatric care. *Acta Psychiatrica Scandinavica,* **69,** 359-72.

DEAN, C. & GADD, E. (1991) Home treatment for acute psychiatric illness. *British Medical Journal,* **301,** 1021-3.

MERSON, S. *et al* (1992) Early intervention in psychiatric emergencies: a controlled clinical trial. *Lancet,* **339,** 1311-4.

Providing intensive treatment and support to acutely ill patients and their carers has been shown in a number of studies, internationally, to be not only cost-effective but also preferred by patients and carers. Those excluded have been patients at significant risk to self or others or in markedly adverse social circumstances.

10. CORNEY, R. & CLARE, A. (1983) The effectiveness of attached social workers in the management of depressed women in General Practice. *British Journal of Social Work,* **13,** 57-74.

With appropriate training, social workers have been shown to be effective in helping people with depression.

Appendix 6.3

EVALUATION OF PSYCHIATRIC TREATMENT METHODS

Psychotherapies

1. Controlled evaluations of family, behavioural and cognitive therapies have demonstrated their effectiveness in a wide variety of conditions including schizophrenia, depression, anxiety, phobias, obsessional neurosis and bulimia. Further evaluation is needed of other psychotherapies to fully interpret their most appropriate use. A wide range of studies on these is described in Milton below.

ANDREWS, G. (1991) The evaluation of psychotherapy. *Current Opinion in Psychiatry,* **4,** 379-83.

CRAIGHEAD, L.W. & CRAIGHEAD, W.E. (1991) Behaviour therapy: recent developments. *Current Opinion in Psychiatry,* **4,** 916-20.

MILTON, J. [Ed] (1992) *Presenting the case for psychoanalytic psychotherapy services. An annotated bibliography.* London: Association for Psychoanalytic Psychotherapy in the NHS, Tavistock Centre, 120 Belsize Lane, London, NW3 5BA.

LEFF, J. (1985) Family treatment of schizophrenia. *Recent Advances in Psychiatry* **5.** [Ed: Granville-Grossman K] London: Churchill Livingstone.

Drug treatments

2. Drug treatments are well established and demonstrably effective in many conditions notably depression and schizophrenia.

MONTGOMERY, S. (1982) Antidepressant drugs. *Recent Advances in Psychiatry,* **4.** [Ed: Granville-Grossman K] London: Churchill Livingstone.

DAVIS, J.M. (1991) The treatment of schizophrenia. *Current Opinion in Psychiatry,* **4,** 28-33.

ECT

3. ECT has been shown to be effective by controlled evaluations against simulated treatments for depressed people who are retarded (slowed in movements and thought) and/or suffering from delusions.

BUCHAN, H., JOHNSTONE, E., MCPHERSON, K. *et al* (1992) Who benefits from ECT? *British Journal of Psychiatry,* **160,** 355-9.

Appendix 6.4

MENTAL DISORDER IN GENERAL MEDICAL AND SURGICAL SETTINGS

A number of studies have described the high levels of mental disorder in general medical and surgical settings. There is now a growing body of evidence demonstrating that psychiatric interventions can have a beneficial effect, for example in:

- reducing length of stay in hospital wards
- reducing admission rates to hospital, for example for children with asthma
- reducing coronary risk
- improving outcomes for elderly people with hip fractures.

ACKERMAN, A.D., LYONS, J.S., HAMMER, J.S. *et al* (1988) The impact of co-existing depression and timing of psychiatric consultation on medical patients length of stay. *Hospital Community Psychiatry,* **39,** 173-6.

BROWN, A. & COOPER, A.F. (1987) The impact of a liaison psychiatry service on patterns of referral in a General Hospital. *British Journal of Psychiatry,* **150,** 83-7.

GLASS, R., MULVIHILL, M., SMITH, H. *et al* (1978) The 4 score: an index for predicting a patient's non-medical hospital days. *American Journal of Public Health,* **8,** 751-5.

LEVITAN, S.J. & KORNFIELD, D.S. (1981) Clinical and cost benefits of liaison psychiatry. *American Journal of Psychiatry,* **138,** 790-3.

HOCHSTADT, N., SHEPARD, J. & LULLA, S.H. (1980) Reducing hospitalisation of children with asthma. *Journal of Paediatrics,* **97,** 1012-5.

MUMFORD, E., SCHLESINGER, H.J., GLASS *et al* (1984) A new look at evidence about reduced cost of medical utilisation following mental health treatment. *American Journal of Psychiatry,* **141,** 1145-58.

PATEL, C., MARMOT, M.G., TERRY, D.J. *et al* (1985) Trial of relaxation in reducing coronary risk: four year follow-up. *British Medical Journal,* **290,** 1103-6.

STRAIN, J.J., LYONS, J.S., HAMMER, J.S. *et al* (1991) Cost offset from a psychiatric consultation-liaison intervention with elderly hip fracture patients. *American Journal of Psychiatry,* **148,** 1044-1049.

ZIMMER, J. (1974) Length of stay and hospital bed utilisation. *Medical Care,* **14,** 453-462.

Appendix 6.5

INTERVENTIONS TO REDUCE SUICIDE

A. ASSESSMENT OF INTERVENTIONS

Improved management of depression in general practice

1. RUTZ, W., VON KNORRING, L. & WALINDER, J. (1992) Long-term effects of an educational program for general practitioners given by the Swedish Committee for the prevention and treatment of depression. *Acta Psychiatrica Scandinavica,* **85,** 83-8.

   This study demonstrated, amongst other things, significant reductions in hospitalisation and suicide rates in response to the program.

Developing more local services

2. WILLIAMS, P., DE SALVIA, D. & TANSELLA, M. (1987) Suicide and Italian psychiatric reform: an appraisal of two data collection systems. *European Archives of Psychiatry and Neurological Sciences,* **36,** 37-40.

   Evidence suggests an association of lower suicide rates with locally provided DGHs compared to areas served by mental hospitals. Some unpublished British evidence also suggests the introduction of community based services may reduce levels.

Changing availability of means to suicide

3. MARZUK, P.M. *et al* (1992) The effect of access to lethal methods of injury on suicidal rates. *Archives of General Psychiatry,* **49,** 451-8.

   KREITMAN, N. (1976) The coal gas story: UK suicide rates 1960-71. *British Journal of Preventative & Social Medicine,* **30,** 86-93.

   Ready availability of lethal methods of injury, eg firearms, barbiturates, coal gas, appears to increase suicide rates. Substitution of other methods does not appear to occur to compensate.

4. CLARKE, R.V. & LESTER, D. (1987) Toxicity of car exhaust and opportunity for suicide: comparison between Britain and the United States. *Journal of Epidemiology and Community Health,* **41,** 114-20.

   TARBUCK, A.F. & O'BRIEN, J.T. (1992) Suicide and vehicle exhaust emissions. *British Medical Journal,* **304,** 1376.

Changes in car exhaust emission standards in the US in 1968 led to a reduction in deaths from exhaust fumes not seen in the UK. Similar controls introduced on 1st January 1992 in the UK and the requirement that new cars are fitted with catalytic converters from 1st January 1993 can be expected to have a similar effect, increasing over time. A specific case is described in which survival appeared to have occurred because of the effects of a catalytic converter.

B. LEVELS OF SUPPORTIVE OBSERVATION

5. The following levels of observation are described by Morgan and Owen in MORGAN, H.G. & OWEN, J.H. (1990) *Persons at risk of suicide. Guidelines on good clinical practice.* Nottingham: Boots.

LEVEL 3: Known place supportive observation

Patient not actively suicidal and judged free from immediate significant suicidal risk.

LEVEL 2: 15 minute supportive observation

Close relationship has been established with patient who is judged not to be actively suicidal, but is considered to be at significantly increased suicidal risk compared with the average psychiatric in-patient.

LEVEL 1: Constant supportive observation

Patient is expressing active suicidal intent, particularly if no close relationship has been established with the patient. Unpredictable psychotic states or recent deliberate self-harm with apparent serious suicidal intent may indicate this level of supportive observation.

CHAPTER 7

IDENTIFYING RESEARCH AND DEVELOPMENT NEEDS

IDENTIFYING RESEARCH AND DEVELOPMENT NEEDS

Action summary

RHAs

- Establish mental health R&D priorities.
- Negotiate lead responsibilities within and between Regions for areas of Research.
- Liaise with Directors of Social Services to co-ordinate research programmes between the NHS and SSDs.

The need for research and development

7.1 Although much research has been carried out in particular areas of mental health, further and ongoing research is needed to determine:

- the causes of mental illness in order to inform efforts in prevention
- the optimal balance of service delivery within and between health and social care
- the most appropriate balance of treatment methods for different conditions
- possible outcome measures against which treatment methods and settings can be evaluated.

Setting research priorities

7.2 The NHS R&D Strategy was established in 1991 with the objective of ensuring that the content and delivery of care in the NHS is based on high quality research relevant to improving the health of the nation.

7.3 An Advisory Group on Setting Priorities on Mental Health Research reported in April 1992. It selected 31 areas of high priority. A call for outline proposals for central funding by the Department of Health in five areas was advertised in May 1992 and research projects will be commissioned at the beginning of 1993.

Centrally funded research

7.4 Research in the following five areas is currently being commissioned using central

funds from the Department of Health:

- Quality of Residential Care for the Elderly Mentally Ill
- Community Care of the Severely Mentally Ill
- Training Packages for use in Primary Care and Community Settings
- Mental Health of the NHS Workforce
- Devising a methodology to establish the mental health needs of a population.

MRC funded research

7.5 The Medical Research Council have advertised for outline research proposals in the following five areas (decisions on funding will be taken in the summer of 1993):

- Compliance with Maintenance Neuroleptics in Schizophrenia
- Prevention of relapse, recurrence and chronicity in depression
- Patient compliance with antidepressant medication and brief psychological treatments for depression in primary care
- Clinical trials of treatments of common disorders in child and adolescent Psychiatry
- The long-term effects on mental health of early abuse and other traumatic events.

