

The Journey to Recovery

**– The Government's vision
for mental health care**



Foreword



This Government has made mental health one of the top three clinical priorities in the NHS. We are backing this up by the largest ever investment in community mental health services. This will allow us to put right, over time, the neglect of mental health services in the past.

The policies we have introduced in the past four years have been designed firstly to provide a clear vision and sense of direction for modernising mental health services, setting out how we want services to develop and grow; secondly to enable and encourage closer partnership working between health and social services and, by no means least, to start investing properly in front line services.

These policies are starting to bear fruit. Many new services are already in place and in every part of the country improvements are well in hand.

There is a lot still to be done, but I am determined to ensure that we allow local people to deliver these changes, in ways that reflect and meet the local needs with which they are all too familiar.

We have set out on the road to recovery.

Jacqui Smith
Minister of Health

Introduction



As many as one in four of us will experience a mental health problem at some time in our lives, which will in turn affect family and friends.

Many *other* people have a direct day to day interest in mental health services. As well as those who use the services, and those who care about them, a wide range of people, through their position or employment, come into contact with mental health services.

This includes local councillors, health service non-executives, CHC members, housing officers, the police, magistrates, employers, GP and hospital staff, volunteers and voluntary organisations.

Few of them are specialists in mental health and it is for them that this booklet has been written. Most will not have seen the various detailed policy documents that have been produced in the past three or four years – yet many may still like to know what Government, together with local mental health organisations, are setting out to achieve.

This booklet provides a short explanation of the policies Government has adopted to improve mental health services for people of working age, what will be achieved for those who use them – and what more still needs to be done.

It is the first step in a broader effort that will be made in the next year or so to keep people informed. There will be an annual national report spelling out what progress has been made, and other publications written for specific staff and other interest groups.

We would welcome your feedback on whether you have found this booklet informative and useful – and on anything more that you feel you would like to know.

Louis Appleby
National Director for Mental Health

Please address any comments on this booklet to:

Julie Nichols, Department of Health, Room 5W28, Quarry House, Quarry Hill, Leeds, LS2 7UE

The legacy

For much of the past hundred years, decaying, depressing old hospitals housed far too many people – often far from their homes – for long periods. Out of hospital, people with mental health problems received little or no help.

In part, this has been due to misplaced attitudes. In the public mind, “madness” has too often been quite wrongly equated to “badness”. Society has shunned and excluded those affected, often denying them work, a decent chance in life, and respect.

The number of people denied their rights in this way is not small. Mental health problems are common – at any one time one in six of us has one. They range from more common conditions, such as depression, to schizophrenia, which affects fewer than one person in a hundred.

Government is now giving mental health the attention – and investment – it deserves. As one of the top three health priorities, new mental health policies aim to:

- undo the legacy of the large institutions – and the stigma inherited from them
- create safe, sound, supportive services – that meet the needs of those who use them
- involve and include people with mental health problems as equal citizens in society.

To overcome a legacy of neglect the Government is committed to:

- new kinds of care that fully meet the needs of people with mental health problems
- new resources – money to pay for more mental health workers
- new ways of planning and managing a single system of mental health and social care
- new laws to support these changes.



John Mahoney and Antony Sheehan
Joint heads of mental health, Department of Health

A century of slow progress

The Victorians who created enormous mental asylums were undoubtedly well intentioned. Sadly, the new “hospitals” quickly became overcrowded and awful places, and people continued to be held, in appalling and largely unchanged conditions, throughout the first half of the twentieth century.

When the NHS inherited these institutions, life in them was still poor. In the post-war years new, more effective, medication became available, and the number of people in hospital started to decline. A Royal Commission led to the Mental Health Act of 1959, and to people receiving care outside of the traditional hospital setting.

A different pattern of mental health care grew slowly from the 1960s onwards. Many places introduced day hospitals, and from the 1970s acute wards in district general hospitals offered an alternative to institutionalisation.

