



The Sainsbury Centre

for Mental Health

DEFINING A GOOD MENTAL HEALTH SERVICE

A Discussion Paper

Jed Boardman & Michael Parsonage

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This discussion paper presents initial calculations on the specification and workforce requirements for a good mental health service: one that would be able to implement in full the 1999 *National Service Framework for Mental Health* and subsequent government guidance.

We welcome your feedback to help us to develop a full specification from which we can produce some financial costings. A series of questions are highlighted throughout this paper and appear in summary at the end.

Please send your responses to:
Dr Jed Boardman
Senior Policy Advisor
The Sainsbury Centre for Mental Health
134-138 Borough High Street
London
SE1 1LB
Email: costsconsultation@scmh.org.uk

A full report will be published in 2006. It is hoped that these results will have a wide range of potential applications, both nationally and locally. These include service and workforce planning, budgeting, financial review and policy monitoring.

The Sainsbury Centre for Mental Health (SCMH) is a charity that works to improve the quality of life for people with mental health problems. We carry out research, development and training work to influence policy and practice in health and social care.

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Introduction

This report is the first output of a major project being undertaken by the Sainsbury Centre for Mental Health on the specification and costing of a good mental health service. The focus is on services for adults of working age in England. In time, the results of this project will have a wide range of potential applications, both nationally and locally. These include service and workforce planning, budgeting, financial review and policy monitoring.

To take advantage of these possibilities, the project analysis is being undertaken in stages and the first of these, described here, is a detailed specification at national level of the full set of services that together make up a good mental health service. The next phase of work will be to undertake a costing of the specified services, again at national level. Consideration will then be given to how the framework that has been developed for national analysis could be adapted for uses locally.

Here, a good mental health service is defined as one which delivers the Government's stated policy objectives for mental health care, particularly the seven standards of the National Service Framework (NSF-MH). In line with the Government's stated 10-year timescale for implementation of the NSF-MH, the service so defined is intended to be available in about the year 2010.

Despite its detailed and extensive nature, the implementation guidance produced by the Department of Health in support of the NSF-MH is not always explicit or prescriptive about the service structures and models that may be needed to deliver the seven standards. As a result, the specification of services described in this report has also drawn on local examples of good practice and on professional judgment. On the whole, a fairly conservative approach has been taken, leaving aside radical new models of service delivery or radical changes in staff roles.

It is clear from these considerations that 'a good mental health service' cannot be uniquely defined. The service specifications set out here represent one possible version of a good service and comments are invited on how they might be modified and refined. Our hope is that it will prove possible to achieve a broad consensus of professional and other opinion on a central model for a good mental health service. Variants on this central model can then be analysed in subsequent work in order to assess the cost and other implications of different patterns of service provision.

Policy background

Mental health services in England have changed considerably over the past 20 years. Community services have developed, asylums have closed and mental health has become one of several priority areas for development.

The present government first set out its view of modern mental health services for adults of working age in the White Paper *Modernising Mental Health Services: Safe, sound and supportive* (Department of Health, 1998a). Importantly, this announced the Government's intention to invest an additional £700 million in mental health services over three years and to create a National Service Framework for Mental Health (NSF-MH) for working age adults. The

White Paper built on already published documents detailing intended reforms to health and social services including: *Our Healthier Nation* (Department of Health, 1998b); *The New NHS: Modern and Dependable* (Department of Health, 1997); *Modernising Social Services* (Department of Health 1998c); *A First Class Service: Quality in the new NHS* (Department of Health, 1998d).

The publication of the *National Service Framework for Mental Health* (Department of Health, 1999) set out for the first time a set of officially sanctioned minimum standards to which mental health services were expected to attain. *The NHS Plan* (Department of Health, 2000a) amplified these by specifying the number of new community teams that were to be developed, linked developments with additional funding and reiterated that mental health was to be one of the three priority areas alongside cancer and coronary heart disease. The subsequent *Mental Health Policy Implementation Guide* (Department of Health, 2001) was published with the intention of supporting the Local Implementation Teams in the delivery of adult mental health policy and set out service specifications for crisis resolution/home treatment teams, assertive outreach teams and early intervention teams.

Subsequent developments suggested that the increased investments for mental health services were not always getting to the services that they were meant to fund (SCMH, 2003) and other policy documents set out additional areas of development that were aligned to the NSF-MH, for example social inclusion (Social Exclusion Unit, 2004) and Race Equality (Department of Health, 2005a). The recent five year review of the NSF (Department of Health, 2004a) suggested some progress towards some of the targets but acknowledged that more needed to be done in some areas, that money had often been diverted to other services and that inequities of provision remained across the country.

The current plan for the development of adult mental health services in England is defined by the National Service Framework for Mental Health, NHS Plan and Policy Implementation Guides. To a large degree these have prescribed the development of services, particularly at the secondary care level, but it remains unclear precisely what a 'good' mental health service should look like, and what staff and other resources are necessary to provide this and its costs.

The National Service Framework for Mental Health

The NSF-MH sets seven standards in five areas, to be delivered over a 10-year period:

- Standard 1 – Mental health promotion and discrimination/exclusion
- Standards 2 and 3 – Primary care and access to services.
- Standards 4 and 5 – Services for people with severe mental illness
- Standard 6 – Services for carers
- Standard 7 – Actions necessary to reduce suicides.

The NHS Plan

Chapter 14 (The Clinical Priorities) set out the details of services to be provided to support the NSF-MH. The priority was to ensure that people with severe and enduring mental health problems receive services that are more responsive to their needs. The Plan provided an extra annual investment of over £300 million by 2003/04 to fast forward the NSF-MH.

In addition to the details the NHS Plan (Department of Health, 2000a) also pointed out that by April 2001, there would be almost 500 extra secure beds, over 320 24-hour staffed beds,

170 assertive outreach teams and access to services 24 hours a day, seven days a week, for all those with complex mental health needs.

The priorities were set for primary care, early intervention in psychosis, crisis resolution, assertive outreach services, services for women, support for carers, high secure hospitals and prison services.

Policy Implementation Guides

The subsequent *Mental Health Policy Implementation Guide* (Department of Health, 2001) was published with the intention of supporting the Local Implementation Teams in the delivery of adult mental health policy. Service specifications were set out for crisis resolution/home treatment teams, assertive outreach teams and early intervention teams and advice given on primary care mental health, mental health promotion, cultural sensitivity, gender sensitivity, involving and supporting service users and carers and workforce needs assessment. Other specific Policy Implementation Guides (PIGs) have been published subsequently (Department of Health, 2002a; 2002b; 2002c; 2002d; Department of Health, 2003a; 2003b; 2003c; 2003d; Department of Health, 2004e).

The NSF 5-year review

The 5-year review of the NSF-MH was published in 2004 (Department of Health, 2004a). In addition to reviewing the progress towards targets over the first five years, it set some priorities for the next five years:

- Inpatient care
- Dual diagnosis
- Social exclusion
- Ethnic minorities
- Care of long term mental disorders
- Availability of psychological therapies
- Better information and information systems
- Workforce redesign with new roles for key staff.

It put mental health services in the context of overall developments in health and social services: “We now need to plan for the next five years in a way that re-casts our NSF in line with the direction that the NHS as a whole is taking – towards patient choice, the care of long-term conditions and improved access to services” (Department of Health, 2004a).

National Institute for Health and Clinical Excellence (NICE)

The National Institute for Clinical Excellence was established in England and Wales in 1999 to provide guidance to the NHS on health technologies (see Department of Health, 1997; Department of Health, 1998d). In April 2005 it combined with the Health Development Agency to form National Institute for Health and Clinical Excellence (NICE) (see Department of Health, 2004b). NICE, an independent organisation, has now expanded its functions to provide national guidance on the promotion of good health and the prevention and treatment of ill health.

The Department of Health commissions NICE to develop guidance. Currently NICE produces three types of guidance:

- **Technology appraisals.** These are recommendations for the use of new and existing medicines and treatments. Existing appraisals of relevance to mental health conditions

are: computerised cognitive behavioural therapy, ECT, atypical antipsychotic drugs for schizophrenia and drugs used in mania.

- **Clinical guidelines.** These are recommendations for the appropriate treatment and care of people with specific diseases and conditions. Mental health conditions presently covered by these include: anxiety, depression, schizophrenia, eating disorders, post traumatic stress disorders and deliberate self-harm.
- **Interventional procedures.** This guidance covers the safety and efficacy of interventional procedures used for diagnosis and treatment. There are currently none directly relevant to mental health services.

NICE is responsible for setting clear standards for treatments provided in the NHS. How healthcare organisations should respond to NICE guidance is set out in the Department of Health's *Standards for Better Health* (Department of Health, 2004c) and the standards, which form the basis of the annual assessment by the Healthcare Commission, include requirements to conform to NICE guidance.

The project

The present project seeks to use the existing plans for mental health services in England to define a 'good' service and to quantify the resources and money necessary to meet this.

This paper details the first stage of the project: to define the details of the basic components that go to make up a 'good' mental health service based on the standards of the NSF-MH.

For this project, the notion of a 'good' service is not defined by quality standards or philosophy, but by describing the range of services and associated personnel required to deliver each of the seven NSF-MH standards, supplemented by the NHS Plan and subsequent policy implementation guidance and using other existing policy and guidance documents. Account is also taken of relevant NICE guidelines. Epidemiological data is used, where available, to define the level of need and to create estimates of staffing required to meet these needs. In each case the 'good service' is to be provided to those aged 16-65 years living in an English catchment area of total population 250,000.

Population base

The population estimates are based on the census for 2001 and the census projections for mid-2003. The total population for England is 49,855,700 of whom 64.4% (32,105,400) are aged 16-65 years. The average population for a catchment area of total population 250,000 is shown in Box 1.