Role of Regional Health Authorities

7.6 The management of the NHS R&D programme has largely been devolved to regions. In addition to advertisements for bids against the 10 centrally and MRC funded research priorities described above, details of the 21 other priorities identified by the Advisory Group on Setting Priorities on Mental Health Research have been sent to Regions to consider in planning their R&D programmes. Regions are required to prepare, publish, resource and implement (and will be held to account for) their own R&D plans.

7.7 In 1992/3, £7 million was 'tasked' to regions to enable them to establish appropriate R&D management infrastructures and systems to identify regional research needs. A new senior post, Regional Director of Research and Development was established and 12 regions have now appointed an RDRD. Multidisciplinary Regional R&D Committees are also being established.

7.8 In drawing up plans and setting regional priorities based on established local R&D needs, RDRDs and R&D Committees need to identify the research capacity available at all levels throughout the region and to balance the differing priorities of service users, primary health care teams, secondary care professionals and service managers. The first sets of R&D plans have been published, and will greatly assist the consultation process within each region. Mechanisms for disseminating the results of R&D are currently being developed as part of the NHS R&D strategy.

7.9 SSDs will also wish to commission research. Liaison and co-ordination with RHAs will avoid unnecessary duplication of effort. The potential for research into the mental health of users of SSDs in particular is considerable.

References

PECKHAM, M. (1991) Research & Development for the National Health Service. *Lancet* **338,** 367-371.
ADVISORY GROUP ON HEALTH TECHNOLOGY ASSESSMENT. *Assessing the effects of health technologies. Principles, practice, proposals.* London: DH.

CHAPTER 8

AGREEING LOCAL TARGETS

AGREEING LOCAL TARGETS

Action summary

All SSD and NHS Managers

- Establish targets for the implementation of service improvements.
- Agree targets for health promotion and mental illness and suicide prevention with healthy alliance partners.

Agreeing local targets

8.1 NHS and SSD managers will want to set challenging but realistic targets to mark their progress towards the health of the nation targets. This is particularly important when agreeing targets with alliance partners (see Chapter 5). Targets should therefore be:

- Specific
- Measurable
- Attainable
- Resourced
- Timebound

8.2 SSDs, RHAs, DHAs, FHSAs and provider units will all wish to set targets. These can be built up in a hierarchy of targets at service provider, purchaser and Regional level. Managers will wish to agree locally targets to meet local needs and priorities. RHAs and FHSAs should ensure that GPFHs state in their business and purchasing Plans how they intend to tackle mental illness – for example, proposed referrals; contract arrangements; use of voluntary services; counselling arrangements etc.

Setting local targets – some examples

8.3 The examples given below suggest some of the areas in which managers may wish to set their own targets within their own settings. They will also wish to agree similar targets with alliance partner to meet the objectives suggested in Chapter 5.

- To draw up a socio-demographic profile by ... and to update on an [annual] basis

- To draw up a profile of service provision by...
- All joint care planning teams (or equivalent) to include users by...
- Regional information strategy to be developed by...
- All provider units to have effective systems for collecting and using data about service contacts by...
- The computerisation of information collection and dissemination in
  50% of DHAs by...
  100% of DHAs by...
- Establishing the number of people with severe mental illness in contact with specialist services by...
- Minimum dataset (including ethnicity and named key-worker) by...
- Regional Strategic Framework established by...
- To reduce vacancies for consultant psychiatrists/occupational therapists/ clinical psychologists from ...% to ...% by...
- To apply the CPA to all patients:
  discharged from hospital by...
  at outpatient clinics by...
- To establish effective mechanisms for integrating CPA and care management by...
- Reduce numbers of detentions under the Mental Health Act for people from black and other ethnic minority groups by 50% by...
- To increase detection rate of depression in General and Social Work practice (assessed by use of local sampling techniques) to ...% by...
- To have an equal opportunities policy covering recruitment and service provision, with a system for monitoring it, in place by...

Suicide targets

8.4 Suicide numbers are small when measured on a local basis. In setting suicide targets, managers should therefore be wary of attaching too much significance to minor fluctuations in seasonal or annual figures as opposed to comparisons over 3-5 year period.

8.5 Targets can usefully be set for implementing specific measures to reduce suicide risk, for example:

- Establish multi-disciplinary audit meetings by...
- To implement observation policies in all units by...
- To achieve questionnaire returns of ...% to the Confidential Inquiry by...
- Establish the District/Local Authority rate of suicide for people with severe mental illness by...
- To stabilise suicide rate in males (16-44) by...

Benzodiazepines

8.6 FHSAs may wish to discuss with GPs agreeing local targets for reductions in benzodiazepine prescriptions. Care should be exercised to ensure that the emphasis in the targets remains on the implementation of appropriate management strategies to deal with the underlying conditions to replace benzodiazepine use.

References

JENKINS, R. (1990) Towards a system of outcome indicators for mental health care. *British Journal of Psychiatry,* **157,** 500-514.
THORNICROFT, G. & STRATHDEE, G. (1991) Mental Health. *British Medical Journal,* **303,** 410-2.

CHAPTER 9

AGREEING STRATEGIES FOR ACHIEVING LOCAL TARGETS

AGREEING STRATEGIES FOR ACHIEVING LOCAL TARGETS

Action summary

RHAs

- Co-ordinate development of comprehensive Region wide strategic framework to be in place by 1994/5, including priorities for capital and revenue expenditure, and establish priorities in corporate contracts.
- Agree with purchasers effective strategies for the full implementation of the Care Programme Approach (CPA).

DHAs, FHSAs and SSDs

- Develop joint community care plan for commissioning and providing mental health services including appropriate strategies to integrate the Care Programme Approach (CPA) and Care management.
- Agree action plans across alliances.

DHAs and FHSAs

- Provide current status report to RHAs and develop strategies in line with the Regional lead.

The need for a mental health strategy

9.1 The delivery of services to people with mental illness is undergoing a rapid shift with the decommissioning of outdated institutions. A planned approach to this change is necessary to ensure that comprehensive locally based services are in place able to offer a high quality of care delivery. Plans will need to reflect the results of population and resource profiles and local needs assessment exercises. Regional Health Authorities are best placed to co-ordinate this process and safeguard against any potential gaps in service provision.

9.2 Strategic planning of mental health services at District and Regional levels was introduced in 1976. However, Regional oversight of the process has varied. The corporate contracting process presents firm opportunities for Regions to take strategic planning forward.

Implementing a mental health strategy

9.3 A strategy for service development in mental illness will need to cover a number of components, including:

- information strategy – assessing needs and current provision (see chapter 11)
- facilities strategy – planned approach to developing a range of community mental health services (see table on p. 71)
- staff strategy - numbers and training need against current resources (see chapter 10).

9.4 District Health Authorities should provide a current status report to assist them in drawing up a baseline against which a strategy can be developed.

9.5 Regions and purchasing authorities can seek detailed advice on establishing and implementing strategic plans in mental health from the Health Advisory Service; the Mental Health Task Force and the Centre for Mental Health Services Development. Further information is at Appendix 9.1.

9.6 DHAs, FHSAs and SSDs will need to develop their own strategies to:

- meet gaps in provision, such as in respite care, psychotherapy and counselling services
- identify potential providers of services, including provision from the independent sector.

9.7 Establishing clearly planned objectives will be particularly important between health and social services to ensure that procedures exist to meet service need at the interface of health and social care.

9.8 The implementation of the Children Act 1989 is having fundamental effects on the purchasing and providing of mental health services for those under 18 years of age, establishing parameters of health authority assistance to LAs. Effective methods to meet the objectives of the act in relation to mental illness should be taken into account in developing joint strategies.

9.9 Similar shared responsibilities exist under the Mental Health Act 1983. Appendix 9.2 details respective responsibilities against which health and social services can agree ways of working.

The Care Programme Approach and care management

9.10 The Care Programme Approach (see Appendix 9.3), which aims to provide a network of care in the community, was introduced in the NHS in April 1991. DHAs are required to initiate, in collaboration with local social services departments, explicit individually tailored care programmes for all in-patients about to be discharged from mental illness hospitals and all new patients accepted by the specialist psychiatric services. The role of the key worker can be significant at times of increased vulnerability, including when suicide risk emerges, ensuring the patient has someone to talk to and enabling appropriate re-assessment and care management without delay.

9.11 Care management is being introduced by Social Services Departments nationally from April 1993 as part of the implementation of Care in the Community. It will have its greatest impact where most of the processes involved are carried out by a care manager who has some measure of responsibility for a devolved budget.

9.12 Care management should benefit people with mental illness by:

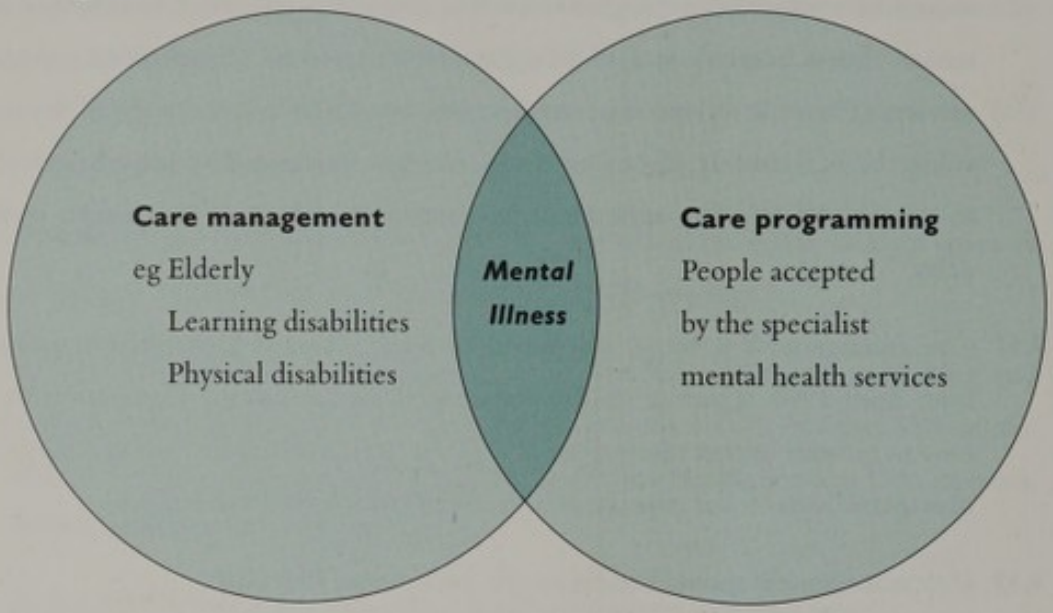
- assisting in identifying people with severe mental illness in the minority of cases where they are not already in contact with specialist psychiatric services and identified through CPA procedures
- ensuring that in cases of significant social need a care manager is appointed to co-ordinate care.