The 1980s saw the start of community mental health teams. Increasingly, non governmental organisations, such as MIND and the National Schizophrenia Fellowship, developed initiatives where people in the community could socialise, get information and help, and develop a sense of self-worth and empowerment.

By the late 1980s, the large hospitals had started to close and those that remained were a fraction of their former size. The *Better Services for the Mentally Ill* set out in a Government White Paper in 1975 had, however, failed to materialise in most places.

In a few areas innovative new services were introduced but, overall, progress was patchy and poor. Services were not meeting needs comprehensively, and those that tried to do so often relied heavily on the commitment of a few pioneering individuals.

In a cash-starved NHS, mental health remained a poor relation among services. Joint planning between health and local authorities was often ineffective; the views of those who used services were rarely sought – and almost never heeded.

The 1990s were not easy times for mental health. Increasingly, staff had to tackle not just mental illness, but drugs, alcohol and violence. Many became frustrated and concerned by the limitations on what they could provide.

With the old asylums closing, and their resources not always reinvested in mental health care, the community too often became a bleak and neglected environment for people with mental health problems.

Hospital beds came under pressure, as the number fell by 3000 between 1987 and 1996, and patients were often shunted off to anywhere that could take them. Shabby, depressing wards – that would never have been tolerated in medicine or surgery – were still common place in mental hospitals. Staff morale was low, and the stigma of being ill remained high.

Several important reports and enquiries in the 1990s found that there were still many defects in mental health services. These included poor communication between the responsible agencies, especially health and social services, and the inadequate use of care plans. One report described the ‘chaos of community care’ – which echoed the experience of many.

New policies for the new millennium

The Government has responded by making mental health one of the top three health priorities – alongside coronary heart disease and cancer. The main planks of its new policies are:

- the white paper *Modernising Mental Health Services*
- *The National Service Framework for Mental Health*
- the chapter on mental health in the *NHS Plan*.

Together, they state a clear and comprehensive plan for mental health services – the first for a quarter of a century. They represent the best opportunity – and the biggest investment – for more than a hundred years, to improve the lives of a large and neglected group of people.

What makes these policies so different?

- The people who use mental health services will be involved, as equal partners and at every level, to ensure the new services make sense
- new policies address the whole range of needs of people with mental health difficulties – from care plans to citizenship
- substantial new money is being provided in every part of the country to make sure the legacy of neglect becomes a part of history
- clear targets have been set, and a timetable for achieving them over the next ten years
- new national and local groups have been made responsible for seeing that this happens.

Modernising Mental Health Services

The new policies were heralded in the 1998 White Paper, *Modernising Mental Health Services*, which proposes local mental health and social services that are:

- **safe** – to protect patients and the public and provide effective care for those with mental illness at the time they need it
- **sound** – ensuring that patients and service users have access to the full range of services which they need
- **supportive** – working with patients and service users, their families and carers, to build healthier communities.

Modernising Mental Health Services

The White Paper sets ten guiding principles. People with mental health problems can expect services that will:

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

The National Service Framework

The *National Service Framework for Mental Health* (NSF) was published in September 1999. It sets out a ten year programme to put in place new high standards of care, which people will be entitled to expect in every part of the country.

The NSF fleshes out the policies in *Modernising Mental Health Services*, by defining models of care and treatment. It also sets milestones and targets against which progress, within timescales, is being measured.

The aims of the National Service Framework standards are:

Mental health promotion – to ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems.

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

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

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

Preventing suicide – to ensure that health and social services play their full part in reducing the suicide rate by at least one fifth by 2010.

The NHS Plan

Published in July 2000, the *NHS Plan* is a programme of radical reform of the NHS. For mental health services there will be over £300 million of new investment by 2004 to implement the *National Service Framework*.

The *NHS Plan* makes a number of pledges for mental health (see panel), including assertive outreach, home treatment and early intervention services for all who need them, more help for people held inappropriately in high secure hospitals or prison, new services for women, and more support for carers.