Box 1: Census data for a catchment area of a total of 250,000 people

	No.
64.4% aged 16-65 years	161,000
49.8% men	80,178
50.2% women	80,822
90.9% white	145,061
9.1% non-white	14,651
72.1% in work	116,081
4.5% unemployed	7,245
23.4% economically inactive	37,674
16.8% living alone	27,048

These catchment area figures using a working age adult population of 161,000 aged 16-65 years will be used as the basis for the population based calculations in this paper. It is assumed that this is an 'average' English population but it is acknowledged that the socio-demographic details of the catchment area, and thus levels of need, will vary greatly across the country and that adjustments will be required to meet the need of these diverse areas.

For each standard the following basic questions have been posed:

What type of service?

We have considered what type of service is implied by present policy and guidance. For some types of service, for example assertive outreach teams, this has been explicit, while for others, for example in primary care, there are no explicit models. For these latter areas, we have chosen to focus on the resource requirements for provision of accepted treatments or services or on current examples of good practice. NICE guidelines have been referred to when standards for treatments are required.

What is the epidemiological base?

As far as possible, population based figures of existing rates of mental health conditions based on population surveys have been used. In some cases this has not been possible and usage figures or official projections have been employed.

What staffing and service configuration is required?

We have focused on what the staffing and service configuration would look like for a total population of a 250,000 catchment area. Services for working age adults are specialist mental health services, generally supplied by health, social and voluntary (independent) sector services working in partnership. Privately funded provision has not been considered. These core specialist services are often supported by further specialist (or 'sub-specialist') services, such as perinatal services or those for people with eating disorders. These are often provided in a patchy manner across the country and rarely reflect the needs of the population. To develop a configuration for a comprehensive set of services both specialist and sub-specialist services have been included, although it is recognised that some of the sub-specialist services may be configured for a population greater than 250,000.

Where possible the estimates for services and staffing are compared to already existing levels.

QUESTION 1: Overall approach

The suggested service specifications are variously derived from official guidance, epidemiological data, local examples of good practice and professional judgment.

- a. Are you content with this general approach?**
- b. Are there any major sources of information that have not been taken into account?**

Standard I – Mental health promotion and discrimination/exclusion

“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.”

What type of service?

There are no nationally accepted models for mental health promotion or guidance for these services within health and social services. Mentality, the mental health promotion team at SCMh undertook a national survey into the state of our public mental health practice in 2004 and found examples of good practice in mental health in local areas (mentality, 2005). Individuals working in this field identified a lack of funding and a lack of local commitment to public mental health work. Much expenditure on promotion is likely to fall to non-health agencies (e.g. DfES), which is outside the scope of this study. The estimates for this study focus on services that may be provided by NHS and social services (or voluntary agencies contracted to these).

Epidemiological base

At present there are no epidemiological figures that are of assistance in calculating the requirements for mental health promotion, so reliance has been placed on a survey of existing provision. The SCMh mentality team also surveyed 16 mental health promotion leads in England to ask about current spending in this area. The survey revealed that some PCTs had:

- 1.5 WTE mental health promotion and coordinator post.
- 1.5 WTE worker to promote mental health within families.
- 1.5 WTE development worker to coordinate self-help groups for people with mental health problems.

In addition, there was a range of programmes and associated budgets. These included: training, locality networks for professionals with a mental health promotion role, mental health promotion and employment, physical activity, mental health promotion for specific at risk groups.

Staffing and service configuration

There are 300 PCTs in England, thus the average PCT covers 164,000 population. There are 1.5 PCTs per 250,000 population. The above staffing numbers have been adjusted for a 250,000 population and are shown in Box 2. Additional sessional time has been added from a public health specialist in the field of health promotion.

Box 2: Health promotion staffing for a total population of 250,000	
	WTE
Mental health promotion specialist	2.3
Mental health family promotion	2.3
Self-help/voluntary services co-coordinator	2.3
Public health specialist	0.2
Total	7.1

QUESTION 2: Mental health promotion

In the absence of nationally accepted models for mental health promotion or guidance for these services, the suggested specifications for Standard 1 are based largely on existing practice.

- a. **Is this too conservative, particularly as the government's 5-year review of the NSF-MH notes that only limited progress has been made in delivering this standard?**
- b. **What other evidence-based assumptions could be made?**

Standards 2 & 3 – 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.”

What type of service?

At present there is no clear model or consensus for mental health services at the primary care level. Knowledge accrued over the years indicates that General Practitioners see and deal with the bulk of people with common mental disorders and a relatively small proportion (10-15%) are passed to secondary care. The two major forms of treatment delivered in primary care are medication and psychological therapies. There is a good evidence base for drug treatments in depression and anxiety and for cognitive behavioural therapy (CBT). In addition, access to psychological therapies is highlighted as a priority area in the NSF 5-year review. The calculations have thus been restricted to antidepressants and CBT.

Epidemiological base

Two main sources of prevalence figures are of relevance:

1. *General Population surveys.*

The Office of National Statistics (ONS) (previously Office of Population Censuses and Surveys - OPCS) surveys of psychiatric morbidity in Great Britain (Meltzer *et al.*, 1995; Singleton *et al.*, 2001) indicate that the prevalence of neurotic disorders in adults aged 16-65

years in England is about 160 per 1,000 population. Thus 25-26,000 adults have neurotic disorders in a population of 161,000.

The rate of onset for neurotic disorders was 6% in the 2000-2001 follow-up study (Singleton & Lewis, 2003). This means that there are likely to be 9,660 adults who develop new neurotic disorders in a total population of 250,000 in one year.

2. *From surveys of people consulting in general practice.*

The most recent estimates are shown in Box 3, taken from Boardman *et al.* (2004).

Box 3: Numbers consulting with depression and anxiety in primary care		
DSM-IV disorder	Rate per 1,000 consulters	Number in population of 161,000
Major depression	107	17,227
Minor depression	29	4,669
Total depression		21,896
Anxiety disorder ¹ (single diagnosis)	31	4,991

¹Includes generalised anxiety disorder (GAD), panic disorder, agoraphobia and social phobia.

The overall figures are very similar to those of the general population, but it is known that many people with mental health problems do not consult their GPs. The primary care figures give the rates for people with new and chronic disorders seen in general practice and can be placed against the actual needs for treatment measured in the same individuals as surveyed. These figures have thus been used to calculate the numbers of people requiring medication and psychological therapy in general practice over a 12-month period.

Calculations for depression

In the Boardman *et al.* (2004) study, 65% of the people with depression had developed this during the previous year (they had new onsets of depression during that year). The study judged CBT to be suitable for 55% of the consulters with depression, and antidepressant medication to be suitable for 70%.

Thus for a catchment area of 161,000 adults there are 14,232 new onsets of depression per year (65% of 21,896). The number of people who require antidepressant and/or CBT in a catchment area of 161,000 will vary depending on the assumptions made.

If 70% of people with new onsets of depression who see their GP require antidepressant medication then 9,962 people will require these drugs. But, not all people who have depression and are seen by the GP have this detected: on average about 60% of this is detected. Thus if only those who are detected and who need medication are given it, then the figure reduces to 5,977 (see Box 4)

The estimates for CBT are more difficult to make as it is uncertain how many people will require CBT in addition to, or instead of, medication. To calculate the numbers who need CBT and the number of therapists required, several assumptions have been made:

- I. CBT will be given to those who do not adequately recover after being given antidepressants. This is in line with NICE depression guidelines. Approximately 60% of people recover after antidepressants: thus 40% will require CBT.

2. People will require 12 sessions of CBT over a 12-week period. This is based on the figures given in the NICE depression guidelines, which recommend 6-8 sessions for mild depression and 16-20 sessions for moderate or severe depression.
3. If a therapist sees four clients per day for CBT then a therapist may have a client list size of 20 people at any one time. Assuming that, on average, the sessions last for 12 weeks, then there will be four 12-week blocks available per year in which to conduct therapy. Thus a maximum of 80 people (4x20) can be seen by each therapist during a year.

These estimates are summarised in Box 4.

Box 4: Estimates for provision of antidepressant medication and CBT in primary care for depression						
Intervention	Number of people with new onsets of depression seen in general practice over 1 year	Need (based on Boardman <i>et al.</i> , 2004)	Total number in population of 161,000 who have need	Total number who have need if assume only 60% detected	Total number needing CBT if 40% do not recover with antidepressants only	Number needing CBT if only 60% detected and 40% do not recover with antidepressants
Medication	14,232	70%	9,962	5,977	-	-
CBT	14,232	55%	7,828	4,697	3,131	1,879

Thus for CBT:

- If all those people with new onsets of depression who do not recover after antidepressants are given CBT, then *39 therapists will be required* (3,131 divided by 80).
- If all those people with new onsets of depression who are detected and who do not recover after antidepressants are given CBT then *23 therapists will be required* (1,879 divided by 80).

Calculations for anxiety

In the Boardman *et al.* (2004) study, 47% of the people with anxiety had developed this during the previous year. The study judged CBT to be suitable for 79% of the consulters with anxiety, and antidepressant medication (SSRIs) to be suitable for 60%.

Thus for a catchment area of 161,000 adults there are 2,346 new cases of anxiety per year (47% of 4,991). 1,408 of these people (or 845 if we consider only those who are detected) who have new onsets of anxiety will require antidepressant medication (Box 5).

Box 5: Estimates for provision of antidepressant medication and CBT in primary care for anxiety				
Intervention	Number of people with new onsets of anxiety seen in general practice over 1 year	Need (based on Boardman <i>et al.</i> , 2004)	Total number in population of 161,000 who have need	Total number who have need if assume only 60% detected
Medication	2,346	60%	1,408	845
CBT	2,346	79%	1,853	1,112

For CBT the assumptions made are:

1. CBT may be given at the same time as medication for people with anxiety. There are no clear guidelines about the timing of a combination of the two types of therapy.
2. People will require 12 sessions of CBT over a 12-week period. NICE guidelines recommend 7-14 hours of CBT for panic disorder and 16-20 hours for generalised anxiety disorder (GAD).
3. If any therapist sees four clients per day for CBT then a therapist may have a client list size of 20 people at any one time. If the sessions last for 12 weeks, thus giving four 12-week blocks per year, a maximum of 80 people in total can be seen by each therapist per year.