9.13 CPA and care management are complementary processes in the care of people with mental illness (see diagram below). All DHAs and SSDs will want to review the implementation of CPA and care management and establish the most effective mechanisms for operating the two approaches to ensure that people do not slip through the mental health care net.

9.14 The key worker role under the CPA and the role of the care manager in care management are distinct. The key worker will usually have some responsibility for service delivery in addition to monitoring the delivery of care, but will not have budgetary control. Although care managers generally act as brokers for services across the statutory and independent sectors and are not involved in direct service

provision, it may sometimes be appropriate for them to be involved in the provision of services for people with mental illness.

Diagram to show the relationship between the Care Programme Approach and care management.



9.15 RHAs and DHAs could usefully organise seminars to assess current issues in the implementation of the CPA and to network effective strategies to overcome any difficulties in implementation. Joint seminars between SSDs and health authorities considering the co-ordination of SSDs should also be considered.

Agreeing action plans across alliances

9.16 Purchasers and providers will need to collaborate closely with alliance partners to establish clear roles in working towards jointly agreed objectives, particularly:

- responsibilities of NHS bodies and other alliance members
- timetables for action
- issues of joint resourcing
- monitoring arrangements, including reports on progress.

References

DEPARTMENT OF HEALTH (1990) *The care programme approach for people with a mental illness referred to the special psychiatric services (HC(90)23, LASSL(90)11).* London: Department of Health.
DEPARTMENT OF HEALTH SOCIAL SERVICES INSPECTORATE (1992) *Care management and assessment: Practice Guidance: Managers Guide.* London: DH.
RESEARCH & DEVELOPMENT FOR PSYCHIATRY (1991) *Case Management Review. Issue 1.* London: RDP.
ROYAL COLLEGE OF PSYCHIATRISTS (1991) *Good medical practice in the aftercare of potentially violent or vulnerable patients discharged from in-patient psychiatric treatment.* London: RCPsych.
RYAN, P. & FORD, R. (1991) *Case management and Community Care.* London: RDP.

Appendix 9.1

SOURCES OF STRATEGIC ADVICE FOR MANAGERS

A. THE NHS HEALTH ADVISORY SERVICE

1. The Health Advisory Service (HAS), created in 1969, is an independent body funded by the Department of Health. Following a Ministerial review in 1991, the HAS has been adapted to the new structure of the NHS. It retains its former brief to give advice on improving standards of management and clinical care and to focus on mental health services (including for children and adolescents), on services for substance misusers and on services for the elderly. It also has new roles to advise purchasing and providing authorities in relation to these services on:

- the strategic and practical aspects of needs assessment for the service specification for and the monitoring of quality standards
- achieving Health of the Nation targets.

2. The strands of HAS's work are:

- thematic reviews
- a Regional programme of general service reviews
- specialist advisory services
- a rapid review service.

Director:	Dr Richard Williams
Address:	Health Advisory Service
	Sutherland House
	29-37 Brighton Road
	Sutton
	Surrey SM2 5AN
Telephone:	081-642-6421

B. THE MENTAL HEALTH TASK FORCE

1. The Mental Health Task Force was announced by the then Parliamentary Under Secretary of State, Stephen Dorrell, in February 1992. Its remit is to ensure the substantial completion of transfer of mental health services away from obsolete hospitals to a balanced range of locally based services.

2. The four key areas of work which have thus far been identified and which will form the basis of the Task Force's work are:

   - service modernisation programme – working with Regions to develop strategic plans on how the remaining outdated institutions will be closed by the end of the century
   - market intelligence – information for managers on closures and costs and the provision of material for purchasers to advance strategic change through the contracting process
   - customer satisfaction – disseminating best practice on user involvement
   - promoting understanding – increasing acceptance of community care for people with mental illness and reducing associated stigma.

Chairman:	David King
Contact:	Alan Bell
Address:	Richmond House
	79 Whitehall
	London SW1A 2NS
Telephone:	071-210-5740/5736

C. THE CENTRE FOR MENTAL HEALTH SERVICES DEVELOPMENT

1. The Centre for Mental Health Services Development is an independent consultancy, attached to King's College London, and staffed by managers and practitioners who have first hand experience of implementing change in mental health services.

2. The Centre's mission is to:

   - help health authorities with the planning and implementation of comprehensive, locally-based mental health services by providing long-term consultancy assistance
   - contribute to the development of national policy from a base of accumulating experience of the successful development of local mental health services.

3. The Centre has developed a process which ensures that all local stakeholders (including service users and carers) are involved in determining local service solutions to meet local needs. This process has been widely employed in England, as well as in Scotland, New Zealand and Australia.

Head of Centre:	Mr John Jenkins
Address:	Centre for Mental Health Services Development
	King's College London
	Campden Hill Road
	Kensington
	London W8 7AH
Telephone:	071-333-4194/4172

Appendix 9.2

RESPONSIBILITIES UNDER THE MENTAL HEALTH ACT

The Code of Practice of the Mental Health Act specifies that local agreements should be drawn up in a range of circumstances (see table)

Para. of Code	Policy requirement under Code of Practice	Responsibility of:		
		H.A.	L.A.	Police
2.11c	Issue guidance to Approved Social Workers (ASWs) about interpreters.		•	
2.14	Issue practical guidance to ASWs on procedures re. displacement of nearest relative (s.29).		•	
2.33	Issue guidance to ASWs re request(s) from nearest relative for ASW assessment.		•	
2.35	Ensure ASWs and doctors receive guidance on use of professional interpreters	•	•	
10.1	Establish joint policy re. police power to remove person to place of safety (s.136).	•	•	•
10.19	Issue guidance to ASWs on powers of entry (s.135).		•	
11.3	Produce policy with Ambulance Service on conveyance of patients to hospital.	•	Take lead	•
13.6	Prepare and publish policy on Guardianship (s.7).		•	
14.5	Hospital Managers' policy on providing information to patients.	•		
16.31	Hospital Managers' "Second Opinion Appointed Doctor" system.	•		
18.13	Policy on the use of restraint.	•		
18.15	Policy on the use of seclusion.	•		
18.27	Policy on use of "secure provision".	•		
19.2	Policy re. behaviour modification programmes.	•		
19.10	Policy on the use of "time-out".	•		
21.2	Policy on procedure re. patients absent without leave (s.18).	•		
24.12	Managers of Special Hospitals policy on withholding mail.	SHA		
25.1	Policy on searching of patients and their belongings.	•		
26.3	To produce procedures of aftercare with local voluntary organisations.	•	•	

Appendix 9.3

CARE PROGRAMME APPROACH

Questions about practical application:

1. **Does the Care Programme Approach just apply to those with chronic mental illness?**

No, it applies to:

a. All people accepted by specialist psychiatric services.
b. All psychiatric patients considered for discharge from hospital.

This ensures that users/patients are all assessed and that none who might be vulnerable are missed because of diagnostic dispute or uncertainty.

Three groups need to be considered:

a. People with severe mental illness whose complex health and social care needs are such that they require care management in addition to the care programme approach.
b. People with severe mental illness who require multi-disciplinary care but do not require care management. They will require regular multi-disciplinary review.
c. People accepted by specialist mental health services who require assessment and treatment by one professional. Consideration will need to be given regularly as to whether other professionals need to be involved in care but for many this will not be necessary. Regular review, as is 'good practice' eg in out-patients or on home visits, will need to occur and be documented.

A multi-disciplinary Care Programme is not of course necessary for all patients. For those with less severe mental illness, with few if any social care needs, a straightforward course of treatment, for example as an out patient, could be appropriate. In these circumstances the Care Programme would consist of the initial assessment and a treatment plan agreed between the Responsible Medical Officer (RMO) and the patient. The RMO would be nominated as the key worker. Such 'minimal' Care Programmes make efficient use of mental health resources by reserving the pan multi-disciplinary approach for those patients with complex health and social care needs while simultaneously ensuring that all patients accepted by the specialist psychiatric services are subject to the Care Programme Approach, particularly the assessment procedures.

2. **Does the Care Programme Approach just apply to those accepted by psychiatrists?**

No, the circular specifies "all in-patients considered for discharge and all new patients accepted by the specialist psychiatric services" and so includes all mental health professionals, including psychologists, approved social workers and community psychiatric nurses, where they receive referrals directly from General Practice and other agencies.

3. **What about people who were already being seen in the community by members of psychiatric teams, prior to 1 April 1991?**

Whilst these are not one of the groups discussed in the circular, good practice should dictate that these are included after the Care Programme Approach is operating for the groups identified above.

4. **What does the Care Programme Approach involve?**

   a. Systematic assessment of the health and social care needs of the patient with particular regard as to whether the patient has a severe and enduring (ie chronic) mental illness.
   b. Drawing up of a package of care agreed with members of the multi-disciplinary team, GPs, service users and their carers.
   c. Nomination of a key worker to keep in close contact with the patient.
   d. Regular review and monitoring of the patient's needs and progress and of the delivery of the care programme.