The NHS Plan will create, by 2004:

- 1000 new graduate mental health staff to work in primary care
- an extra 500 community mental health team workers
- 50 early intervention teams to provide treatment and support to young people with psychosis and their families
- 335 crisis resolution teams
- an increase to 220 assertive outreach teams
- women only day services
- 700 extra staff to work with carers
- more suitable accommodation for up to 400 people currently in high secure hospital
- better services for prisoners with mental illness
- a care plan and keyworker for every prisoner leaving prison with serious mental illness.

Reform of the mental health act

Whenever possible, people with mental health problems should be treated without the use of any compulsion. When this is not possible, a modern mental health service must be supported by legislation that reflects new patterns of care and treatment, respects civil liberties, and promotes effective recovery.

Current mental health law was conceived in the 1950s, with some revision in 1983. The White Paper *Reforming the Mental Health Act*, published in December 2000, puts forward proposals which will keep the best of the existing, tried and tested law, whilst introducing new safeguards for service users and more focus on their individual needs.

Key changes in mental health law include:

- the introduction of a new tribunal system, to authorise any use of long term compulsion only on the basis of assessed needs and individual care and treatment plans
- the possibility of compulsory orders being based in the community, rather than in hospital
- new specialist independent advocacy services available to anyone who is being treated under the Act.

The system for the use of compulsory powers will also be simplified. This will make it clearer when compulsory treatment may be appropriate, due to the risk of self-harm or due to the substantial risk of significant harm to others.

Modernising the Care Programme Approach

The *Care Programme Approach* (CPA) has been central to Government policy since 1991. It was seen as a crucial means to ensure that, following the closure of the old, long stay, hospitals, people with mental health problems received the care they needed, rather than lose contact with services and end up homeless or exploited.

The Care Programme Approach

CPA requires that everyone accepted for treatment or care by mental health services should have

- their needs for treatment and care assessed
- a package of care (care plan) to meet those needs drawn up
- a named mental health worker (keyworker or care co-ordinator) to keep in close touch with them
- a regular review of their needs and their care plan.

Sadly, as late as 1998, studies showed that in many areas CPA was not working. Many service users had inadequate care plans, if one was drawn up at all. Very few received a copy, or knew what was in it. Some did not even know whether they had a care plan, or who was their keyworker, and were not aware of review meetings to discuss their care.

In 1999 revised guidance simplified CPA to two levels of complexity (standard and enhanced), required amalgamation with the social services system of care management, and stressed the need for a written care plan covering a wide range of service users' needs.

Good care planning remains the vital gateway for appropriate access to the new range of services and supports. The more consistent approach now being adopted will be audited at local level, to ensure that any remaining difficulties are overcome.

Modern mental health services

Effective, modern, mental health services must be co-ordinated, so that a comprehensive, integrated system provides continuity of care. Within that system, new services and teams will target help for certain groups that need it most.

Although such an integrated system will contain much that is new, there is no intention of “throwing out the baby with the bathwater”. Those aspects of current mental health services which have proved that they can work well will be retained or enhanced. Examples include community mental health teams, the Care Programme Approach, appropriate hospital care, and many voluntary sector services.

Help at the onset of illness

Some serious mental health difficulties, such as schizophrenia, usually first occur during teenage years or the early twenties. Often young people will be unwell for six months or more before they get any help.

To remedy this unacceptable situation, early intervention teams will be able to provide the intensive support and help that every young person who develops a first episode of psychosis needs.

These teams operate in ways that young people can relate to, providing help and advice on managing symptoms, and will base their care on the belief that engagement, rather than compulsion, is the key to success.

Help in a crisis

At the moment, the only option for most people needing urgent mental health care is admission to hospital. Often this results in too long a period away from home, work and social networks, and can mean that all of these are damaged or lost.

In some areas, special crisis resolution teams make an urgent visit to anyone who is thought to need to go into hospital. Often, the crisis can then be resolved, and by providing intensive treatment at home, a great many hospital admissions can be avoided.

This type of service is one that many people prefer.