These estimates are summarised in Box 5.

Thus for CBT:

1. If all those people with new onsets of anxiety are given CBT then *23 therapists will be required* (1,853 divided by 80).
2. If all those people with new onsets of anxiety who are detected are given CBT then *14 therapists will be required* (1,112 divided by 80).

The figures for new cases of depression can be combined with those for new cases of anxiety to give the total amount of medication and CB therapists required (Box 6).

Box 6: Total need for medication and cognitive behavioural therapists in primary care					
	Total cases	Number in population of 161,000 who need treatment		Number of CB therapists	
		Maximum - if treat all people with new onsets who are in need	Minimum - if treat people with new onsets in need, who are detected	Maximum - if treat all people with new onsets who are in need	Minimum - if treat people with new onsets in need, who are detected
Medication					
Anxiety	2,346	1,408	845	-	-
Depression	14,232	9,962	5,977	-	-
Total	16,578	11,370	6,822	-	-
CBT					
Anxiety	2,346	1,853	1,112	23	14
Depression	14,232	3,131 (those who do not respond to antidepressants = 40%)	1,879	39	23
Total	16,578	4,984	2,991	62	37

The limitations of the above estimates are that:

- a. The calculations only include people with new onsets of depression and anxiety. A significant number of these people have long-term conditions and thus will require treatment over longer periods. This longer term group is not considered here, but may form a significant proportion of those seen by secondary services and thus some will be covered by the staff in those services.
- b. They only focus on those people with depression and anxiety (these groups overlap as they contain people with mixed anxiety and depression, the largest single diagnostic

- group). Other related conditions, such as obsessive compulsive disorders and eating disorders, are not included. These groups will require mainly psychological interventions. However they are relatively small and many will receive secondary services.
- c. Other psychological therapies (e.g. counselling, psychodynamic psychotherapy, family and couple therapy) are not included. These may be required for some people with specific needs.
 - d. Other means of delivering psychological therapy are not considered e.g. computerised methods or group approaches. The NICE guidelines suggest the use of other therapies such as bibliotherapy, self-help and computerised CBT which may be a means of reducing the number who require one to one CBT, but there are no algorithms to help calculate these numbers. The CB therapists would have a role in assessing patients and introducing them to these approaches.

If CBT is to be provided for all those who need it in general practice, the staffing figures may be made up of the types of mental health worker outlined in Box 7.

Box 7: Proposed therapists required for primary care	
Type of therapist	For 62 CB therapists
Clinical psychologist	31
CB therapist	20
CBT nurse therapist	6
Recent graduate	5

The higher figure for psychological therapists has been used as it is assumed that the services would wish to treat those people in need who present to the GP.

The 'recent graduates' are the 1,000 new graduate psychologists planned for primary care (Department of Health, 2003c). The CB therapist is presumed to be specifically trained and paid at the same rate as counsellors who already work in primary care.

In addition 500 gateway workers are required for all England, thus giving 2.5 per 250,000 population (Department of Health, 2003d).

How does this compare to other estimates?

In a recent paper delivered to a Cabinet Office seminar, Layard (2005) estimated that 10,000 cognitive behavioural therapists are required to provide adequate services for anxiety and depression. If 62 therapists are required for an area of 250,000 then 12,338 are required for the whole of England.

In this section we have elected to focus on the medication and psychological therapies required to meet the needs of those with anxiety and depression who present to primary care personnel. The associated staffing needs are considerable. No assumptions have been made about the specific means of delivering the psychological therapies. Further thought needs to be given to the types of mental health personnel required, their training and the most effective means and systems of delivering these therapies and their quality assurance.

QUESTION 3: NSF Standards 2 and 3

There is no clear model for mental health services at the primary care level, so the key specifications (relating to medication and psychological therapies) have been built up from a variety of sources.

- a. **Are you content with the main assumptions used, as summarised in boxes 4-6?**
- b. **For reasons explained in the paper, the specifications are derived from data relating to the number of people with new onsets of anxiety and depression presenting to GPs. Is this the correct approach?**
- c. **The numerical estimates relate mainly to depression and anxiety. Should more attention be given to other neurotic disorders (obsessive compulsive disorders, phobias etc)?**

Standards 4 & 5 – Services for people with severe mental illness

“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-coordinator
 - advises their GP how they should respond if the service user needs additional help
 - is regularly reviewed by their care co-coordinator
- 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 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-coordinator, and specifies the action to be taken in a crisis.”

What type of service?

In comparison to services in primary care, specialist mental health services are more clearly prescribed in the NHS Plan and Implementation Guides. This section covers: community based teams, inpatient services (including aftercare accommodation) and day services.

However, it is recognised that these speciality services must be complemented by forensic services and other sub-speciality services, for example perinatal and eating disorder services. These sub-speciality services are considered at the end of this section.

Epidemiological base

The population figures for these standards may be based on the OPCS and ONS surveys (Meltzer *et al.*, 1995, Singleton *et al.*, 2001), Boardman *et al.* (2004) and estimates of mental illness from the Sainsbury Centre for Mental Health (1998) (see Box 8):

Box 8: Estimates of mental health problems in the population		
	Rate	Number for total population of 250,000 (161,000 aged 16-65 years)
From OPCS/ONS		
Neurosis	160 per 1,000 adult population	25,760
Psychosis	4 per 1,000 adult population	644
Alcohol dependence	47 per 1,000 adult population	7,567
Drug dependence	22 per 1,000 adult population	3,542
From Boardman et al. (2004)		
Total non-psychotic mental illness in general practice	278 per 1,000 adult population	44,758
From Keys to Engagement (SCMH, 1998)		
Severe mental illness	2,000-4,000 per 100,000 general population	7,500 (5,000 - 10,000)
Severe and enduring mental illness	300-1,500 per 100,000 adult population	1,449 (483 - 2,415)
Severe and enduring mental illness who are difficult to engage	14-200 per 100,000 adult population	172 (23 - 322)

I. Community Based Teams

Community Mental Health Teams

The Mental Health Policy Implementation Guide for CMHTs (Department of Health, 2002a) views these teams as the mainstay of the system and the core around which newer services are developed. They should offer people short-term contact services and continuing treatment, care and monitoring. Their functions include:

- work with primary care to provide a single point of entry
- assessment
- a multidisciplinary team approach
- regular review, including multidisciplinary and multi-agency review
- a range of interventions
- liaison with other parts of the health system and other agencies
- provision of discharge and transfer arrangements.

The Mental Health Policy Implementation Guide (MHPIG) (Department of Health, 2001) recommends that each CMHT serve a population of 10,000 – 60,000 depending on the local levels of morbidity and travelling distances. It suggests a staffing of 8 whole time equivalent (WTE) care-coordinators each with a maximum caseload of 35 people (and suggests a maximum caseload for the team of 300-350). The suggested staff mix is:

3-4	community psychiatric nurses (CPNs)	}	
2-3	approved social workers (ASWs)	}	care-coordinators
1-1.5	occupational therapists (OTs)	}	
1-1.5	clinical psychologists		
1	consultant psychiatrists		
1-1.5	other medical staff		
1-3	support workers		
1-1.5	WTE secretaries		
	Reception staff		
	IT and audit support		

For the purposes of the present calculations it is assumed that:

1. CMHTs need to cover two separate functions: assessment and continuing care.
2. Most assessments will be requested by primary care.
3. The referral rate from primary care is 15% of all people with mental health problems seen in primary care.
4. Users needing continuing care will be those with severe and enduring mental illness.
5. The case load per team is 325. This is based on a *maximum* caseload size as opposed to an *ideal* size.

For the continuing care element of the team

If there are 1,449 people with severe and enduring mental illness in an adult population of 161,000 and each CMHT should have a caseload of 325, then 4.5 CMHTs are required for a total population of 250,000. Thus, for this local population, if care-coordinators are to have a caseload of no more than 35, then 41.4 staff (1,449 divided by 35) are required to look after this group of users, all of whom are assumed to be on CPA. The PIG assumes that only 280 of the 350 will be on enhanced CPA, but this may be optimistic as in this case all the users have severe and enduring mental illness, thus all ought to be on enhanced CPA. If care-coordinators are to take on additional service users who are not on CPA then additional staff will be required.

For the assessment element of the team

A possible 44,758 users of CMHT services are seen in primary care. About 55% of these are new cases each year (based on Boardman *et al.*, 2004) and the referral rate from primary care is 15%. This means that 3,693 people with new onsets will be referred each year.

Thus 821 will be referred to each of the 4.5 teams each year (which equates to 16 per week or 3-4 per day). If we assume that one assessment can be done by a member of staff each day and additional follow-up consultations will be required, then 4 extra staff are needed for this component of the team. But extra staff will also be required to cover annual and study leave – an additional 28.4% staff are needed to cover this (see inpatient section for a

justification of these calculations). Thus, a total of five additional staff is required for the assessment component of the team.

Taking these two basic estimates and considering the staffing recommendations made by the FIG, the staffing for each team and for the population of 250,000 may look like that outlined in Box 9.

Box 9: WTE Staff required for a total population of 250,000 - CMHTs		
Staff	WTE per CMHT	Total staff for 250,000 total population (i.e. for 4.5 teams)
<i>For Continuing Care</i>	Total = 9.2	Total = 41.4
CPN	4.9	22
Social workers	2.7	12
OT	1.6	7.4
<i>For Assessment</i>	Total = 5	Total = 22.5
CPN	3	13.2
Social workers	2	9.0
<i>Other clinical staff</i>	Total = 9	Total = 40.5
Consultant	1	4.5
Other medical	2	9.0
Clinical psychologist	1	4.5
Support workers	4	18
Team leader	1	4.5
Admin staff	3	13.5
Total staff	26.2	117.9

The number of support workers assumes that one of these per team will be a specialist in employment and benefits for users, one will work with those from BME communities (Department of Health, 2004e) and a third will be an support, time and recovery (STR) worker (Department of Health, 2003a).