5. **How do you decide if someone has a 'severe and enduring mental illness'?**

For most psychiatrists and mental health workers, this does not usually prove a difficult clinical decision. It is a judgement made on the basis of severity and duration of symptoms and disability which may lead patients to have severe social problems because of their inability to cope with ordinary living. This inability to cope might necessitate repeated or lengthy hospital admissions or day care attendance, sheltered accommodation, or long-term medication. Repeated requests for assistance from a person and/or her/his carer should alert staff to the possibility of unmet need.

6. **Who can be a keyworker?**

Any mental health worker can be designated a key worker. A psychiatrist

assessing a patient in an outpatient clinic may become the keyworker but this would normally be a non-medical role when other team members are involved in the care of a patient. For most patients with severe and enduring mental illness, a social worker or a community psychiatric nurse or a worker with a non-statutory agency (eg a housing association) would be appropriate.

7. How should a key-worker be nominated?

Procedures for nomination or allocation of key workers in community mental health teams continue to cause concern. Priorities need to be established and allocation made in a way that reflects patient need and ensures that differing professional skills are used to the best effect. The patient should, other than where inappropriate, be involved in discussions on the allocation of a key worker.

In most teams the person making the initial assessment of a patient referral usually continues as keyworker. This generally saves time and ensures maximum continuity of care. It does however make equitable, appropriate and efficient initial allocation of referrals particularly important. This should be the responsibility of suitably trained and experienced team leaders and consultants who can review the appropriateness of the initial assessor continuing as key worker and re-allocate as necessary.

Where a patient is about to be discharged from hospital, the decision about who their key worker should be, needs to be made collaboratively prior to discharge by the multidisciplinary team led by the consultant. This should be at a pre-discharge ward round or review to which the patient and carers would normally be invited. The General Practitioner needs to be informed about the proposed Care Programme, who the key worker is, and how to contact them. When a patient discharges himself, a team review may not be possible but nevertheless consultation with community agencies, including the General Practitioner and Social Services Department, and any carer involved, is desirable.

8. What if agreement cannot be reached on keyworker allocation?

When the referrals accepted are placed in priority order allocation is made by team leaders and consultants, this should not arise within teams. Differences in allocation and prioritisation policies between agencies may however need to be addressed at

local level. There may also be a need to develop procedures to resolve problems when all possible key workers feel overstretched.

9. What are the responsibilities of a keyworker?

a. To use their professional skills collaboratively in assisting patients and maintaining regular contact with them. This should include consultation with carers.

b. To provide support and care in a positive, assertive, manner ensuring that it is offered and available in as acceptable a way as possible to the patient/user.

c. To act as a consistent point of contact for users, carers and other professionals.

d. To ensure the user is registered with a GP and then to work in close contact with the primary care health team (PHCT) and other involved professionals.

e. To be aware of other resources and provide information or refer as appropriate.

f. To ensure the user is registered with a GP and receives both health promotion and chronic disease management.

g. To assist in planning and then monitoring the delivery of the agreed care package, record decisions made about it and ensure that it is reviewed at regular intervals.

10. What should a review consists of?

a. Where more than two workers are involved a review meeting will usually need to be convened. These are however very costly in professional time and so need to be brief with clear agendas. It may be appropriate to review a small group of patients/users who are involved with the same group of professionals at review meetings on the same day.

b. Where only one or two workers are involved, a specific review needs to take place and be documented with consideration given to involvement of other professionals and services but a review meeting as such may not be necessary.

11. How regularly should reviews occur?

This needs to be determined at the time of keyworker allocation and thenceforth at each review with provision for convening reviews rapidly if circumstances warrant it. Where change is occurring or potential problems are foreseen, reviews will need to be more regular but there is benefit in scheduling reviews of those whose situation is

stable at six monthly or even annual intervals. This ensures regular review and a familiar face and contact point if relapse occurs or situations change eg a carer becomes ill.

12. How should the Primary Health Care Team be involved in the CPA?

a. Exchange of information between professionals with user/patients' informed consent prior to discharge from hospital or a care episode and at regular intervals thereafter is fundamental: just as GPs refer users to secondary care, the concept of referring back to primary care needs to be utilised

b. Agreed understanding of clinical responsibilities (eg for physical health checks, in provision of specific treatments or medication supplies, and follow-up arrangements) needs to be ensured. Where users/patients move between districts, liaison between respective CMHTs (Community Mental Health Teams) and PHCTs (Primary Health Care Teams) is essential

c. Social care needs and plans particularly require consideration by PHCTs

d. Clear mechanisms for routine and emergency contact between CMHTs and PHCTs need to be specified and disseminated locally.

13. What if a patient discharges him/herself from hospital or is at risk of so doing?

a. Carers, the patient's General Practitioner, and keyworker, if already nominated, need to be informed immediately. Where the patient specifically forbids contact with the carer, they can nevertheless be contacted if they are deemed to be at risk from the patient. In virtually all circumstances attempts should be made to persuade the patient of the benefit of such contact being made.

b. The patient should be offered follow-up care, either by visit to the home or outpatient care.

c. A keyworker should be nominated to try and contact patients who discharge themselves, and occasionally may have to visit even when a patient has refused follow-up. The patient retains the right to refuse to see them, subject to statutory provisions, but at a later stage may be re-established and/or assistance made available to carers even under these difficult circumstances.

d. There should also be consultation with any social worker involved with patients' families (eg in relation to children in the family).

14. What if a patient refuses contact?

a. Where this occurs a multi-disciplinary discussion (although not necessarily a meeting) may establish alternative ways of presenting a care plan which is acceptable to the patient. The patient may opt only to accept a part of the programme offered and as far as possible, the programme should be sufficiently flexible to accommodate this.

b. Even if the programme is wholly rejected, the offering of contact on a regular basis in consultation with the patient's GP should continue.

c. The carer also should be offered assistance on a regular basis and a reliable point of contact.

15. Will a patient always require the CPA?

By no means – where improvement occurs such that the person may be discharged from the psychiatric services as no longer needing their assistance, they will no longer require a care programme. However they should not be discharged simply because contact is lost or progress is not being made. Where someone discharges themselves from psychiatric care, the same action as when they discharge themselves from hospital should apply, as above.

CHAPTER 10

DEVELOPING HUMAN SKILLS AND RESOURCES

DEVELOPING HUMAN SKILLS AND RESOURCES

Action summary

RHAs and Directors of SSDs

- Review provision of specialist mental health workers.

DHAs, FHSAs and Directors of SSDs

- Promote, via contracts, multi-disciplinary team working and health and social care audit.

FHSAs

- Work with NHS provider units and SSDs to develop and support joint training for primary health care teams.

NHS Providers and Managers of SSDs

- Review provision of specialist mental health workers and develop multi-disciplinary team working.
- Assess training needs and opportunities and establish training programmes as necessary.

Staff development

10.1 The primary resource available to managers is the staff who will be implementing the programmes to achieve the Health of the Nation targets. Staff will need to be developed to meet their own personal aspirations and to maximise their contribution to the service.

10.2 Managers and other professional staff who have been involved in developing locally based services to replace mental hospitals and in implementing change in other areas will be an invaluable resource – in information, inspiration and training.

10.3 In order to define efficient health and social care in increasingly community-based services, DHAs and SSDs will want to establish the number and deployment of trained staff – including psychiatrists, psychologists, CPNs and social workers – to most effectively meet the needs of their local populations.

10.4 SSDs will also need to consider the balance of workers between specialist and generic teams.

10.5 DHAs will need to specify within their purchasing contracts where they wish to see the attachment of psychiatrists to acute and community units.

10.6 Managers will need to take account of the availability of staff when moving towards community care; the balance of staff between specialisms; and the availability and training of support workers.

10.7 The following table gives an example staff profile, relating staff to population base. Targets can be set in ratios of staff to population and in numbers of vacancies etc.

	Total	Rate per 100,000 population	Vacancies
Consultant Psychiatrists:			
Mental illness			
Forensic			
Old age			
Psychotherapy			
Child & Adolescent			
General Practitioners with further training or qualifications in mental health:			
Clinical psychologists:			
Therapists:			
Occupational therapists			
Physiotherapists			
Art & drama therapists:			
Psychiatric Nursing Staff:			
Total (qualified)			
CPNs			
Social workers:			
specialist mental illness			
approved social workers			

10.8 Action should be taken to address any shortfalls in staff numbers identified, for example through additional funding.

10.9 Training for *all staff* – primary health care teams, social workers, day and home care staff, midwives, casualty staff and hospital and community doctors and nurses – is critical to:

- a better understanding of the needs of users and carers
- the effective management of risks and illnesses
- improved recognition and assessment of suicidal risk, depression and anxiety
- develop management skills, especially for doctors and nurses.

10.10 A number of common steps could be taken to implement effective training for staff, including:

- identifying mental health skills requirements for individual staff group and audit individual staff members' training needs
- identifying staff, users and carers who have such skills to share and identify gaps in trainer availability
- commissioning external training as appropriate. Consider using voluntary and user based organisations and certain modules of existing Approved Social Worker (ASW) courses
- liaison between secondary care providers and primary care to provide training opportunities
- ensuring quality control with, for example, regular user feedback.

10.11 Providers may wish to concentrate staff development in particular on the implementation of the Care Programme Approach. DHAs may wish to run seminars – for the NHS, LA, voluntary groups, users and carers – to ensure staff are aware of their responsibilities and given the tools to develop effective local implementation strategies. RHAs can encourage healthy alliances within their strategic framework.

10.12 All professional groups would benefit from the development of general and specialist skills in:

- appropriate care and treatment of postnatal mental illness, eating disorders and pre-senile dementias

- counselling techniques
- behavioural, cognitive and family therapies
- equal opportunities – particularly for women and ethnic minority users of services
- communication and presentation skills
- restraint techniques.