Help for frequent users

A small number of people use a lot of mental health services. They are frequently admitted to hospital, often compulsorily, but sometimes lose touch with services soon after discharge. Often they suffer from a dual diagnosis of substance misuse and serious mental illness. A small proportion also have a history of offending.

For this group, assertive outreach teams providing intensive support at home can keep in touch with them, reduce the amount of time they spend in hospital, and help them enjoy a better quality of life.

Community teams

Community mental health teams (CMHTs) will continue to have an important role to play in supporting service users and families in community settings. They should provide the core around which modern mental health services are developed. Their responsibilities may change over time but, working with primary care, they will be the main pathway for referrals to the more specialist teams.

CMHTs, in some places known as primary care liaison teams, will also continue to care for the majority of people with moderate to severe mental illness in the community.

Better help in hospital

Hospitals will also continue to play an important part in mental health care. An effective support system must get the balance right, between better community-based care and high quality, therapeutic inpatient care in good accommodation.

The NHS has been set three national objectives which are:

- to ensure good standards of dignity and privacy for hospital patients
- to achieve the *Patient's Charter* standards for segregated washing and toilet facilities
- safe hospital facilities for patients who are mentally unwell.

What it means ...

...for all of us

Any of us could experience a mental illness at any time. One in four of us will do so during the course of our lives. The Government aims to reduce that figure by improving the mental well-being of the general population, especially people who are most vulnerable to mental ill health.

Another aim is to reduce the stigma and discrimination which faces those of us who do fall ill, and so work against social exclusion or marginalization.

A campaign called “mind out for mental health” has been launched to challenge discrimination by raising awareness of mental health, starting with employers, the media and young people.

One of the biggest problems we could face when we do experience mental health difficulties is keeping our job – or getting work afterwards.

Research undertaken for the Government has shown a poor understanding among employers about mental health issues. The *mind out for mental health* campaign includes a programme – *working minds* – to challenge discrimination in the workplace against people with mental health problems.

The NHS will set an example – health and social services have been asked to promote the employment of people with mental health problems in the services they provide.

Greater opportunities will also be sought for people with mental health problems to access suitable housing, education, welfare benefits and other services, to help empower them to participate in society.

By March 2002, local services must agree plans for mental health promotion, based on local needs, including action in specific settings which could include schools, the workplace and prisons. The plans must also include action at a local level to reduce discrimination.

NSF 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.

...when we consult our family doctor

When we, or a member of our family, experience a mental health difficulty it is likely to be one of the very common mental health problems – such as anxiety or depression. This can be triggered by the sort of life event that can affect any of us – marital problems or break up or other relationship difficulties, redundancy or other money worries, or bereavement.

The first place we go for help will usually be our family doctor. In fact, one in four GP consultations are with people experiencing mental health problems, most of whom are not referred to specialist mental health services.

New guidelines for GPs will ensure that all the people they see with a mental health problem have their psychological needs assessed.

A thousand new mental health workers, trained in proven brief therapy techniques, will help GPs and their primary care teams look after common mental health problems.

In addition, 500 new “gateway” community mental health staff will work with general practitioners and primary care teams, with NHS Direct, and in each accident and emergency department. They will respond to people who need immediate help, and be able to call on crisis resolution teams if necessary.

By 2004, people in all age groups, including children, will have easier access to help if they experience a mental health problem.

Providing more help in primary care will ease the pressure on GP services and have a big impact on the health and well being of the population.

NSF 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.

NSF 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.

...if we use specialist mental health services

For a few of us, our mental health problem will be sufficiently difficult that the best help can be provided by people with specialist training in mental health. Our family doctor may therefore refer us to the specialist mental health services. Usually this will be to a consultant for an outpatient appointment or to a community mental health team.

Care plans

We will then be involved in agreeing a care plan, which identifies our needs and how they can best be met, what we think our recovery goals should be, and what should happen if we experience a crisis. Care plans should recognise our broader social needs.