The number of administrative staff includes two secretaries and one receptionist per team.

This means that 896 teams are required for England with 22,566 staff and a caseload of 288,351 people with severe and enduring mental illness (out of estimated range of 94,288 - 471,438). If greater coverage is required then the staffing estimates will inevitably increase.

How does this compare to other estimates?

The Durham service mapping data shows that in 2003 there were 830 CMHTs in England (Glover *et al.*, 2004), with a total of 16,390.72 staff (i.e. 19.75 per CMHT) and a total caseload of 309,893 (mean of 373 per team). This gives one team per 37,866 adult population (59,203 per total population).

Assertive Outreach Teams

Assertive outreach teams (AOTs) aim to support people with severe and enduring mental health problems who do not otherwise maintain contact with services. They were established to keep people out of hospital by giving them intensive support in the community for as long as is needed.

The MHPIG (Department of Health, 2001) suggests that each team covers a total population of 250,000 and that each team should have 90 service users at any one time with an ideal 10:1 ratio of users to care-coordinators. The team should be made up of CPNs, ASWs, OTs, a clinical psychologist, a consultant psychiatrist and other medical staff.

If we assume that there are 172 people with severe and enduring mental illness who are difficult to engage, and thus suitable for assertive outreach, in a total population of 250,000 and that there will be a 10:1 users to staff ratio, then 17 care-coordinator staff will be needed.

The appropriate staffing for the team is shown in Box 10.

Box 10: WTE Staff required for a total population of 250,000 – Assertive Outreach Teams	
Consultant psychiatrist	0.5
Other medical staff	1
Clinical psychologist	1
Team manager	1 }
CPNs	11 } care
OT	2 } coordinators
Social worker	3 } total no. =17
Support worker	3
Admin staff	1
Total	23.5

This means that for the total England population there should be 199 teams with staff of 4,676 and total caseload of 34,228 people.

How does this compare to other estimates?

The NHS Plan (Department of Health, 2000a) set a target of 220 assertive outreach teams. In 2003 there were 238 assertive outreach teams (AOTs) in England (Glover *et al.*, 2004), with a total of 1,899 staff (i.e. 8 per AOT) and a total caseload of 9,130 (mean of 38.4 per team or 45.8 per 161,000 adult population). This gives one team per 134,897 adult population (209,478 total population). By March 2004, 263 teams were in place, employing 2,282 staff (Department of Health, 2004a). This suggests that there are sufficient numbers of teams, but inadequate numbers of staff.

Crisis Resolution Teams

Crisis resolution and home treatment teams (CRTs) were established to offer immediate support to people with severe mental health problems in a crisis. They aim to offer an alternative to inpatient admission and to 'gatekeep' admissions to hospital. They offer short-term, intensive treatment and support during the crisis period to those who are not admitted to hospital.

The MHPIG (Department of Health, 2001) does not specify how many CRTs per unit population. It suggests each team should have a caseload of 20 to 30 service users at any one time. The staffing levels suggested are: 14 designated named workers per team (team leader plus up to 13 others) which include CPNs, ASW, OT, psychologists, support workers, medical staff (consultant and staff grade) and an administrative assistant.

To calculate the staffing for one of these teams we need to know:

- a. *The likely number of crises occurring over a unit of time.* One of the purposes of a CRT is to provide an alternative to admission, thus the overall numbers of admissions should provide a guide to the number of possible crises (as the team should assess all these if they are to provide the 'gateway' to acute inpatient units). In 2001/2002 there were 120,994 admissions to psychiatric hospitals in England (HES data from www.dh.gov.uk). This equates to 608 per 250,000 total population per year. Thus there are likely to be 608 crises in the 250,000 catchment area (or 12 per week, 1.7 per day). If the team operates over 24 hours and this is split into three eight-hour periods then six people will be needed to assure that two workers are available to do assessments at any time.
- b. *Length of time in contact with CRT.* This is more difficult to calculate, but if a month period is considered, then in week one 12 people will be seen, half of whom are still seen after one week, when a further 12 arrive (total = 18). In week three these are halved again and a further 12 added (3 + 6 + 12 = 21) and the same happens in week four (1 + 3 + 6 + 12 = 22). This would be in the range of service users suggested by the PIG (20-30). Thus the PIG estimates may be used and a maximum 30 patient team caseload assumed. It will also be assumed that the care-coordinators can have 2-3 people on their individual caseloads at any one time. This means 12 (30/2.5) clinicians will be needed for this function.

Thus a total of 18 staff are needed for assessment and key worker functions. It is assumed that this will be provided by CPNs and social workers and the remainder of the team will support these core staff (see Box 11).

Box 11: WTE Staff required for a total population of 250,000 – Crisis Resolution Teams	
Consultant psychiatrist	1
Other medical staff	1
Clinical psychologist	1
Team leader	1
CPNs	14
Social worker	4
Support worker	4
Admin staff	1
Total	27

This means a total of 5,373 staff are required for 199 CRTs for England.

How does this compare with other estimates?

The NHS Plan (Department of Health, 2000a) proposed 335 dedicated teams across England by the end of 2004. In 2003 there were 125 crisis resolution teams in England (Glover *et al.*, 2004), with a total of 1,416 staff (i.e. 11.3 per CRT) and a total caseload of 3,433 (mean of 27.5 per team or 17.2 per 161,000 adult population). This gives one team per 256,843 adult population (1 per 398,846 total population). By March 2004, the number had risen to 168, employing 2,173 staff (Department of Health, 2004a). Whilst the number of teams is rising there is a shortfall in the staff required.

Early Intervention in Psychosis Teams

Early intervention teams were introduced to offer tailored care and support to people aged between 14 and 35 experiencing their first episode of psychosis. Their aim is to identify

young people who are developing a severe mental health condition and to provide them with a service that is appropriate to their age group and personal situation.

The MHPIG (Department of Health, 2001) gives figures for new users and total caseloads for teams covering one million total population. It estimates that there will be 150 new cases per year and that each will see the service for three years. This gives a total caseload of approximately 450. The PIG suggests dividing the service into a number of teams (three or four), each managing a caseload of 30 to 50 new cases per year and 120 to 150 in total. The suggested staffing levels cover a team with a caseload of 120 to 150. They include a total 10 WTE care-coordinators (including team leader) with a service user to care-coordinator ratio maximum 15 to 1. It also recommends the team includes 0.5 WTE adult consultant psychiatrist, 1.0 WTE non career grade psychiatrist and 0.1 WTE child and adolescent (CAMHS) consultant psychiatrist.

The number of new cases of psychosis that occur each year is about 38 per 250,000, which is identical to that quoted in the PIG. The overall PIG figures will therefore be used to calculate the staffing numbers: 135 cases per team with case load per care-coordinator of 10 (13.5 care-coordinators). The figures are shown in Box 12.

Box 12: WTE Staff required for a total population of 250,000 – Early Intervention Teams	
Consultant psychiatrist (Adult)	0.5
Consultant psychiatrist (CAMHS)	0.1
Other medical staff	1
Clinical psychologist	1
Team leader	1 }
CPNs	9 } care
Social worker	2 } coordinators
OT	1.5 } = 13.5
OT assistant	1
Support worker	2
Admin staff	1
Total	20.1

To implement these 199 teams nationally would require 4,000 staff.

How do these estimates compare with others?

1. The NHS Plan (Department of Health, 2000a) set a target of 50 early intervention teams by the end of 2004. In 2003 there were 36 Early Intervention Teams in England (Glover *et al.*, 2004), with a total of 166.18 staff (i.e. 4.6 per EIT) and a total caseload of 1,059 (mean of 29.4 per team or 5.3 per 161,000 adult population). This gives 1 team per 891,817 adult population (1 per 1,384,881 total population). By the time of the 5-year NSF review (Department of Health, 2004a) there were 41 teams. The review acknowledged that the formation of these teams lagged behind the other modernisation teams. The teams were smaller than planned, employing a total of 174 staff.
2. Lambeth Early Onset (LEO) in south London. This is a well staffed team with a good service that serves an area with a rate of onset of first episodes of psychosis of around 40/100,000. LEO takes all referrals of people with a possible or definite psychosis from Lambeth (pop 265,000 adults) aged 16-35. The team sees approximately 90 new cases per year. The LEO service consists of two teams. An

assessment team (LEO-CAT) is made up of 7.5 WTE staff. It works with GPs, A&E departments and other agencies, does initial assessments and initiates treatment before handing over to the LEO community team. The LEO Community Team consists of 12.7 WTE staff and provides continuing care and supervision for two years. The total staffing is thus 20.2 WTE.

The proposed early intervention teams have the potential to improve the services for young people with psychoses significantly and have a preventative function. A sustained investment and effort is required to increase the number of teams with adequate numbers of suitably trained staff.

Support Services

In addition to the core health and social services teams, community based support services will also be required. They may include:

1. *Advice and information services.*
These already exist at the national level e.g. NHS Direct, Samaritans. It would also be expected that all teams would have information about their local services available for users and carers.
2. *Advocacy services.*
These are often run locally by the voluntary sector.
3. *Befriending and voluntary schemes.*
These are often run by the voluntary sector as part of their support services.
4. *Self-help and mutual aid groups.*
Again these are often run by the voluntary sector as part of their support worker services.
5. *Service user groups.*

Some workers from these services may be based in day care services and allied to the CMHTs.

QUESTION 4: Community-based teams

- a. **Are you content with the assumptions on caseloads and on staffing levels per team?**
- b. **What other assumptions would you make?**

QUESTION 5: Support workers

Many areas of the country have support workers employed by voluntary sector organisations, which may also supply other community based services (e.g. day services).

- a. **How many support workers may be required?**
- b. **What assumptions underlie the calculation of these numbers?**

II. Inpatient Services

What type of services?

Community services must be backed-up by good quality acute inpatient services. It is assumed that they must provide places for asylum, for crisis management and for therapeutic activity. They should be supported by a range of residential accommodation and rehabilitation facilities.