10.13 Joint training between different staff groups and across health and social services will enhance inter-professional collaboration and team working to the benefit of service users and staff.

10.14 Training on assessing suicidal risk needs to be made widely available for staff in areas where contact with suicidal patients regularly occurs. This will also include staff in accident and emergency departments and general medical wards; SSD social workers; and members of emergency duty teams in addition to DHA and SSD mental health professionals.

Primary care

10.15 A substantial amount of mental illness is undetected in primary care, leading to inappropriate treatment or referral. 40% of people who commit suicides consult their GP in the previous week. Training and further education for all staff who work in primary health care – GPs, practice nurses, health visitors, district nurses, and midwives – in the recognition and effective treatment of depression and the assessment and management of suicide risk could have a marked effect on:

- reducing suicide rates
- appropriate referral to social workers and other sources of social support
- the graded replacement of benzodiazepines with non-prescribing interventions.

10.16 The Defeat Depression campaign is developing training packages for use in general practice. Similar packages could be developed locally for recognition and management of other mental disorders.

10.17 A senior GP fellow at the Royal College of General Practitioners has been appointed to take a national lead in continuing GP education in mental illness, with the task of

expediting the education of the primary health care team in this area and cascading information through Regional Advisors in General Practice. Regional Advisors in General Practice are well placed to co-ordinate the development of training in mental illness for GPs as part of their continuing medical education.

10.18 FHSAs may wish to consider encouraging GPs to consider the composition and deployment of the primary health care teams and their integration with secondary care, including:

- the employment of additional practice nurses and counselling support staff. It is essential that these staff are appropriately trained and access consultancy services where appropriate
- establishing consultancy services from CPNs, psychologists and psychiatrists.

Clinical psychologists

10.19 The longstanding shortage of clinical psychologists across the country needs to be addressed. In order to meet current demand for specialised services, providers will need to develop guidelines for the prioritisation of referrals and a consultancy model of working (as advocated by the Manpower Planning Advisory Group).

Social workers

10.20 A minimum of 50% of *all* people on social workers caseloads, irrespective of whether individuals are accepted by the mental health services, other specialist (eg elderly, children) or generic teams, have a mental illness.

10.21 Other than when local circumstances dictate, evidence suggests that attaching social workers to mental health rather than area-based teams leads to the provision of better mental health care.

10.22 Social Service Directors should give serious consideration to designating senior management posts in planning and service provision with mental specific health responsibilities in order to preserve the focus on mental illness within the organisation.

10.23 All social workers – including those working in non-specialist mental health settings – would benefit from basic or further training in:

- recognition of mental health problems, including assessment of suicide risk

- steps to help people with mental illness, including appropriate referral for specialist clinical opinion and treatment.

Occupational and other therapists

10.24 Staff trained in the provision of therapy services are generally in short supply. The main therapists working in the treatment of mental illness are:

Occupational therapists	developing skills of independent living.
Art, music, drama therapists	work in psychotherapies.
Speech therapists	develop speech and communication skills for relationship building.
Physiotherapists	influence psychological health through physical approaches such as the use of relaxation, exercise and the management of disabilities.
Dietitians	dietary advice for anorexia, dietary neglect and in pre-discharge.

Psychiatrists

10.25 Shortages are progressively but slowly being addressed as part of central personnel planning. RHAs should consider increasing the supply of psychiatrists by funding vacant Senior Registrar posts as a matter of urgency.

Nursing staff

10.26 All nurses, midwives and health visitors have a role to play in contributing to the achievement of the mental illness targets. It is essential that appropriate numbers and an appropriate skill mix are employed and that they receive appropriate education and training to enable them to make that contribution. The Common Foundation Programme of Project 2000 should give pre-registration students a better understanding of psychological needs and problems. Further post-registration programmes will need to be developed for qualified staff, for example, in dealing with mothers with young children etc.

10.27 The Registered Mental Health Nurse is the specialist nurse who is educated and trained to provide care and treatment for people with mental illness and to contribute to prevention and health promotion. Mental health nursing has undergone radical

changes over recent years and a review has been instituted by the Secretary of State to report on how best, in the interest of patient care, to equip and deploy valuable nursing resources. Managers will want to assess the local availability of qualified mental health nurses in specialist areas in in-patient and community settings such as:

- acute care
- care of elderly people with mental illness
- rehabilitation settings
- substance misuse
- forensic psychiatry.

10.28 Locally organised training for staff already in post could enhance skills in areas such as:

- behaviour therapy
- family therapy
- psycho-dynamics
- psycho-social skills.

Multi-disciplinary team working

10.29 The integrated delivery of services to meet the social and health needs of users of mental health services require a high degree of integrated working between staff. Each member of a multi-disciplinary team brings specific skills, although there will be overlap particularly in relation to psychological management. A multi-disciplinary team will normally consist of:

- nurse
- psychiatrist
- social worker
- occupational therapist
- psychologist.

10.30 Emergency duty teams and crisis intervention teams include a psychiatrist approved under Section 12 of the Mental Health Act, an approved social worker and, in crisis intervention teams a CPN. They are usually available on a 24 hour basis for assessment and management of patients. Teams will respond to requests from GPs, police surgeons etc.

Developing Audit

10.31 Audit, or less formally, review, should take place across primary and secondary care, as well as between health and social services, to identify any issues at the interface of service provision. Staff co-operation in multi-disciplinary audit of treatment and care and cases of suicide or parasuicide will greatly assist in developing good practice.

10.32 Management can facilitate the process of multi-disciplinary audit by enabling staff time to meet.

10.33 Suicides of people who are not in touch with specialist mental health teams should be reviewed by the primary health care team wherever possible. Primary care review can be co-ordinated through Medical Audit Advisory Groups, and would benefit from close working with District Medical Audit Committees, the aim being to increase knowledge of suicide and its prevention.

10.34 FHSAs will also wish to support the development of review of benzodiazepine use and management policies.

References

General

NHSTD (1992) *Training and User Involvement in Mental Health Services.*

Primary care

CORNEY, R.H. & JENKINS, R. (1992) *Counselling in primary care.* London: Routledge.

DARLING, C. & TYRER, P. (1990) Brief encounters in general practice: liaison in general practice psychiatry clinics. *Psychiatric Bulletin,* **14**, 592-594.

DEFEAT DEPRESSION CAMPAIGN *Defeat Depression: management guidelines.* Department of Health Publications (in press).

GASK, L., BOARDMAN, J. & STANDART, S. (1991) Teaching Communication Skills: A problem based approach. *Postgraduate Education for General Practice* **2**, 7-15.

Social work

FISHER, M., *et al* (1984) *Mental health social work observed.* National Institute Social Services Library No.45.

HUXLEY, P. (1988) *Social Work Practice in Mental Health.* Aldershot: Gower.

ISSAC, B., MINTY, E.B. & MORRISON, R.M. (1986) Children in care – the association with mental disorder in the parents. *British Journal of Social Work,* **16**, 325-9.

DEPARTMENT OF HEALTH SOCIAL SERVICES INSPECTORATE (1991) *Approved social workers: developing a service.* London: DH SSI.

Nursing

BROOKER, C. (1990) *Community Psychiatric Nursing: a Research Perspective.* London: Chapman & Hall.

BROOKER, C. & WHITE, E. (1992) *Community Psychiatric Nursing: a Research Perspective. Volume 2.* London: Chapman & Hall.

Clinical psychology

DEPARTMENT OF HEALTH MANPOWER PLANNING ADVISORY GROUP (1990) *Clinical Psychology Project: full report.* London: Department of Health.

ROBSON, M.H., FRANCH, R. & BLAND, M. (1984). Clinical psychology in primary care: controlled clinical and economic evaluation. *British Medical Journal,* **288**, 1805-8.

WILCOCK, P. & ROSSITER, R. (June 1990) Clinical psychology and General Managers. *Health Services Management.* 139-41.

Inter-professional collaboration

FALLOON, I. & LILLIE, F. (April 7 1988) Science in the community. *Health Service Journal* **98 5095**: 392.

GOOD PRACTICES IN MENTAL HEALTH/IAMHW (1990) *Community mental health teams/centres information pack.* London: GPMH.

KINGDON, D.G. (1992) Interprofessional collaboration in mental health. *Journal of Interprofessional Care,* **6, 2,** 141-8.

WEAVER, T. & PATMORE, C. (1990) United fronts. *Health Service Journal,* **100, 5223**: 1554-1555.

CHAPTER 11

DEVELOPING INFORMATION RESOURCES

DEVELOPING INFORMATION RESOURCES

Action summary

RHAs and Directors of SSDs

- Co-ordinate and oversee the development of a mental health information system, suitable for computerisation as quickly as possible.

NHS Purchasers and Directors of SSDs

- Develop a mental health information system compatible with other purchasers within the Region.

FHSAs

- Assist in improving and standardising mental health data collection within primary care.

NHS Providers and Managers of SSDs

- Discuss with mental health teams and service users their requirements for collated information.
- Establish compatible information collection (manual & IT) between health and social services.

The need for information

11.1 Information on service provision, service use, population needs and the epidemiology of mental illness is sparse and of poor quality. Unreliable and irrelevant information has often been collected at great expense, whilst real information needs have been ignored. Information is integral to:

- assessing needs
- resource management and planning
- joint working and purchasing between health and social care professionals
- ensuring the effective delivery of appropriate care to the individual
- measuring the effectiveness of different treatments and treatment settings
- supporting effective audit.

11.2 A more coherent and cost effective approach to the collection, dissemination and use of information is therefore essential. This is not only the case within the NHS, but also between health and social services.

11.3 Strategic reviews of information collection are now occurring within mental illness services, including:

- Public Health Information Strategy – a review of central needs for information
- Community Information Systems for Providers – a review of NHS needs for community services
- Personal Social Services Information Systems Strategy – a review of personal social services data collection.

