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Health Policy Matters

HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

Introduction by Peter Kennedy

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The National Service Framework (NSF) for Mental Health highlights the new standards for mental health services. Though it is not prescriptive about how they are to be achieved, it is raising hopes amongst users, carers and the people delivering services.

Most areas start from a low base. There is great concern and dissatisfaction about acute in-patient care, which accounts for two-thirds of mental health budgets. Alternative services like home treatment and assertive outreach are difficult to implement and have quite high risks of failure. It has yet to be demonstrated that psychological therapies shown to be efficacious in small randomised controlled trials will be effective and affordable under normal service conditions.

The NHS is giving much higher priority to research on service delivery and organisation. 'Learning Centre' techniques imported from the US are being developed to engage clinical teams in implementing service changes on a broad front over much shorter periods of time than has been seen hitherto.

As this analysis of the NSF illustrates, much closer linkages are required between service development, service evaluation, and training. New approaches are needed in all three areas.

Background

A number of factors underpin the government's decision to target mental health as the first in a series of NSFs promised in the Health White Paper:

- Recognition of the impact of mental health problems on the health of the population and the associated costs to society as a whole.[1] Common mental health problems such as anxiety and depression affect one in six adults. Around 1% of adults aged 16–64 will experience a severe mental illness, like schizophrenia.[2]
- Concern about gaps in service and inexplicable variations in the quality and standard of provision.
- Frustration about the pace of change in services and a perception by politicians that community care was failing in key areas.
- A need to improve the co-ordination of care and a recognition that no single agency can provide solutions.[3] An integrated approach is required as social services, housing, education and employment services all have an important role to play alongside the NHS in responding to the needs of people with mental health problems.
- The political impact of some high profile cases where inadequate care and co-ordination was found to have compromised the safety of patients and the public.

The NSF was developed as a result of the work of an External Reference Group, which consulted widely across the relevant sectors. It is aimed at mental health services for working age adults with a further NSF for Older People due to be published later this year.

The NSF identifies seven standards for services. Each is accompanied by a rationale with suggested interventions based on a review of research evidence. Examples of good practice are included. Local flexibility based on need is encouraged, but there is a clear political imperative, over time, to ensure equity in provision of and access to services across England and Wales.

This issue: Mental Health

Implementing the National Service Framework

This issue of *Health Policy Matters* looks at the key standards in the NSF for Mental Health and examines the evidence for effective strategies. It identifies the implications and lists action points for service providers and local stakeholders.

Full text on our web site at www.york.ac.uk/depts/hstd.

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The seven standards

Mental health promotion

Standard one

Health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Primary care and access to services

Standard two

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

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

Standard three

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care
- be able to use NHS Direct, as it develops, for first level advice and referral on to specialist helplines or to local services.

Effective services for people with severe mental illness

Standard four

All mental health service users on the Care Programme Approach (CPA) should:

- receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk
- have a copy of a written care plan
- be able to access services 24 hours a day, 365 days a year

Standard five

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

- timely access to an appropriate hospital bed or place, which is:
  - in the least restrictive environment consistent with the need to protect them and the public
  - as close to home as possible
- a copy of a written after care plan

Caring about carers

Standard six

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

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- have their own written care plan which is given to them and implemented in discussion with them.

Preventing suicide

Standard seven

Local health and social care communities should prevent suicides by:

- meeting the previous six standards *and in addition*:
- supporting local prison staff in preventing suicides among prisoners
- ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk
- developing local systems for suicide audit to learn lessons and take any necessary action.

The evidence

Service mapping

There is evidence that health promotion targeted at those at high risk, such as adults and children with poor social and economic circumstances and adverse life events, can be effective at preventing mental illness.[4]

Local plans should ensure that education, housing, and employment services work with health, social and voluntary sector agencies in such programmes. The resourcing of this activity will require a change of focus in the existing health promotion budget and other resources related to health promotion.

There is concern about the pressures on acute beds, the poor quality of care in acute wards[5,6] and there is a recognition that many people's outcomes would be improved in a system offering more flexible options for staffed accommodation.[7] Service mapping will need to ensure that a spectrum of care is available, from independent living in people's own homes through to supported accommodation and secondary/tertiary care.

Service access

The NSF highlights the lack of adequate crisis services and 24 hour access for people in distress. There is evidence that crisis resolution and home care services provide an effective alternative to hospital admission.[8] As NHS Direct develops it will need good links to specialist local and national helplines and to services.

The workforce

It is known that cognitive behavioural therapy is effective in a range of mental disorders [9] and there is growing evidence for its effectiveness in psychosis.[10,11] Family interventions in schizophrenia may decrease hospitalisation, increase compliance and reduce relapse.[12] The newer atypical anti-schizophrenia drugs may well be more acceptable to service users, but their real world acceptability, clinical and cost effectiveness has yet to be demonstrated. In the meantime mental health professionals can make their own contribution to medication management and compliance by being sensitive to untoward side effects, adjusting doses and avoiding polypharmacy.[13] In building effective capacity, training programmes will need to develop those skills for which there is clear evidence of effectiveness.