For the inpatient and residential units it has been assumed that:

1. Staffing levels on wards should reflect the additional staff required to improve care and therapeutic activity requirements in these residential units. For example the acute inpatient units should be able to provide increased amounts of psychosocial care and activities as well as manage crises safely and securely. The rehabilitation units should provide active rehabilitation and be linked to specialist and community facilities.
2. Psychiatric intensive care units (PICUs) will be required and the size of a PICU is eight beds.
3. Staffing should be made up of a mixture of professions and of qualified and non-qualified staff.

Epidemiological base

The types of inpatient services and the numbers of beds have been based on the figures from the National Beds Inquiry (Department of Health, 2000b). As part of its remit the Inquiry examined the need for inpatient and residential care for those with mental health problems. It provided estimates for the number of beds required for a range of facilities, including acute and residential units. It did not give estimates for the staff that would be required for these units. The estimates are shown in Box 13 and compared to current estimates.

Box 13: National Beds Inquiry projects for inpatient and residential care			
	2005-6	2010-2011	2003 estimated provision (from Durham Mapping report (Glover <i>et al.</i>, 2004) unless stated)
	<i>Number places</i>	<i>Number places</i>	<i>Number places</i>
High secure	994	816	Approx 900 ¹
Medium secure and Long-term secure	2,592	2,543	Estimated 2,800 ²
PICU	1,429	1,583	812 PICU + 751 low secure, high dependency
Acute inpatient	16,097	15,934	20,319
NHS long-stay	1,761	0	2701 residential rehabilitation beds
24 hour staffed beds	4,100	5,853	1492 NHS 24 hour nurse staffed care + 2719 residential care homes
High staffed hostel	15,608	14,873	6254 registered care homes ³
Day-staffed hostel	9,635	7,532	1,076 staffed group homes
Unstaffed group homes	5,661	7,461	943 unstaffed group homes + 13,462 supported housing places

¹ From Fender (2004)

² From current estimates

³ The Durham Mapping Report suggested that these figures may be unreliable as older adult places may be included (Glover *et al.*, 2004).

The projections from the National Beds Inquiry for 2010-2011 have been used to calculate the staffing required. We believe that the estimates for inpatient rehabilitation may be

unrealistic as it is difficult to foresee no need for rehabilitation inpatient units for the groups of people with severe and enduring mental health problems. We have thus used what we believe is a reasonable estimate of 10 beds per 250,000 population. The inpatient provision for forensic services is discussed later in this document.

The calculations for each type of unit will be taken in turn.

Acute Inpatient Units

There is no generally accepted formula for calculating the nursing establishment and associated grade mix for acute inpatient units (e.g. Warr, 1995; Buchan & Dal Poz, 2002).

Several approaches exist (Buchan *et al.*, 2000), but the calculations here use the professional judgment approach (Cox, 2004). This approach asks professionals to assess ward activity and review available information in order to reach a consensus judgment concerning the number of nurses required to effectively manage a ward. The estimates made here assume that the bed numbers will decline but the people who are admitted will be more acutely ill and require high levels of nursing. In addition the ward will function as a therapeutic environment and nursing and other staff will require time to undertake these necessary activities.

Our calculation assumes that nurses on a 20-bed unit will work in shifts of six early, six late and four on nights. This will require a complement of 25 nurses to cover the ward for a seven day period (assuming 40 working hours per nurse in each seven day period). On top of this allowances need to be made for paid leave on the ward which include:

Paid leave	17.0%	(reflecting <i>Agenda for Change</i> (Department of Health, 1998e) adjustments).
Training	4.1%	(including professional development, supervision and appraisal)
Sickness	5.0%	(based on a target of 13 days per year)
Practice governance	2.3%	(including research and audit work)

This gives a total increase of 28.4% on the basic staffing level. Thus for a 20-bedded ward the total number of nurses required is 25 plus 28.4% i.e. 32.1 staff.

Our calculation also assumes that:

- The ward manager should be full-time and supernumerary.
- The Modern Matron role (see Department of Health, 2000a; 2000b) is additional to the Ward Manager role.
- There are two deputy ward managers who focus on practice development, leadership and management support, but are not supernumerary.
- The ratio of qualified to unqualified is set at 70:30, but need not be rigid and should reflect local conditions and priorities. Thus for a 20-bedded ward 22.5 qualified and 10.6 unqualified staff are required.

PICUs

For an 8-bedded PICU it is assumed that:

1. Five staff are required to cover the early and late shifts, while four are needed for the night shifts. This means that 21 nurses are required to cover over seven days.
2. The same 28.4% addition as for acute units is required, taking the total to 26.9 staff.
3. The ratio of qualified to unqualified is 70:30 (18.8 qualified and 8.1 unqualified).

Rehabilitation Wards

For a 10-bedded rehabilitation wards it is assumed that:

1. Four staff are required to cover the early and late shifts, with two covering the night shifts. This means that 15 nurses are required to cover for seven days.
2. The same 28.4% addition as for acute units is required – 19.26 staff required.
3. The ratio of qualified to unqualified is 70:30 (13.5 qualified and 5.76 unqualified).

The Rehabilitation ward will be run as part of the district specialist rehabilitation services. Consultant medical staff will cover both the inpatient and community rehabilitation services. The community rehabilitation team will cover all the hostel accommodation in the 250,000 population (see later).

24 hour Hostel Accommodation

For a 10-bedded 24-hour hostel it is assumed that:

1. Three staff are required to cover the early and late shifts and one at night. Ten nurses are thus required to cover for seven days.
2. The same 28.4% addition as for acute units is required – 12.84 staff required.
3. The ratio of qualified to unqualified is 70:30 (9 qualified and 3.84 unqualified).

Other Hostel Accommodation

The other staffed hostels will need 1 member of staff for each bed.

The staff will all be support workers and may be managed by a voluntary sector organisation. This type of accommodation may also be considered under the Supporting People strategy (Office of the Deputy Prime Minister, 2005).

These nursing estimates have been combined with estimates for other staff. The full staffing estimates for these inpatient and residential units are shown in Box 14.

QUESTION 6: Inpatient and residential services

Estimates of numbers of places needed are taken from the National Beds Inquiry published in 2000.

- a. Do any of the figures require modification in the light of subsequent developments?
- b. Are you content with the staffing assumptions, particularly for acute inpatient units?

Box 14: Projected number of residential places for an illustrative total population of 250,000 in year 2010 and the associated staff

Facility	Beds	WTE															
		Psychiatrists				Clinical Psychologists	Nurses			Occupational Therapists			Therapists		Social Worker	Support Workers	Admin
		Cons	SpR	SHO	Staff grade		Ward manger	Registered	Support Worker	Experienced	Basic grade	Technical Instructor	Psycho-therapist	Art, Music, Drama	Social Worker	Support Worker	Admin
Med + LT Secure	13	1.0	0.5	1.0	0.5	1.0	1.0	18.8	8.1	1.0	1.0	1.0	0.5		1.0		1.0
ICU/Local secure	8	1.0	0.2	1.0		0.4	1.0	18.8	8.1	0.8							1.0
Acute Hospital	80	4.0	2.0	4.0	2.0	4.0	4.0 + 1.0 Modern Matron	89.9	38.5	4.0	4.0	2.0	0.5	1.0	4.0		4.0
Rehabilitation ¹	10	1.0	1.0		1.0	1.0	1.0	13.5	5.76	1.0		1.0			0.5		1.0
24-hr staffed	30						3.0	27.0	11.52								
High staffed hostel	75																75 (+ 3 managers)
Day staffed hostel	38																38 (+ 2 managers)
Unstaffed group homes	38																
Total		7.0	3.7	4.0	3.5	6.4	10.0 + 1 Modern Matron	168.0	71.98	6.8	5.0	4.0	1.0	1.0	5.5		7.0

¹ NHS Inpatient Rehabilitation units were not included in the National Beds Inquiry projects for 2010/2011.

SHO = senior house officer

SpR = specialist registrar

III. Day Care and Employment Schemes

What type of service?

There is no currently accepted model for day care and the NSF-MH says little about it. The new emphasis on social inclusion, however, points to providing employment and educational opportunities and support to engage in more mainstream provision such as leisure facilities (Social Exclusion Unit, 2004). However this does not consider the importance of day care provision to service users for such things as support, social activities and drop-in facilities.

Many parts of the country experience a dearth of day provision and have a very narrow provision of services. Yet, day care run by the voluntary sector can be creative and acceptable to service users. Recent Rethink reports (Rethink, 2004; 2005) highlighted the need for access to services of many people with enduring mental health problems who may have many unmet needs and may benefit from stable day services.

The principles of the services considered here are that:

- There should be a spectrum of such services, including appropriate day services, for example for women and BME groups.
- Services may be flexible in their referral criteria and times of opening. Some may be open five days per week and 9.00am – 5.00pm, whilst others may operate extended hours or weekend opening.
- They should support the other mental health teams and inpatient services in the area
- They are generally not directly run by the NHS, but by social services or the independent sector.
- The local NHS Mental Health Trust should help support the services through some form of umbrella body, through which day care activity is coordinated. This may include securing agreement about referral so that one referral form covers all the day care or that service users can attend sessions at more than one centre. This gives more choice and flexibility.
- Links should also be made to non-mental health provision such as leisure services.

For vocational services a similar spectrum and flexibility of service is required which provides links with educational and training facilities. In addition, there should be links with volunteer organisations such as the local Volunteer Bureau, Time Banks and the Capital Volunteering Scheme. The spectrum of such services could include: supported employment (there is an evidence base for these), Social Firms, Transitional Employment schemes, Sheltered Employment. These services may not be devoted only to those with mental health conditions and are paid for through either block contracts or by individual payments.

It is assumed that, in the service proposed, there may be little use for NHS day hospitals as many of these may be replaced by the new community teams. Day centres and drop-in services can cater for a wider group of users and for people from BME communities and women. Leisure and educational services may be provided by local authorities and some link workers may be added to assist with these.