11.4 If information systems are to be effective it is particularly important for those collating the data to disseminate summaries of it back to the front line staff who collect it. This will provide them with information of use in the context of their service delivery. By engendering a greater feeling of ownership, it will also ease collection and ensure greater reliability.

Comprehensive mental health information systems

11.5 Comprehensive mental health information systems which register all users referred on to specialist psychiatric or social work care should be established. This will provide aggregate information for use by management and support effective care management by:

- facilitating the effective sharing of information between members of mental health teams, helping to improve the delivery of services to people with severe mental illness. Inefficient systems and sometimes rapid staff turnover can lead to service users slipping through the care net
- assisting in the proper implementation of the CPA by ensuring reviews occur regularly and patients are not lost to the mental health services.

11.6 The use of mental health registers causes great concern amongst service users and is seen as a means of labelling people. In addition to the care management benefits described above, a comprehensive system will avoid the subjectivity, stigma and possible discrimination (such as when seeking employment) attached to mental health registers.

11.7 People who are at increased risk of suicide could be signified with an alert status within their personal record. For example, people who have attempted suicide are 100 times more likely to attempt to take their own life in the following year. People should be informed when they are put on alert status other than exceptional circumstances – such as when the information is seen as life threatening. The decision not to inform should not be taken lightly, should be agreed between health and social service staff and should have management agreement. No information should be withheld under the terms of the Data Protection Act. Primary health care teams should be informed of a patient's alert status.

11.8 User's access to information held on them should be simple and users should be informed of their right of access to this information. Any information supplementary to basic administrative requirements should be discussed with the user.

11.9 The use and disclosure of information is subject to current guidance on the confidentiality of health information and is also set out in LAC(88)17 and full safeguards should be built into all systems.

Implementing a mental health information system

11.10 RHAs are best placed to take a strategic overview of information developments. Purchasers and providers will all need to be involved in this process, carrying out their own information audit and establishing compatible mental health information systems.

11.11 Rapid progress will need to be made towards computer based systems in provider units to ensure the most efficient implementation of a mental health information system.

11.12 Computerisation of patient administration systems at provider level is particularly important to facilitate effective care programming. Computerisation will assist in tracking patients to ensure that they are not lost to the services which can maintain contact with them at times of need.

11.13 The joint working between health and social services at all levels including service delivery will greatly benefit from the introduction of information technology which

is compatible. The change-over to computer systems will need to be well managed across as well as within both sectors.

11.14 Data collection in primary care has great potential for providing community based information about psychiatric morbidity as long as due attention is given to reliability and validity of categories used. Data collection in primary care should be done under local agreement. FHSAs have a facilitating role in achieving this.

11.15 Stages in the implementation of a mental health service user information system may include:

11.15.1 ***Information audit:***

investigate current information flows – within the NHS and between NHS and SSDs – and rectifying blockages;

establish information needs – at service provider (both management and staff), purchaser and Regional level. Staff and service users should be involved in this process;

review current information technology in mental health and consider appropriate IT for mental health information systems.

11.15.2 ***Establishing mechanisms for implementation:***

establish joint information collection between health and social services;

establish timetable for introduction of compatible computer systems.

References

DEPARTMENT OF HEALTH NHSME (1992) *Information systems in mental health.* London: NHSME.
ROYAL COLLEGE OF PSYCHIATRISTS (1992) *Report of Mental Health Services Information Group.* London: RCPsych.
SAYCE, L. (4 July 1991) Registering: A risky business. *Social Work Today,* 12-13.

Appendix 11.1

MENTAL AND BEHAVIOURAL DISORDERS, INCLUDING DISORDERS OF PSYCHOLOGICAL DEVELOPMENT

The International Statistical Classification of Diseases, and Related Health Problems, Tenth Revision, Volume 1 (ICD-10) describes 10 broad categories of mental and behavioural disorder. These are re-produced below with the permission of the World Health Organisation.

F0 Organic mental disorders, eg
- F00-F03 Dementias
- F04 Organic amnesic syndromes
- F05 Delirium

F1 Mental disorders due to use of psychoactive substances, eg
- F10 Alcohol
- F11 Opioids
- F12 Cannabinoids

F2 Psychoses, eg
- F20 Schizophrenia
- F22 Persistent delusional disorders
- F25 Schizoaffective disorders

F3 Affective disorders, eg
- F30 Manic episodes
- F31 Bipolar affective disorder
- F32 Depressive

F4 Neurotic, stress-related and somatoform disorders, eg
- F40 Phobic anxiety disorders
- F41 Generalized anxiety disorder
- F42 Obsessive-compulsive disorder
- F43 Stress and adjustment disorders
- F44 Dissociative disorders
- F45 Somatoform disorders

F5 Behavioural syndromes associated with physiological disturbances and physical factors, eg
F50 Eating
F51 Sleep disorders
F52 Sexual dysfunction

F6 Disorders of adult personality and behaviour, eg
F60 Specific personality disorders

F7 Mental retardation

F8 Disorders of psychological development, eg
F80 Disorders of speech and language
F84 Includes autism and Asperger's syndrome

F9 Disorders with an onset in childhood

Appendix 11.2

INFORMATION REQUIREMENTS

1. Information systems need to be capable of sorting and extracting at different levels of detail and for different purposes – management and care staff. This appendix describes in broad terms some of the information managers may wish to consider including in designing a mental health information system. Although much will similar to basic information collected in good patient information systems throughout the NHS, a mental health information system will also need to collect information on broader socio-demographic characteristics to develop epidemiological data. (See also Appendix 3.3 on brief standardised assessment measures).

2. A minimum data set of information for mental health services is being drawn up as part of the Community Information Systems Project and will be discussed with the NHS in 1993.

3. Information areas that managers should consider including in an information database are:

   Name
   Address/Postcode
   Unique identifier (eg NHS number)
   Date of Birth
   Sex
   Marital status
   Ethnic origin (OPCS Census classification)
   Housing tenure (eg owner occupier, council, NHS or social services residence, homeless etc)
   Living alone indicator
   Household composition
   Employment status
   Source of referral (eg GP, social worker etc)

Mental illness condition (ICD-10 classification)

Physical illness (ICD-10 classification)

Physical disability (ICD-10 classification).

Detained under Mental Health Act (legal status).

Key worker profession (eg CPN, ASW etc).

Treatment (eg drug, ECT, therapy etc).

Additional information for suicides and parasuicides

Severely mentally ill indicator

Previous parasuicide(s)

- date(s)
- method(s)

Method of suicide/parasuicide

Contact with GP recent to suicide/parasuicide (inc reporting symptoms etc)

Changes in family circumstance recent to suicide/parasuicide (eg bereavement, divorce etc).

CHAPTER 12

ESTABLISHING PURCHASING AND MONITORING ARRANGEMENTS

ESTABLISHING PURCHASING AND MONITORING ARRANGEMENTS

Action summary

All NHS and SSD Managers

- Continue to review mechanisms of quality assurance.
- Establish joint monitoring mechanisms between NHS and LAs.
- Involve voluntary organisations and users in monitoring processes.

RHAs

- Monitor DHAs and FHSAs through corporate contracting process.
- Establish Codes of Practice for using non-NHS bodies in monitoring processes.

FHSAs

- Can assist and monitor GP fund-holders in developing purchasing plans.

NHS (DHA and GPFH) Purchasers and Directors of SSDs

- Develop contracts for a wide range of services, including the CPA, and the provision of continuing care and emergency access (including medical staff approved under the Mental Health Act).
- Develop joint purchasing arrangements.
- Use contracting process pro-actively to negotiate with existing and potential providers to achieve changes in service provision.

Contracting

12.1 Contracting is a powerful tool with which purchasers of mental health services can shape service provision and implement change.

12.2 Purchasers need to develop a clear vision of service development – based upon a thorough assessment of need, a respect for autonomy and an understanding of the

range and suitability of different service settings and treatments. Prospective contracting – drawing up provisional contracts looking forwards over a five to ten year period – will draw this vision to the attention of the service by:

- setting a timescale for change and progress.
- signalling purchasing intentions to existing and prospective providers enabling them to put in place the mechanisms to meet the planned contracts.

12.3 Contracts should aim adequately to describe what should be delivered without being over-prescriptive in the finer detail of how providers are to meet the objectives set. Contracts will clearly to need address the needs of users.

12.4 The Report of the Health of the Nation Focus Group, First Steps for the NHS, issued in November 1992, set out a first tier of key recommendations for consideration in the contracting process for 1993/4. Purchasers will also want to consider what other measures they will need to incorporate in their future contracts, using the proposals outlined in this handbook as guidance. Some of the key areas purchasers will wish to address in their contracts are:

- user involvement – including access to advocates
- the range of services required
- quality standards – including the rights of users
- staff – making time available for training and multi-disciplinary audit of treatment and suicide as well as direct patient care; ensuring that skill mix in teams is addressed
- service providers' responsibilities under the Mental Health Act and Children's Act
- arrangements for emergency access to members of mental health teams, including to staff recognised under the Mental Health Act
- the implementation of the CPA and care management, including arrangements in discharge planning
- the provision of services for particular groups – such as the need for continuing care beds and services for mentally disordered offenders. Contracting provides an opportunity to incorporate the services for mentally disordered offenders into mainstream services
- monitoring arrangements – including independent monitoring

- clear policies for managing suicidal patients in hospital, including observation policies.

12.5 The following table suggests some of the key considerations purchasers may wish to take into account when seeking to purchase the needs of particular groups or conditions.