NSF standard four

All mental health service users on CPA should:

- receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk
- have a copy of a written care plan which:
 - includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator
 - advises their GP how they should respond if the service user needs additional help
 - is regularly reviewed by their care co-ordinator
 - be able to access services 24 hours a day, 365 days a year.

NSF standard five

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

- timely access to an appropriate hospital bed or alternative bed or place, which is:
 - in the least restrictive environment consistent with the need to protect them and the public
 - as close to home as possible
- a copy of a written after care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

By March 2002, the written care plan for those people on the enhanced Care Programme Approach must show plans to secure:

- *suitable employment or other occupational activity,*
- *adequate housing,*
- *appropriate entitlement to welfare benefits.*

By March 2004, this requirement will apply to everyone on CPA.

Early intervention in psychosis

If we are under thirty-five and have developed psychosis, such as schizophrenia, we will receive the early and intensive support we need, through the new early intervention teams which are being set up.

By 2004, this will benefit an estimated 7,500 young people each year.

Crisis resolution

If our problems are so acute that we could require admission to hospital, we will have the choice of earlier and more effective treatment in our own home.

A total of 335 crisis resolution and home treatment teams will be established, which will treat an estimated 100,000 people a year who would otherwise have to be admitted to hospital.

By 2004, all people in contact with specialist mental health services will be able to access crisis resolution services at any time.

The demand for beds will be reduced by 30% and there will generally be no admissions to distant hospitals, unless the expert care of a specialist centre is needed.

Assertive outreach services

The small number of us who become very high users of mental health service services, will benefit from assertive outreach and intensive input seven days a week.

A further 50 teams will be introduced, in addition to the 170 teams already established.

By 2004, assertive outreach teams will be in place to provide such support for everyone who needs it.

...for women

More women than men use mental health services, but services are not always sensitive to the specific needs of women. Women are more likely to suffer from anxiety, depression and eating disorders. One in ten have post-natal depression after childbirth. Women can be vulnerable when receiving care in a mixed sex environment. More attention is needed to the links between childhood sexual abuse and adult mental distress, particularly in women. Very few services are available at present for women who self harm.

Far too many women are kept in conditions of high security, simply because no other service is available for them. The development of alternative services for patients who should not be detained in high secure hospitals is therefore of particular importance for women.

Every health authority in the country must now provide women-only community based day services – as well as providing women-only accommodation in hospital facilities.

A national strategy for women's mental health is being developed. It will pull together mental health issues of concern for women and link with the work of other Government departments. The strategy will ensure that women are listened to and that their views are translated into real change. It will also value the contribution made by the voluntary sector particularly for women in crisis – such as survivors of domestic and sexual violence.

...for people from minority ethnic groups

For far too long the needs of people from minority communities have not been adequately met by mainstream mental health services.

The black and minority ethnic population fares worse than the majority population: African-Caribbeans are 3-6 times more likely to be detained as a result of being diagnosed as suffering from schizophrenia; women born in India and East Africa have a 40% higher suicide rate than those born in England and Wales. For those aged 25–34 the rate is 60% higher.

Many of the services outlined in the *NHS Plan* have proved to be accessible, and far more acceptable, to black and minority ethnic service users. For example black people sometimes regard hospital as a part of the criminal justice system, and the choice to be treated at home puts mental health services in a whole new light. Life on a hospital ward is also alien to the experience of many Asian people.

A strategy to further improve services in the area of ethnicity and mental health is being developed.

...for carers

When carers are asked, what the majority want most is for mental health services to be provided around the clock. They also require time off from caring. This can reduce the social isolation that goes with the job – especially caring for someone with severe mental illness.

New staff will increase the breaks available for carers, and strengthen their support networks.

NSF 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.

...for people in high secure hospitals

Some 300–400 patients in high secure hospitals do not need to be there, but no suitable alternative is available.

200 long-term secure beds are being provided to allow patients to move on, and there will be additional community staff to provide intensive support when people are eventually discharged.

Up to 400 patients will be able to move from the high secure hospitals to more appropriate accommodation.