Epidemiological base

It is assumed that the day care and employment services will cater for over half of the 430 people on enhanced CPA for a population of 250,000 at any one time. There will be an additional group of people with long-term problems who are not on CPA and will also require some day service contact. Rethink (2004; 2005) estimated that 50,000 people had

been in contact with services over a long period of time, their needs had stabilised but their quality of life, and that of their carers, remained poor.

To estimate the number of staff required for meaningful daytime activity, the current provision in one London borough has been used as a guide. The day services cover a mixed inner city population of 250,000 and include no NHS provision. They offer a range of services and some operate after 5.00pm and at weekends. One centre is for African and Caribbean people. At present the services have a total of 36 staff.

To this staffing should be added six 'Bridge Builders': workers who will offer assistance to users to provide links with other agencies (e.g. employment, voluntary work, education and leisure) in the local community.

Box 15 shows the number day staff required for a total 250,000 population.

Box 15: Staffing for day units – for total population 250,000	
Staff	WTE
OTs	2.0
Managers	4.0
Deputy managers	4.0
Senior project workers	6.0
Other project workers	16.0
Admin workers	4.0
Bridge Builders	6.0
Total	42

How does this compare with current estimates?

There is no indication of staffing levels in the Durham report (Glover *et al.*, 2004), but the services are:

264 NHS Day services across 174 LITS
711 Day Centres or Resource Centres
183 CMHT Day Centre services
397 Drop-in Services
150 Sheltered Employment Services
289 Training and Education Services
238 Supported Employment Services

It is not certain how many different types of work scheme operate in England. Some surveys estimate that there are at least 135 organisations offering sheltered employment, 77 providing open employment and about 50 Social Firms (Crowther *et al.*, 2001; Grove & Drurie, 1999). A survey in the northwest of England found high variation in provision and a poor relationship between the schemes identified and the needs of the areas in which they operated (Crowther & Marshall, 2001).

Current provision suggests that there is a need to develop clearer models and a policy on day care and vocational services that equates with developments in social inclusion.

QUESTION 7: Day care and employment schemes

A wide range of assumptions is possible in this area and the figures used are based on a local example of good practice.

- **Is this appropriate as a model for national application?**

IV. Forensic Services

Forensic services work with people at the interface of law and mental health services. They are concerned with the assessment, treatment and clinical management of mentally disordered people who have committed grave offences (or who are deemed capable of committing grave offences). These services have mainly been based in inpatient units, the high secure units (Broadmoor, Ashworth and Rampton) and in medium secure units which offer shorter term assessment and treatment. There has been less emphasis on community based forensic services, although this is changing.

Inpatient Beds

There is an insufficient understanding of the capacity required for forensic beds over the next decade. The Department of Health has commissioned an independent report on requirements for medium and high secure services, which is said to be reporting imminently.

The difficulty in calculating the high and medium secure bed requirements is that forensic services are essentially capacity based. Figures on the prison populations suggest a high level of unmet need for which forensic services have inadequate capacity. Future developments will bring additional pressures on forensic services. These include the implications of the new Mental Health Bill; the criminal Justice Act 2003 in which sentences aimed to protect the public will be based on actuarial assessments of risk; the development of 'Dangerous and Severe Personality Disorder' (DSPD) units in prisons and special hospitals; the impact of multi-agency public protection arrangements; and the creation of mental health teams for prisons (Department of Health/HM Prison Service, 2001).

High Secure Beds

Currently high secure beds are based in the three special hospitals (Broadmoor, Rampton and Ashworth). The number of people resident in the three hospitals has reduced since 1985 from a peak of 1,750 to 1,300 at the end of 1999 when a survey was carried out to examine the beds in high secure hospitals (Fender, 2004). Between 2000-2004 the Accelerated Discharge Programme (ADP) led to the redistribution of 400 patients to medium secure units, thus further lowering the number of residents.

The present plans are to keep each secure hospital and to have each take patients from specific parts of England and Wales. All women will be based at Rampton as will patients with learning difficulties and those who are deaf. New DSPD units will be based at Broadmoor and Rampton. Fender (2004) gave projections for 2010 of:

- Ashworth - about 210 beds required
- Broadmoor - about 257 beds required
- Rampton - about 353 beds required

These figures are in agreement with the 820 beds projected by the National Beds Inquiry for 2010/2011.

Medium Secure Beds

It is estimated that there are about 2,800 medium secure beds in England (14 per 250,000 total population) with about 40% being provided by the independent sector (Royal College of Psychiatrists, 2005a). There are an additional 706 beds for people with learning disability.

The National Beds Inquiry suggested 13 per 250,000 population (total of 2,543 projected for 2010/2011). In the absence of better data these figures will be used here. However it is likely that this is an underestimate and may need to be revised in the future.

For 13 beds in a Medium Secure Unit it is assumed that:

1. The number of staff required to cover the early, late and night shifts are the same as for an 8-bedded PICU: five for early and late shifts and four at night. 21 nurses are required to cover for 7 days.
2. The same 28.4% addition as for acute units is required – 26.9 staff required.
3. The ratio of qualified to unqualified is 70:30 (18.8 qualified and 8.1 unqualified).

See Box 14 for the actual staffing of medium secure units.

Community Forensic Teams

There may be some parallel here with general adult community schemes, but these teams are presently in their infancy and there is no guidance as to their structure and function. There is a need to consider the community management of offenders and those discharged from secure services and these teams may cover these tasks. Components of such a service may include:

- Consultation/liaison with local CMHTs to advise on risk and criminal justice matters, including advice on patients with complex needs involving risk and/or offending.
- Management of a small caseload of high risk individuals in the community and patients on restriction orders with complex needs.
- Providing a resource to multi-agency public protection arrangements (MAPPAs) in the area.
- Consultation/liaison to Probation and other agencies within the national offender management system.
- Overseeing Court Liaison and Court Diversion arrangements.

The actual number of people requiring support from this team is not known, but based on teams operating in south London the desirable staffing for an area of 250,000 total population might be that shown in Box 16.

Box 16: WTE Staff required for a total population of 250,000 – Community Forensic Teams	
Staff	WTE
Consultant psychiatrist	1
SpR (specialist registrar)	1
Clinical psychologist	1
CPNs	5
Social workers	3
Administrator/secretary	1
Total	12

There is no current data indicating how many of these teams exist in England, but anecdotal evidence suggests there are few.

Prison In-reach Services

The NSF-MH applies to all working age adults, including prisoners. The Department of Health and Prison Service set out their strategy for modernising mental health services in prisons in December 2001 (Department of Health/HM Prison Service, 2001). The aim was to provide a range of services available to prisoners over the forthcoming three to five years, in line with the NSF-MH and the NHS Plan (Department of Health, 2000a).

Type of service

There are three major groups at which services should be aimed: those with mental disorders, those with substance abuse and those with learning difficulties.

Two types of team are required,

- a. The equivalent of CMHTs for prisons (these may also incorporate a dedicated member of a learning disability service within the team).
- b. Dedicated substance misuse teams. These teams could consist of addiction nurses and specially trained prison staff, with input from GPs. They may link with similar workers, for example CARAT (Care, Assessment, Rehabilitation and Throughcare) and PASRO (Prisoners Addressing Substance Related Offending) workers. They could offer detoxification, drug counselling, methadone maintenance and other pharmacological treatment and encourage seamless through care.

Epidemiological base

The distribution and prevalence of mental health problems in prisons differ substantially from the general population and people with mental health problems are significantly over-represented in the prison population. Multiple diagnoses are common. Singleton *et al.* (1998) study found that 9 out of 10 prisoners met their criteria for at least one mental health diagnosis, most of whom had more than one.

There are 139 prisons in England and Wales. About 140,000 people pass through English and Welsh prisons in any one year. At the end of September 2005 there are approximately 77,000 people in prison (HM Prison Service, 2005) and that figure is projected to rise to 91,500 by 2010 (Home Office, 2005).

In an average male prison (for example Brixton with 800 prisoners) the ONS study would suggest that up to 720 prisoners will have mental health symptoms meeting a research definition for a mental disorder including:

- 48 with schizophrenia
- 320 with depression, anxiety and related conditions
- 272 dependent on drugs
- 512 with personality disorder.

Self-harm and completed suicide are also present at a substantially higher level than in the general population.

There is a very high use of drugs and alcohol among prisoners (see Borrill *et al.*, 2003; Litiano & Ramsey, 2003; Bullock, 2003). Before imprisonment:

- About half of prisoners have used cocaine or heroin recently.
- 82% of heroin users and 37% of crack cocaine users were consuming it every day.
- Over 60% used cannabis and 40% amphetamine.
- 66% of heroin users were also consuming crack cocaine.
- 54% of prisoners were using at least one type of illegal drug daily before imprisonment.
- About 50% give evidence of moderate or severe dependence.
- Severe dependence is found more frequently in women.
- About 30% had “severe alcohol problems” (Litiano & Ramsey, 2003; Bullock, 2003).

Drug withdrawal on admission may lead to self-harm. 11% of suicides occur during the first 24 hours in prison, 33% in the first week and 47% in the first month. Of these 62% of these are problematic drug users (HM Prison Service, 2001).

While in prison, the frequency of drug misuse in general is much less than outside prison, but 54% of prisoners use cannabis, 27% heroin and 15% illicitly obtained tranquillisers. Use of other drugs is less common, for example 7% still use cocaine, 3% on a daily basis (Singleton *et al.*, 1998), while 44% of those using drugs before imprisonment abstain while in prison. Yet about 25% of those who have ever used heroin used it for the first time while in prison (Bullock, 2003).

There are wide variations in the estimates on the number of offenders with learning difficulties in prisons. Murphy *et al.* (1995) surveyed 157 male prisoners in HM Prison Belmarsh and found that 33 responded that they had a learning difficulty or had attended special school.