	Examples of purchasing considerations
Homeless people	Requirements for supported accommodation; Specialist teams or workers.
Children and Adolescents	Protection of specialist mental health workers, teams and units. Co-ordination of service delivery between child and adult, mental health, generic social services and education services.
Elderly people	In-patient dementia assessment facilities, respite, day care and community services including CPNs.
Black and other ethnic minority groups	Issues of access and acceptability. Interpreting and advocacy services.
Women	Choice of female keyworker/theropist. Single sex areas in units.
Mentally disordered offenders	Integration with mainstream services. Inclusion of court diversion scheme and local secure units.
People with learning disability and mental illness	Co-ordination of service delivery between child and adult mental health and specialist learning disability services.
People with eating disorders	Access to specialist in-patient facilities on sub-Regional basis. Availability of family and cognitive therapy.
People with puerperal disorders	In-patient facility – local, but need for appropriately trained and experienced staff may necessitate tertiary referral.
Liaison psychiatry	Defining responsibility in contracts with provider units.
Physical and mental illness	Definition of responsibility for liaison psychiatry services in contracts with provider units.
Pre-senile dementias, brain damage	Advantages of local provision balanced against development of more specialist but sub-regional units.

12.6 The Mental Health Act Commission has a statutory duty with regard to detained patients and in response to a survey of Health Authorities has developed contract guidance for contracting for Mental Health Act services (see Appendix 12.1).

Joint purchasing

12.7 Joint purchasing now offers an effective mechanism through which funding for mental health services can be channelled. Joint Consultative Committees may be appropriate to have oversight. Joint purchasing will:

- facilitate a seamless service
- ensure the most appropriate delivery of care
- increase inter professional co-operation
- eliminate the duplication of resources.

12.8 The cultural differences between the NHS and SSDs should not be underestimated. Perseverance may be needed in negotiating a mode of working acceptable to both organisations. A staged approach to the inclusion of all specialist mental health services in a joint purchasing arrangement will facilitate the transition. In moving towards joint purchasing, DHAs, FHSAs, GPFHs and SSDs will wish to consider:

- drawing up an agreed strategy and plan, including timetable, for full implementation of joint purchasing, ensuring that a full range of services is available during the period of transition
- identifying specific areas – such as staffed residential accommodation for people with mental illness, or day care etc – for initial joint purchasing. Joint Care Planning Teams can be useful in developing and defining areas to be covered
- establishing a system to identify those patients properly the responsibility of the NHS and therefore entitled to free health and social care
- establishing jointly staffed community teams in each locality and better systems of joint work between social workers, CPNs and GPs and other members of primary health care teams
- transferring resources with patients as they move from long-stay hospitals to social service settings.

Monitoring progress

12.9 Monitoring is integral to management arrangements. Monitoring will assist in:

- assessing progress towards local and national targets
- identifying any inhibitors in making progress towards targets and enabling early and effective management action
- ensuring that service users do not suffer loss of benefit at the interface between health and social service delivery of care
- ensuring equal opportunities in service provision are effectively applied, for example by having a named person in the purchasing authority to monitor equal opportunities practice in providers.

12.10 Particular aspects of monitoring which managers at both purchaser and provider level will want to consider include:

- monitoring both quantity and quality aspects of service provision
- monitoring patients' rights – particularly where people are detained under the Mental Health Act
- monitoring from the user's perspective to help identify gaps in the service which otherwise may go unnoticed
- joint monitoring between the NHS and SSDs.

12.11 Effective monitoring of services can be enhanced by the inclusion of monitors independent of the health or social services, particularly organisations representing or controlled by users. They may be especially helpful in monitoring quality standards, such as accessibility and information provision etc. Monitors may include:

- Community Health Councils
- voluntary organisations
- advocacy workers
- user groups
- primary care workers.

12.12 Purchasers and providers can support them in this role by:

- making full information available
- ensuring rights of access to premises and appropriate management meetings
- providing adequate funding.

Regional role in monitoring

12.13 RHAs will need to monitor DHAs through corporate contracts. They can call upon the Health Advisory Service to assist in monitoring good practice (see Appendix 12.2).

12.14 RHAs can be influential in ensuring that CHCs and the voluntary sector organisations are given a role in helping to monitor services.

Central monitoring

12.15 The NHS Management Executive (NHSME), RHAs and the Social Services Inspectorate (SSI) have discrete and specific roles in monitoring progress towards the Health of the Nation Mental Health Targets and the implementation of the Community Care Act, which will contribute towards meeting these targets in mental illness.

12.16 The role of the SSI towards SSDs is less directive. However, SSI has specific responsibility for monitoring the use of the Mental Illness Specific Grant and powers of inspection of certain services.

References

BRITISH PSYCHOLOGICAL SOCIETY (1992) *On advising purchasers.* Leicester: BPS.

GLEAVE, R. & PECK, E. (1992) Images of the contracting process. *Journal of Mental Health,* **1,** 219-229.

GROVES, T. (1990) After the asylums: the local picture. *British Medical Journal,* **300,** 1128-1130.

HOOD, S. & WHITEHEAD, T. (August 1990) One path to a comprehensive District psychiatric service. *Health Services Management,* 174-7.

KNAPP, M. & BEECHAM, J. (1992) Costing mental health services. *Psychological Medicine,* **20, 4,** 893-908.

LAVENDER, A. & HOLLOWAY, F. (1988) *Community Care in Practice.* Chichester: Wiley.

MURPHY, E. (1991) *After the asylums.* London: Faber and Faber.

PECK, E. & SMITH, H. (1991) *Contracting for mental health services.* National Health Services Training Authority.

REED, J. & LOMAS, G. (1984) *Psychiatric services in the community.* London: Croom Helm.

Appendix 12.1

CONTRACTING FOR PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983

The following are suggested paragraphs prepared by the Mental Health Act Commission for inclusion in contracts or service agreements covering services which will or may include services for patients detained under the Mental Health Act 1983.

A. The appropriate requirements and procedures contained in the Mental Health Act 1983 (the Act) and the Regulations made under the authority of that Act shall be complied with in respect of any person to whom the Act applies whilst a patient receiving services under this contract/service agreement.

B. Reports shall be submitted at the required intervals to the Mental Health Act Commission in accordance with powers delegated to it by the Secretary of State in fulfilment of his responsibilities under S.61 of the Act in respect of patients to whom this section applies.

C. The statutory 'Managers' as defined in the Act and amendment (the district health authority or directors of the trust) will ensure that their responsibilities:

   i. to review the continued detention of patients in respect of whom the Responsible Medical Officer has submitted a report in accordance with S.20 of the Act.

   ii. in the exercise of their powers of discharge under S.23 of the Act to consider requests by detained patients for a review of their detention.

   are delegated to a committee or sub-committee of the authority or trust board which shall include only non-executive members and be properly authorised in accordance with S.23(4) of the Act. Non-executive and any co-opted members should be suitably experienced or receive training.

   They will also ensure that their other statutory powers and duties are clearly delegated to competent officers and properly fulfilled.

D. The guidance contained in the Code of Practice issued by the Secretary of State in accordance with S.119 of the Act together with any subsequent amendments and additions shall be observed as minimum standards.

E. In addition to compliance with the requirements of the Hospital Complaints Procedure Act, 1986 arrangements should be made to handle complaints from mentally disordered people which recognise that their state of mind may prevent them from formulating complaints or may lead to valid complaints being regarded as a manifestation of their condition.

F. The death of any person which occurs whilst detained under the provisions of the Mental Health Act, 1983 shall immediately be notified to the Mental Health Act Commission. Copies of reports for any inquest and arising from any investigation into the circumstances surrounding the death should be provided to the Commission together with the date of any inquest.

G. No patient covered by this contract/service agreement shall be disadvantaged or suffer adverse discrimination in any aspect of their care or treatment as a consequence of cultural, racial or sexual characteristics, or any form of handicap and the requirements of relevant legislation must be observed.

Appendix 12.2

Examples of Service and Staff requirements for Contracting

Area of Need [1]	Examples of Service Response	Examples of Staff Involvement
Mental health problem	Psychotherapy, medication, 'crisis' accommodation	GP, Multi-disciplinary team (MDT)
'Challenging' behaviour	Psychotherapy, advocacy, medication, in-patient care	MDT, voluntary agency
'Negative' behaviour	Sheltered day occupation, recreational activities, stimulating environment	Occupational, speech, art therapist, MDT
Problems in self-care	Rehabilitation service, day care, support in home, supported accommodation	Occupational therapist, MDT
Social problems	Welfare rights advice, 'drop in centre'	Citizen's advice bureau, Social worker, MDT
Physical health	Physical care, unit for pre-senile dementia	GP, chiropodist, physiotherapist, dietitian
Behaviour in relation to care – 'compliance'	Assertive outreach, care management, advocacy	MDT, voluntary organisations
Quality of life	Patients council, quality circles	Managers, MDT

[1] From 'Brief Standardised Assessment' (see Appendix 3.3).

CHAPTER 13

EVALUATING OUTCOMES AND DISSEMINATING INFORMATION

EVALUATING OUTCOMES AND DISSEMINATING INFORMATION

Action summary

All NHS and SSD Managers

- Agree criteria and establish mechanisms for evaluating measures to achieve targets.
- Establish mechanisms to publicise local strategies and progress towards targets.

The need for evaluation

13.1 Evaluation is necessary to understand whether and why particular initiatives are succeeding or failing. It will highlight areas where methods of health promotion and service provision will need to be developed or changed and suggest strategies to achieve these changes. Managers will wish to evaluate the structure, process and outcome of each project.

Criteria for evaluation

13.2 The following, based upon work by Shaw (see References), suggest criteria against which evaluation can take place:

appropriateness:

the service or procedure is what the population or individual actually needs.

equity:

a fair share for all the population according to their needs.

accessibility:

services are not compromised by undue limits of time, distances or information on user rights or the services available and do not exclude particular groups due to its characteristics, structure, ethos or referral system.

effectiveness:

achieving the intended benefit for the individual and for the population.

acceptability:

services are provided such as to satisfy the reasonable expectations of patients, providers and the community.

efficiency:

resources are applied to the maximum benefit of each service user without being to the detriment of another.

13.3 It is important to evaluate the quality of service delivery as well as quantitative targets.

13.4 As with monitoring, independent evaluation carried out by users of services and voluntary organisations can provide useful insights.