Co-ordination and liaison

Most people with mental health needs are seen in primary care settings. Meeting the needs of staff in primary care for training in the recognition and detection of mental health problems, for assessment skills and implementing effective interventions will be vital. PCGs are charged with a duty to develop protocols for referral, assessment, treatment and care with specialist services. The specific needs of

people with serious mental illness mean that co-ordination of care is vital and this is one of the key past failures.[14] The Care Programme Approach in the NHS and Care Management, as applied in local authorities, must now be fully integrated. Local managers are required to ensure that the number of integrated health and social services Community Mental Health Teams (CMHTs) increase by 50% between 1999-2002. Assertive community treatment (ACT) can be effective in reducing admissions and in maintaining contact with people who are difficult to engage.[15] ACT teams are now being established at a rapid pace but it will be important to ensure that they are developed in accordance with the emerging evidence on factors which determine their effectiveness.

Better co-ordination is also required between mental health and A & E services. Improved liaison can provide better assessment and speedier access to treatment and services, as a contribution to reducing deliberate self harm and suicide.[16]

The problems of mental health and co-existing substance misuse mean that there needs to be better arrangements between these services.[17] Large numbers of people who commit suicide have a history of substance misuse.[18]

Prison suicides have increased by over 300% between 1986–1997.[19] CMHTs must provide support with risk assessment in prisons and in-reach services to improve the quality of mental health care in prisons.

Users and carers

All agencies need to ensure that users are fully involved in the planning, delivery and evaluation of mental health services. Users and carers must also be involved in education and training to ensure services are responsive, culturally sensitive, gender sensitive and acceptable to people. Many user groups are suggesting they take a more formal role in providing user led advocacy services and agencies will have to rise to this challenge. The Carers (Recognition and Services) Act 1995 has not been implemented well in mental health services despite evidence that carers welcome a comprehensive assessment of their needs.[20]

Service configuration

A range of different service models is developing across the country. Somerset, for example, has experimented with a fully integrated health and social care provider Trust for mental health. Manchester HA and the City Council have created a joint post to lead mental health services in the City. The NSF permits applications from Primary Care Trusts (PCTs) to provide mental health services, against strict conditions. However some Health Select Committee members have suggested that PCTs may lack the expertise required to assume responsibility for mental health services.[21] Whatever the local arrangements may be it is vital that primary care, specialist mental health services, social care and other agencies are co-ordinated in such a way as to deliver real progress and not present obstacles to achieving the aims of the NSF.

Implications for services and local stakeholders: key messages

The NSF poses challenges for local commissioners, managers and service providers in all sectors. The government has stated that it sees a ten year framework for its delivery, which allows time for realistic planning. See below for a list of key issues for immediate action.

Action points

- Map the local service provision and identify any deficits including workforce, information and management resources, and local health promotion activity.
- Establish a local implementation team with clear roles for key players and clear reporting lines and accountability. Ensure that credible business plans, with objective and measurable targets are fully integrated into local Health Improvement Plans.
- Ensure user and carer views inform all aspects of NSF implementation and build a good database of local, regional and national user and carer networks that can assist.
- With all agencies and colleagues in the local health and social care economy, consider how the new flexibility to pool budgets under the NHS Act (1999) might assist faster and better-focused development. Local Health Improvement Plans need to reflect the emphasis on 'whole systems working' in providing an integrated mental health service.
- Consider some longer term local goals, say over a five-year time-frame, and agree some early milestones for measuring success.
- Involve the education consortia early to assess the human resource and training implications for the short, medium and longer term. Recruiting and retaining a skilled and flexible workforce across sectors will be vital.
- Aim for shared in-service training across agency and professional boundaries, supported by input from users and carers
- Develop joint monitoring systems, involving service users which can track the progress of services and any new initiatives.
- Ensure that local R & D activity in mental health supports the implementation of the NSF. In addition to continuing research activity into the effectiveness of clinical interventions and the dissemination of these findings, it will be important to investigate the most effective ways to organise and deliver services.
- Ensure the early development of a communications strategy to share what is being considered locally with all agencies and stakeholders.
- Ensure there is robust review of all local health promotion activities to reflect the new emphasis on health promotion in mental health.

How will implementation of the NSF be monitored?

Progress on the implementation of the NSF will be conducted within the NHS and the Personal Social Services Performance Assessment Frameworks. Some performance indicators are identified within the NSF and more are being developed.

Whilst local flexibility in the implementation of the NSF is allowed, the government is serious about assessing the effectiveness of services through these indicators. There will be a rolling programme of reviews of local services carried out by the Commission for Health Improvement in partnership with the Social Services Inspectorate and the Audit Commission. The National Institute for Clinical Excellence, working with a new standing committee, will be developing further guidance on evidence based practice.

Conclusion

The NSF has been broadly welcomed, though some user groups remain suspicious of a real intention to involve them in shaping and evaluating services. It gives strategic direction and the establishment of clear standards sets out what service users can expect from mental health services. There is little to disagree with in the standards but some are very broad and vague and others present difficult challenges. Most of what is contained within the NSF is not new but the requirement to ensure that all the component parts of a comprehensive service are in place is a new departure. The key issue is to consider creative local frameworks that foster local ownership of NSF action and make effective partnership working a reality. Ensuring that the NHS at local level takes appropriate leadership when necessary will be crucial, but clinical factors alone and issues relating to beds, bricks and mortar must not dominate local thinking. Questions of work, leisure, housing, economic well-being, educational opportunity and supportive social networks are equally vital in delivering real improvement to people living with mental health needs. Even allowing for some double counting, the government has made new monies available through modernisation funds and it is clear that they expect to see substantial progress on meeting the standards set out in the NSF.

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