...for people in prison

At any time about 5,000 people with a serious mental illness are in prison. It is important to improve the detection and treatment of prisoners' mental health problems.

New partnerships, between the NHS and local prisons, will employ some 300 additional staff.

All people in prison who have severe mental illness will receive treatment, and none will leave prison without a care plan and a care co-ordinator.

...for people with severe personality disorder

A very small number of people, who have a severe personality disorder, pose a risk to other patients, staff, and the public as well as to themselves. Suitable services have not been available to help such people, or to manage their behaviour. The role of the current Mental Health Act is not clear, either.

Specialist help for this group of people is being developed, in local mental health services, in regional forensic services, in high secure hospitals and in prisons. A programme of research and evaluation is backing this up. New legislation will set out clearer powers to manage people who pose a serious risk of significant harm to others as a result of their mental disorder, including those with severe personality disorder.

The aim is to help individuals – many of whom are also among the most needy and disadvantaged people in our society – to accept responsibility for their problems and, by changing their behaviour, work towards successful re-integration into the community.

By 2004, an additional 140 places in high secure hospitals together with provision in medium secure units and community hostels will be provided for people with severe personality disorder.

...for people at risk of self harm or suicide

Preventing suicide, or deliberate self harm, is not an easy matter – but the Government has set a firm target to reduce the number of suicides by one fifth by 2010.

The thrust of new mental health policy, and other Government policy, is to make society a better place to live, and to ensure that, if we do have mental health problems, there are safe, sound, supportive services available.

All these developments should help to reduce suicide, but further work is being undertaken, including development of a National Suicide Prevention Strategy to ensure a co-ordinated approach.

In the meantime a range of action has been taken including:

- reducing the pack sizes of paracetamol and aspirin
- supporting people who are at high risk of suicide.*

* Such as developing the CALM helpline (0800 58 58 58) currently covering Cumbria, Merseyside, Greater Manchester and Bedfordshire only to support young men at the onset of depression.

By March 2002 all patients with a history of severe mental illness or deliberate self-harm, must be followed up, by personal contact with a mental health professional, within 7 days of discharge from hospital.

By March 2002 psychiatric in-patient units must review their physical environment and reduce access to means of suicide.

NSF standard seven

Local health and social care communities should prevent suicides by:

- promoting mental health for all, working with individuals and communities (Standard one)
- delivering high quality primary mental health care (Standard two)
- ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an A&E department (Standard three)
- ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard four)
- providing safe hospital accommodation for individuals who need it (Standard five)
- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard six).

and in addition:

- support local prison staff in preventing suicides among prisoners
- ensure that staff are competent to assess the risk of suicide among individuals at greatest risk
- develop local systems for suicide audit to learn lessons and take any necessary action.

Making it happen

The *NHS Plan* and the *National Service Framework* have set out some radical changes to mental health care. To make sure these changes happen – and that the people who use services feel the difference – will take a lot of effort, over several years, with everybody concerned working well together.

Planning change together

At national level the changes are being overseen by a new Mental Health Taskforce Board. It includes representatives of Government, the NHS and social services, service users and voluntary groups.

Professor Louis Appleby has been appointed National Director for Mental Health, and chairs the Task Force. Senior staff at the Department of Health are co-ordinating national work for each NSF standard, as well as for the essential “underpinning programmes” of workforce, information, and research and development.

Mental Health Task Force Mission Statement

We aim to develop mental health services that are planned and delivered around the needs and aspirations of service users, and specifically that:

- treat individuals living with mental health problems with dignity and encourage their full involvement in their care
- respect cultural and ethnic diversity and tackle discriminatory practices
- respect the role and skills of carers, acknowledging them as partners in care and supporting them in this role
- promote positive mental health and take effective steps to reduce stigma and discrimination
- make the best and most effective treatments available, when and where they are needed
- respond appropriately to need, so that people with acute illness receive prompt access to care, and so that those with a broad range of health and social needs – including housing, occupation and finance – receive comprehensive care
- emphasise safety, particularly of service users themselves
- are delivered by a workforce who are skilled, of high morale and able to adopt new ways of working.