Service requirements

A currently unpublished report on prison psychiatry from the Royal College of Psychiatrists (2005b) recommended that the number of consultant psychiatrist posts required depends on the size and nature of the prison:

Category B local remand prison of 500 places (Category B are prisoners who do not require maximum security, but for whom escape needs to be made difficult):

0.5 WTE consultant (general adult or forensic)
0.5 WTE non-consultant grade
Plus 0.2 WTE addiction specialist sessions and
Psychotherapy input – 3 sessions.

Category A local remand prison of 500 places (Category A are prisoners whose escape would be highly dangerous to the public or national security):

0.75 WTE consultant (general adult or forensic)
0.5 WTE non consultant grade.
Plus 0.2 WTE addiction specialist sessions and
Psychotherapy input – 3 sessions.

Category B dispersal prison of 500 places

0.5 WTE (forensic or forensic rehabilitation)
0.5 WTE non consultant grade and
Psychotherapy input – 3 sessions.

Category C and D dispersal prison (Category C are prisoners who cannot be trusted in open conditions but who are unlikely to try to escape; Category D are prisoners who are trusted enough to wander freely but must show up for daily roll calls). These are unlikely to require full psychiatric team so perhaps 0.3 WTE per 500 places but with same access to specialist services through a Mental Health Trust.

The staffing required for teams for a hypothetical category B prison of 550 inmates is shown in Box 17.

Box 17: Staffing for hypothetical category B prison of 550 inmates	
CMHT Staff	WTE
Consultant psychiatrist	0.5
Consultant psychotherapist	0.3
Staff grade doctor	0.5
Clinical psychologist	0.5
CPN (including 1 *LD trained)	3.0
OT	1.0
OT helper	2.0
Technical instructor	1.2
Social worker or probation officer	0.5
Counsellor	0.5
Creative therapist	0.5
Speech and language therapist	0.5
Total	11.0
Substance Misuse Team Staff	
	WTE
Addiction specialist	0.2
CPNs	3.0
Total	3.2

*LD = learning disability

If there are 58 Category A and B remand and dispersal prisons in England with approximately 32,395 places then, assuming that the numbers of staff above are required for 550 inmates, 648 CMHT staff and 188 substance misuse staff are needed for these services. There are 43 category C and open prisons with approximately 20,935 places; if 0.3 consultant psychiatrists are required for 500 places then 13 additional consultant psychiatrists are required. The figures for the prisons are taken from HM Prison Service (2004).

QUESTION 8: Forensic services

As with other inpatient services, the figure for medium-secure beds is taken from the National Beds Inquiry, but this looks particularly in need of revision because of the rapid growth in secure provision in recent years.

- **What other assumption might be used?**

QUESTION 9: Prison services

Prison in-reach services are undergoing major change.

- **Are there local examples of good practice which could be used to underpin the service specifications in this area?**

V. Sub-Speciality Services

The main specialist adult services outlined in this document will require additional support for specific groups of service users. These sub-speciality services include general hospital liaison services, perinatal services, services for people with eating disorders and personality disorders and services for deaf people. These services may cover populations in excess of 250,000.

I. Liaison Psychiatry Services

Services required

These are for the provision of general services to an entire acute hospital, with possibly some sessional input into specific units, for example oncology units, although additional funding may be needed for these.

Epidemiological base

The figures for liaison services have been taken from the Royal College of Psychiatrists/Royal College of Physicians (2003) report. The figures are based on:

1. Estimates of likely demand (from House & Hodgson, 1994).
2. A District General Hospital of 600 beds in a catchment area of 250,000.
3. Provision of general services to the entire hospital, with some liaison with specialist units.
4. For a Teaching Hospital in an inner city area, with many specialist and tertiary centres – extra staff may be required e.g. 2 full-time consultants.

<i>Estimated workload</i>	<i>Annual rate of patients seen</i>
Deliberate self-harm (DSH)	500
A&E episodes	200
Ward referrals	200
<i>Outpatient contacts</i>	
New	100-150
Follow-up	500
Specific liaison with one or two units	100

The staffing required is shown in Box 18.

Box 18: WTE Staff for a total population of 250,000 – General Hospital Liaison services	
Staff	WTE
Consultant	1.0
SpR (specialist registrar)	1.0
SHO (senior house officer)	1.0
Liaison nurses	5.0
Clinical or health psychologist	2.0
Secretary	1.0
Total	11.0

2. Perinatal Services

Services required

These services are targeted to women of child bearing age. The types of services required include:

- Mother and baby inpatient unit
- Specialist community mental health team
- Liaison services for obstetrics and primary care
- Parenting skills assessment
- Day hospital service.

Epidemiological base

Women are at increased risk of having an affective illness following childbirth and women with pre-existing mental health problems also face the risk of relapse or recurrence following childbirth. The main types of conditions are depression and affective psychosis. The rate of these disorders is usually expressed as that per 1,000 births (or women delivered) (see Royal College of Psychiatrists Report, 2000a). The birth rate is approximately 12.5 per 1,000 population. Figures for a population of 250,000 are shown in Box 19.

Box 19: Rates of mental health disorders in women following childbirth		
Disorder	Rate per 1,000 births	Number in total 250,000 population
Major depression	100	312
Moderate – severe depressive illness	30-50	156
Referred to psychiatric services (new episodes of postnatal psychiatric disorder)	20	62.5
Admitted with psychosis	2	6.25
Admitted with non-psychotic depression	2	6.25
Chronic schizophrenia	2	6.25

The report on *Perinatal Maternal Mental Health Services* (Royal College of Psychiatrists, 2000a) gives recommendations for the type and configuration of perinatal services. Given the delivery rates and rates of perinatal disorder it is probably not necessary to set up specific sub-specialist perinatal services for populations of 250,000 and it may be better to consider larger populations of, say, one million. The recommended services for one million population are:

- Mother and baby inpatient unit – six beds
- Consultant perinatal psychiatrists
- Specialist community mental health team
- Outpatient clinics (three per week), obstetric liaison service, primary healthcare liaison service, parenting skills assessment
- Day hospital service.

Staffing for this is shown in Box 20.

Box 20: WTE Staff for a total population of 1 million – perinatal services	
Staff	Number WTEs
<i>Medical (work across PN services)</i>	
Consultant psychiatrist	1.5
SpR (specialist registrar)	1.0
SHO (senior house officer)	1.0
<i>Community Team</i>	
Nurses (1 nurse manager and 7 G or F grades)	8.0
Social worker (works across PN services)	1.0
Clinical psychologist (works across PN services)	1.0
<i>Mother and Baby Unit (6 beds)</i>	
Nurses	7.0
Nursery nurses	7.0
<i>Day Hospital</i>	
Nurses	5.0
Nursery nurses	5.0
Administrators	3.0
Total	40.5

3. Eating Disorder Services

Services required

These are services directed at people suffering from specific conditions. Eating disorders are most common in young women and the services required are for both adults and adolescents. Adult services will be considered here, but liaison between adolescent services, paediatric services and primary care will be necessary. Two types of service may be required:

1. High intensity treatment team providing outpatient, day patient, inpatient and outreach services.
2. Outpatient treatment team providing outpatient and outreach services.

Epidemiological base

These are taken from the Royal College of Psychiatrists report on *Eating Disorders in the UK* (Royal College of Psychiatrists, 2000b). The rates of eating disorders in women are shown in Box 21.

Box 21: Rates of eating disorders in women			
Disorder	Incidence	Prevalence	Number in total 250,000 population (80,822 women aged 16-65 years)
Anorexia nervosa	8.6 per 100,000	0.3%	242
Bulimia nervosa	12.4 per 100,000	1.0%	808

Box 22 shows the services and staffing for a total population of one million people suggested in the Royal College of Psychiatrists (2000b) report. This staffing covers the provision for the two teams described above.

Box 22: WTE Staff for a total population of 1 million – eating disorder services	
Staff	WTE
<i>Medical</i>	
Consultant psychiatrist	1
Consultant psychotherapist	1
SpR (specialist registrar)	1
SHO (senior house officer)	0.5
<i>Nurses</i>	
Nurses	24
Psychologist	2
Family therapist	2
Occupational and/or creative therapists	3
Chef	0.5
Dietician	1
Secretary	2.5
Administrator/manager	1
Total	39.5

4. Local Personality Disorder Services

Services required

The document *Personality Disorder: No longer a diagnosis of exclusion* (NIMHE, 2003) recommended that service provision for personality disorder can most appropriately be provided by means of:

1. The development of a specialist multidisciplinary personality disorder team to target those with significant distress or difficulty who present with complex problems.
2. The development of specialist day patient services in areas with high concentrations of morbidity.

Epidemiological base

Moran (2002) reviewed the epidemiology of personality disorders for the Department of Health review that led to the publication of *Personality Disorder: No longer a diagnosis of exclusion* (NIMHE, 2003).

Community studies of the prevalence of unspecified personality disorder report prevalence figures ranging from 10-13% (de Girolamo & Dotto, 2000). Community rates of Cluster B types (histrionic, narcissistic, antisocial and borderline personality disorders) are about 5.7%. Personality disorders are more common in younger age groups (particularly the 25-44 year age group) and equally distributed between men and women, although the sex ratio for

specific types of personality disorder is variable e.g. antisocial PD is commoner among men). In psychiatric settings, the prevalence of personality disorders is probably high but difficult to quantify.

Several general points emerge from these studies:

- In general, the rate of personality disorders among psychiatric outpatients and inpatients is high, with many studies reporting a rate of greater than 50%.
- Borderline personality disorder is generally the most prevalent category in psychiatric settings.
- Personality disorders are particularly prevalent among inpatients with drug, alcohol, and eating disorders, often reported to be in excess of 70%.
- Commonly, people meeting criteria for one category of personality disorder also meet the criteria for other personality disorders. This may be a true concurrence of discrete personality disorder categories, or may represent the failure to define disorders precisely.
- There is some comorbidity between personality disorders and other mental health conditions.

In these settings people with Cluster B personality disorders attract the most attention. People with Cluster B personality disorders share the characteristic of poor impulse control and often present to hospital services when intoxicated or in crisis, threatening deliberate self-harm or aggression to others.