13.5 Methods of evaluation will need to be agreed jointly with alliance partners.

Dissemination of information

13.6 DHAs, FHSAs and SSDs should work together to ensure that information is shared between managers, clinicians and social workers to ensure that staff understand the processes and change being implemented and have an opportunity to feed back information. Managers will want to ensure staff and the local population are informed of:

- the goals of the strategy
- the reasons for the strategy and the chosen targets
- progress towards the primary and local targets.

13.7 If the local population is going to work with the NHS to achieve the targets set out in the Health of the Nation, it needs to be given full and accurate information. Public relations exercises which hide difficulties and problems will soon lead to distrust and undermine progress.

13.8 Similarly, informing alliance partners of any process and outcomes developments in implementing strategies for change will enable them to work most effectively with the NHS and SSDs in order to achieve the aimed for improvements in mental health and reduction in suicide rates. Networking information between alliance partners can help:

- spread good ideas
- give a sense of achievement
- boost morale.

13.9 Achievement of the primary targets will not be instantaneous. In particular, the poor information base and historic mismatching of resources to need in the provision of mental health services will need to be addressed before real progress can be made. An honest appraisal of the local situation should be made and disseminated.

13.10 In addition to forming alliances with local media to spread information, such as through regular editorial space in local newspapers (see chapter 4), managers may also wish to establish specific organs of communication both with the public and between alliance members. This process may best be led at Regional level.

References

CHARLWOOD, P. (1992) Managerial creativity and mental health services. *Journal of Mental Health*, **1**, 201-6.

CLIFFORD, P. *et al* (1989) *Assuring quality in mental health services.* London: Research & Development in Psychiatry/Free Association Books.

INSTITUTE OF HEALTH SERVICE MANAGERS (1991) *Managing mental health services: Report of project group chaired by P Charlwood.* London: IHSM.

KING, D. (1991) *Moving on from mental hospitals to community care. A case study of change in Exeter.* London: Nuffield Provincial Hospitals Trust.

MCKEE, L. & PETTIGREW, A. (17 November 1988) Managing major change. *Health Services Journal*, 1358-60.

PECK, E. (1991) Power in the NHS: Case study of a unit considering NHS Trust status. *Health Services Management Research*, **4, 2**, 120-30.

SHAW, C. (1986) *Introducing quality assurance.* London: King's Fund Centre.

SMITH, H. (1992) Quality in community care: moving beyond mediocrity. *Journal of Mental Health*, **1**, *207-21.*

ANNEX

POLICY PERSPECTIVE

A.1 In-patients numbers in mental illness hospitals have risen and fallen dramatically over the past two centuries.

- Rehabilitation and early discharge regimes had been established in many hospitals by the 1950s, notably Mapperley, Netherne and Warlingham Park and the reduction in beds, in the former particularly, had been occurring for a number of years before the national peak of 1954.
- The introduction of a new generation of effective drugs, especially anti-psychotics and anti-depressants, also contributed. But in other European countries, including France where chlorpromazine was first introduced, the peak number of patients resident in mental illness hospitals came years after that in England and in a number of countries, eg Japan and Korea, where such drugs are readily available, residency continues to rise.
- Social attitudes and social policies appear to be crucial.

Mental Health Policy Developments 1957-1992

1957 Report of the Royal Commission on the Law relating to Mental Illness and Deficiency
1959 Mental Health Act
1962 Hospital Plan for England and Wales. Ministry of Health White Paper
1975 Better Services for the Mentally Ill. DHSS White Paper
1976 Joint Care Planning: Health and Local Authorities. DHSS Circular
1981 Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England. DHSS
1983 Mental Health Act
Care in the Community. DHSS Consultative Document
1985 House of Commons Social Services Committee Report on Community Care with special reference to adult mentally ill and mentally handicapped people
1986 Making a Reality of Community Care. Audit Commission
1988 Community Care: Agenda for Action. Sir Roy Griffiths
1990 Caring for People. Community Care in the Next Decade and Beyond White Paper
NHS and Community Care Act
House of Commons Social Services Committee Report on Community Care: Services for People with a Mental Handicap and People with a Mental Illness Community Care in the next Decade and Beyond: Policy Guidance DH Care Programme Approach
Mental Illness Specific Grant
1992 Mental Illness Key Area in "Health of the Nation". DH White Paper

A.2 'Care in Action' (1981) identified three main tasks for health authorities developing services for people with mental illness:

- to create a local, comprehensive mental illness service in each health district, reducing the catchment area of multi-district mental illness hospitals to their own districts
- to create a psychogeriatric service in each health district
- to arrange for the closure of those mental illness hospitals which are not well-placed to provide a service to their local district, and which are already near the end of their useful life.

A.3 'Care in the Community' (1983) reinforced this bringing together a number of themes including joint working and cost-effectiveness.

A.4 MIND's 'Common Concern' published in the same year has been influential by:

- describing the views of a multi-disciplinary group on the philosophy and components of comprehensive services
- drawing attention to the burgeoning user/self-advocacy movement.

MIND's Eight Principles:

A local comprehensive service is one which:

1. Values the client as a full citizen with rights and responsibilities, entitled to be consulted and to have an active opportunity to shape and influence relevant services, no matter how severe his or her disability.
2. Aims to promote the greatest self-determination of the individual on the basis of informed and realistic choice.
3. Aims to provide and evaluate a programme of treatment, care and support based on the unique needs of the individual, regardless of age or severity of disability.
4. Aims to minimise the dependence of the client on professional resources, but which does not allow this as an excuse to withdraw appropriate services.
5. Aims to meet the special needs arising from disability through a locally accessible, fully co-ordinated multi-disciplinary service offered by appropriately trained staff.
6. Is easily accessible locally, and delivered, wherever possible, to the client's usual environment.
7. Plans actively for those in institutions to reintegrate into society if they so wish.
8. Aims to enhance the individual or collective capacity to cope with or alleviate distress.

A.5 The Social Services Select Committee of the House of Commons (1985) expressing concern about community services commented that:

'any fool can close a mental hospital: it takes time and trouble to do it properly and compassionately'.

A.6 The Audit Commission reported similarly in 'Making a Reality of Community Care' (1986). The Report of the Committee of Inquiry into the Care and After-Care of Sharon Campbell (1988) investigated the circumstances in which a social worker, Isobel Schwarz, was killed by a severely mentally ill person. It concluded with a series of recommendations for action.

A.7 NHS and Community Care Act.

A.7.1 The relevant general policy aims underlying the Act are:

- to enable people to live as normal lives as possible in their own communities
- to provide the type and quality of service that will support each individual to take the fullest possible part in social and community life
- to give more choice and influence to service users and to carers.

A.7.2 It gives a leading role to Local Authority Social Service Departments as purchasers of services for 'care in the community';

- making explicit the duty to assess the social needs of the individual for services
- requiring community care plans to be formulated in consultation with other key agencies.

A.8 Joint Department of Health/Home office Review of Services for Mentally Disordered Offenders and others requiring similar services.

A.8.1 The Steering Committee was established under the chairmanship of Dr John Reed to determine whether:

- changes are needed in the current level, pattern or operation of services
- ways of promoting such changes can be identified having regard to The NHS and Community Care Act; the recommendations of the Efficiency Scrutiny on the Prison Medical Service (now Health Care Services for Prisons); and any relevant recommendations from the Woolf Inquiry.

A.8.2 Consultation papers were issued during the course of the review (January 1991-July 1992) which contained 270 recommendations. Some have already been endorsed by Ministers and others are still being consulted on, and will then be considered further. A final report was published in November 1992.

A.8.3 Ministers have reaffirmed the Government's policy that wherever possible **mentally disordered offenders should receive care and treatment from health and social services rather than in custodial care.**

A.8.4 They have also endorsed five guiding principles which are that patients should be cared for:

- with regard to the quality of care and proper attention to the needs of individuals
- as far as possible, in the community, rather than in institutional settings
- under conditions of no greater security than is justified by the degree of danger they present to themselves or others
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life
- as near as possible to their own homes or families, if they have them.

A.9 Central London Homeless Mentally Ill Initiative.

A.9.1 Five multi-disciplinary psychiatric teams have been established in Central London to re-introduce homeless people with mental illness to mainstream mental health services. Specialist hostel provision is being developed to supplement that already provided by voluntary organisations and statutory services and longer term accommodation is to be provided through the Housing Corporation. Evaluation of the project is being carried out by Research and Development for Psychiatry.

A.10 Care Programme Approach – aims to improve co-ordination of services and collaboration between the various statutory agencies involved, users and carers.

A.11 Care management – is led by Local Authorities and will combine with the CPA in co-ordinating care for those with the most complex needs.

A.12 Mental Illness Specific Grant – is payable to Local Authorities to enable development of social care services. Over 500 projects were funded in the first year of the grant's operation. The grant is monitored by SSI.

A.13 The Mental Health Task Force – in response to a review of services for the severely mentally ill, a Task Force is being established, led by Mr David King, former District General Manager of Exeter Health Authority, to expedite the effective implementation of mental illness services.

A.14 The Capital Loans fund was set up to assist authorities in developing community based services in advance of closing old mental hospitals. Bridging finance has been made available to RHAs since 1990/1 totalling £63 million in 1992/3. This has allowed the creation of over 1400 community places by 17 different projects.

A.15 A Review of Mental Health Nursing was announced by Secretary of State in April 1992. The Report will be submitted to Ministers in October 1993. The review's terms of reference are:

"In the light of developments in the provision of services for people with mental illness to identify the future requirements for skilled nursing care."

A.16 Finally, the inclusion of mental illness as a key area in Health of the Nation clearly signals the commitment that Ministers have to developing comprehensive mental health services of high quality. Follow up to the White Paper has included the publication in November 1992 of "First Steps for the NHS", setting out a range of possible actions which the NHS might take in 1993-94, and this handbook.

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