At local level, in each health and social care community, there is a local implementation team (LIT) to plan and deliver change. It too comprises the statutory services (such as health, social services and housing) for the area, together with service users, carers, and local voluntary groups that either provide care themselves, or campaign for better mental health care.

Each local implementation team has produced a local implementation plan (LIP) setting out how the NSF standards, the NHS Plan, and other changes will be translated into new local services – and how the money provided to do this will be spent.

Working together in this way at local level is crucial, if the wide range of needs of people with mental health problems are to be met properly.

One of the characteristics of mental health services is the range of people who frequently need to be involved in the care plan of a single individual; suitable accommodation, adequate income, meaningful occupation, and family support all play a part alongside competent diagnosis, treatment and care

The NHS cannot achieve this on its own – and nor should it. Many everyday needs can best be met by the other organisations that make up local communities, with the NHS and social care services working in partnership with them.

Managing services together

Closer working between the NHS and social services – the two main providers of mental health care – is the key to making the changes work.

In the future, new organisations – called care trusts – will see a merger of health trusts and social services under a single management.

In many areas, care trusts will specialise in mental health, providing integrated mental health hospital and community services in a local area. In a few others, primary care trusts will take on the whole range of mental health services including – as soon as possible – social care, in partnership with local authorities.

All new local management arrangements must meet the following standards:

- inpatient and community services must be managed by the same body
- there should be moves towards integration with social care services
- there must be a track record of interest in mental health
- the trust should be large enough to provide a range of services and attract strong leadership
- they must build on the partnerships established through local implementation teams.

Support to help it all happen

Policy implementation guide

In March 2001, NHS chief executives and directors of social services were called to a meeting with the Minister of Health. They were given an implementation guide to support the local changes required in adult mental health services.

The guide describes the new services to be introduced in detail, but with an emphasis on tailoring them to local needs, by involving all local stakeholders in planning the changes.

The policy implementation guide will be added to over time, as further work in progress becomes available. This will include women's services, support to carers, links with the criminal justice system, dual diagnosis, inpatient care, community mental health teams, and personality disorder.

The National Institute for Mental Health (England)

Widely differing methods are used to treat mental health problems, and the variable quality of care around the country is unacceptable. There is, however, little evidence to show which methods work best, and poor systems for sharing what knowledge there is about good practice. New research is badly co-ordinated, and training programmes have difficulty keeping up to date. Service users have few opportunities to influence research or training.

These problems are to be tackled by a new National Institute of Mental Health for England (NIMHE). It will develop partnerships – between Government and other agencies, service users, carers, professionals and managers, and be the development arm for national mental health policy.

NIMHE's research network will help develop research expertise, support large scale studies, advise on priorities so that relevant research is undertaken, and ensure that the findings, best practice and new guidance are made available to mental health services and professionals. The Institute will also promote effective training in support of best practice and identified priorities.

The new National Institute will have a small central organisation with a Director and support staff, but with a wider network in the regions, to ensure that effective methods are disseminated throughout the NHS. A website will be developed to assist in this.

NIMHE will play a major part in driving forward the changes for mental health services set out in the *National Service Framework* and the *NHS Plan*.

Making sure there are enough staff

For mental health services to grow, more staff will be needed. Making sure enough staff are attracted to work in mental health – which has not been easy in the past – will be a big challenge.

As well as recruiting – and keeping – staff, it is important that they are able to develop the right skills for the new ways of working which new services will require.

There is also more that can be done to make use of the experience of service users.

All mental health services will be expected to recruit and train service users as part of the workforce.

Cultural and racial issues will be an integral part of pre-qualification training for all health care workers, and services will be expected to be staffed by people who represent the community they serve.

Information

A national Mental Health Information Strategy was launched on 19 March 2001, and addresses the information needs of service users, carers, clinicians and managers. It describes the information systems required to support modern mental health care delivery – and maps out a path, from the existing inadequate mental health information systems to the provision of high quality information to everyone using, or working in, mental health services by 2005.

The strategy will ensure that clinicians and practitioners, and all decision-makers, including users and carers, have the information which they need to enable them to meet the standards in the National Service Framework.

Improved information will support service user empowerment and improved, safer care.

One means of ensuring integrated service user information will be to develop an integrated mental health electronic record. This will be shared by the NHS specialist mental health services and social care, whilst ensuring security and confidentiality are maintained.

Timetable for change

Much progress has already been made. For example, a lot of areas have new assertive outreach teams in place already, and many new secure places and several hundred staffed beds have been provided in the last three years.

The major increases in funding to pay for the changes set out in the *NHS Plan* – more than £300 million over the next three years – will occur from 2002 onwards. This allows a year of planning and preparation, so that the new services can be introduced between 2002 and 2004.

Establishing progress

To check on how well these changes are being introduced locally, a practical monitoring programme is under way, based on local people assessing their own progress.

Each local implementation team has reviewed and mapped the services currently provided in its area. It regularly assesses how far these services meet the standards set out in the *National Service Framework*, and other targets. Teams get regular feedback from the Department of Health, and an annual national report will indicate progress across the country as a whole.

A major piece of work is underway, to develop outcomes for services that are relevant to the experience of service users. These will be measured in terms of mortality, morbidity, quality of life, and user and carer satisfaction.

What more needs to be done?

This is not the end of the story. The policies now being put in place deal with some of the most pressing problems experienced today by people who use mental health services. They lay the foundation for a single, modern, system of mental health care – in which the needs of users and carers are central. They will stop mental health being the poor relation of the NHS and set us on the journey to recovery.

There is already further work being done in other areas mentioned in the *NHS Plan*, such as women's services, support to carers, and links with the criminal justice system. There is also more to do for people who have a dual diagnosis or personality disorder.

What has been done so far points the way. Working systematically through the stages of providing safe, sound and supportive services will deliver a better, more focused, mental health system. It will make a significant step towards the ultimate goal – a society more sensitive to mental distress, where people with mental health problems do not have to suffer discrimination, and where recovery based on service user and carer aspirations is a real possibility for the majority.

Recovery

Historically, people with mental illness were often not expected to recover. For example, people with schizophrenia were generally perceived as having a poor outlook, having to live their life in a uniformly downward spiral of persistent symptoms.

This perception has influenced the public view of people diagnosed as having mental illness, as being ultimately unable to take control of their lives and to recover. Services of the future will talk as much about recovery as they do about symptoms and illness.

We need to create an optimistic, positive approach to all people who use mental health services. The vast majority have real prospects of recovery – if they are supported by appropriate services, driven by the right values and attitudes.

The mental health system must support people in settings of their own choosing, enable access to community resources including housing, education, work, friendships – or whatever *they* think is critical to their own recovery

Claiming citizenship

To enable and empower people with mental health difficulties to take their full place in society, as citizens with rights, requires a number of conditions to be met.

First, their health and social needs must be met. The policies and plans already in place should go a long way towards achieving this – by addressing not only the medical needs that arise from mental illness, but the basic needs of every day life which most of us take for granted.

These needs are basic to self respect and recovery, and include an acceptable place to live, meaningful occupation, further education and training if necessary and access to – and information about – entitlements and benefits.

Secondly, for many people – especially those with long term and enduring mental health problems – social networks can be difficult. Friendships can be hard to make or sustain, and the attitudes of others in the community a job to cope with.

Opportunities to engage in ordinary social activities, and community development initiatives, can play their part – as can stronger, supported, networks for service users.

Thirdly, we have much more to do to change public perceptions of mental health. Negative expectations and experiences – and the resultant stigma – have severely affected the lives of people who have mental health problems, their families and friends. Hand in hand with improvements to services, a change in attitude must take place.

It will take work at both national and local level to foster the understanding that mental illness is no more to be frowned at than breaking a leg, and to reduce and eliminate once and for all the stigma that still unjustly surrounds mental health.

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