Given the difficulty in establishing a firm prevalence of these disorders, but knowing that many of this group will already be in contact with mental health services (or will have had past contact), the types of service considered here to be provided locally are outpatient based assessment, a psychological therapies team and a day service team. The treatments provided should be evidence based (see Bateman & Tyrer, 2002). The teams should provide assessment and eclectic treatment and liaise with the other adult teams in the area. Sufficient seniority will exist to provide adequate skills, experience and supervision and sessional therapists trained in a range of therapies will be required. A team of at least 6-7 personnel is required to make a 9.00-5.00 day facility viable. These teams will be linked and share personnel. Box 23 shows the requirement for a population of 250,000.

Box 23: WTE Staff for a total population of 250,000 – local personality disorder services	
Staff	WTE
Consultant psychiatrist/psychotherapist	1
SpR (specialist registrar)	1
Clinical psychologist	2
Team leader (I grade or equivalent)	1
Deputy (G grade or equivalent)	1
Social worker	1
Nurse therapist	5
Sessional psychotherapists	3
Art (or other creative) therapist	1
Administration/secretary	2
Total	18

5. Services for Deaf People

The Department of Health published *A Sign of the Times*, a consultation document concerned with the development of a national strategy for mental health services (both health and social care) for people in England who are deaf or deafblind (Department of Health, 2002e). The document covers the NSF-MH standards for adults of working age who are deaf or deafblind. The principles of the document were:

- That national standards of mental health care apply equitably to people who are deaf.
- That the deaf community can conveniently access mental health services that are communicatively and therapeutically appropriate to their needs.
- That deaf people can play a leading role in the provision of such mental health services.

There is no evidence that deaf people have any different levels of psychiatric morbidity than those who are not deaf. Thus they are contained in the figures quoted earlier in this paper.

For services for adults the document took as its basis the Health Advisory Service report *Forging New Channels* (BSMHD, 1998). It recommended a strategic framework for commissioning and delivering specialised services based on a four-tier model of service provision for both children and adults:

Tier 1 - would involve the development of “local services”, including primary health care and local mental health services, aimed at improving recognition and earlier intervention.

Tier 2 - would be “augmented local services”. This envisaged links between local mental health services and the specialist centres, with the latter providing consultation, training and information to the former. At Tier 1 and Tier 2, responsibility for individual patient management would remain with the local service.

Tier 3 – “dispersed services provided by the very specialised services” suggested the consolidation and formalisation of current outpatient and community services provided by the three centres. At Tier 3, the specialised services would take lead responsibility for patient management, at times offering coordinated care with the local service.

Tier 4 – “specialised services provided at the centres of special expertise” – concerned a continuation of the current specialised inpatient and day patient services provided by the three specialist centres.

For resources the document proposed that as a disadvantaged group, deaf people should receive the same degree of access to health care as any other member of the population. It suggested that, where good practice exists, many of the recommendations should already be in place. Primary care trusts and mental health services were asked to consider whether their arrangements for deaf people need to be strengthened to meet the standards set out in this document and to implement these through better use of existing resources.

The document asked people to consider two options for the delivery of services at the intermediate tier:

1. Local mental health provider trusts develop services to meet the needs of their deaf community within the context of their LIT and local CAMHS development strategies.
2. The three existing specialised deaf services develop comprehensive multi-agency and multi-professional community services all over the country, and provide care-coordination for all patients in their care.

The document suggested that those responsible for specialised mental health commissioning will need to review their investments to ensure that improvements can be delivered. It was recognised that forensic services for deaf people with mental health problems would be a significant and necessary investment and consideration is being given to the provision of central support for this purpose (they suggested beds at Rampton, which are included in our estimates).

For workforce planning and training the document recommended:

- To employ more deaf people in health and social care.
- To increase professional training opportunities for deaf people.
- To recruit and retain staff to offer specialised services.
- To map current specialist workers with the deaf people in relevant services.
- To encourage local mental health communities to include specialised services for deaf people in their local directories.
- To influence the development of a greater number of British Sign Language (BSL) interpreters to be available to health services. Regional educational confederations could be influential in the training of interpreters in co-operation with their professional organisation.
- To encourage training in deaf awareness across mental health professions in all agencies (education; health; social services; probation) in pre-registration and continuing professional development education and training.

There are no available results of the consultation. In view of this we might assume the second option and find out the existing staffing for the three specialised deaf services and use these in our future calculations.

QUESTION 10: Sub-speciality services

The underlying estimates of prevalence for personality disorders are uncertain and may not reflect need.

- **We would particularly welcome comments on the appropriate level of provision for personality disorder services.**

VI: Staffing for the Implementation of the Proposed Mental Health Act

It is inevitable that the proposed new Mental Health Act will require an increase in staff for its implementation. The assumptions that this should be based on depend on the final details of the Act and its implementation. There is likely to be an increase in the numbers of examinations, compulsions, Mental Health Tribunals and appeals, expert panels and need for advocates. The estimates given in the Department of Health's *Regulatory Impact Assessment* (Department of Health, 2004f) are shown in Box 24.

Box 24: Staffing estimates for the proposed new Mental Health Act (Department of Health, 2004f)			
Staff	1983 Act requirements	Estimated new Act requirements	Increase (%)
Psychiatrists	260	390	130 (50%)
Other medical staff	60	80	20 (33%)
Qualified nurses	20	110	90 (450%)
Other nurses	20	40	20 (50%)
Other clinical disciplines	0	80	80 (-)
Social workers	430	480	50 (12%)
Administrators	320	510	190 (60%)
Advocates	0	140	140 (-)
Legal members	30	110	80 (267%)
Lay members	80	110	30 (38%)

These figures should be considered additional to the ones proposed in this paper for the purposes of service delivery. The estimates should be regarded as tentative and more informed estimates should be made as more information emerges.

Standard 6 – Services for carers

“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.”

What type of service?

There is no set model for carers’ services and no clear estimate of needs. It is assumed that there will be a new team covering the 250,000 catchment area which may be associated with the CMHT or local voluntary agencies (Department of Health, 2002f).

Epidemiological base

Using the estimate that there are approximately 430 people on enhanced CPA for a population of 250,000, we may assume:

75% need carer assessments (total = 322)

50% of these carers will need some input at any one time (total = 161)

15% need intensive input at any one time (total = 48)

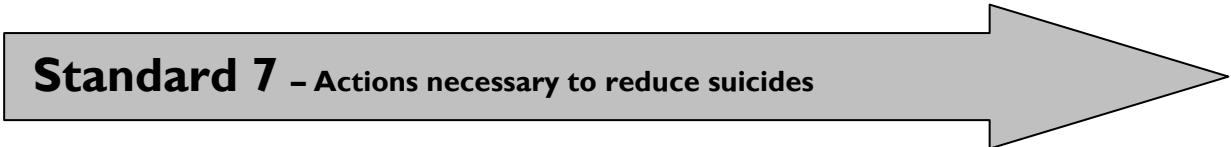
Those requiring intensive input will need 7 hours of support worker time per week.

The estimated staffing is shown in Box 25.

Box 25: WTE Staff for a total population of 250,000 – carers services	
	WTE
CPN	5
Social worker	6
Support worker	8
Total	19

How does this compare to other estimates?

Figures from 2003 (Glover *et al.*, 2004) show that 155 LITs provided at least one dedicated carer service. Eight LITs reported providing no carer services and 11 LITs only provided these from within a Mental Health Day or Resource Centre. The services available were: 280 carer support services. These were varied and included training courses, carer development workers, assessment teams, telephone helplines. 177 carer support groups. 90 services for respite and short breaks.



Standard 7 – Actions necessary to reduce suicides

“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.”

STANDARD 7

No separate estimates are required for Standard 7.

Summary of staffing needs to implement the NSF for Mental Health

The total staff requirements for mental health professionals calculated in this paper for the NSF-MH are shown in Box 26 together with the existing staffing levels, where known. The existing staffing levels indicate staff working in all mental health fields, with the exception of consultants, and the actual numbers of staff working in adult mental health is not known. Thus the increase required that is quoted in column five is an underestimate in many cases.

Box 26: Staffing increases required for a Good Mental Health Service

Staff	Number per 250,000 population	Total number for England	Current staffing ⁽¹⁾	Increase required
Consultant psychiatrists (adult)	14.9	2971	1776	1195 (67.3%)
Consultant forensic	2	399	209	190 (90.9%)
Consultant psychotherapists	2.3	459	92	367 (400%)
Consultant CAMHS	0.1	20	-	-
Other medical staff	28.6	5,703	NK	NK
Nurses	303.7	60,618	41,585	19,033 (45.8%)
Social workers	46.25	9222	4200	5022 (120%)
Occupational therapists	21.5	4277	4,626 ⁽²⁾	?%
Clinical psychologists	51.2	10,209	5,518	4,691 (85.0%)
Psychotherapists (including CBT)	24	4,786	723	4,063 (562%)

⁽¹⁾ Figures taken from *NSF Five-year Review* (Department of Health, 2004a) and *New Ways of Working* (Department of Health, 2005b)

⁽²⁾ The 13,879 are generic OTs. The number working in all mental health services is thought to be approximately a third of this figure.

NK = not known

QUESTION 11: Coverage

We want to ensure comprehensive coverage of the services that are required for delivery of the National Service Framework for Mental Health.

- a. Has this been achieved?
- b. Are there any important omissions?

Discussion

The approach taken in this paper has been to describe a good mental health service in terms of what would be needed to deliver it to a given population of 250,000. This then allows the overall staff requirements for England to be estimated. The specifications have been based on the NSF-MH and its associated documents where possible. However the NSF-MH does not provide a complete description of a mental health service, so gaps have had to be filled with other policy or guidance documents or with a pragmatic approach to what constitutes a 'good' mental health service.

The NSF-MH does not specify in detail how its standards are to be met. These have been interpreted in this paper in the form of a service model. This is easier in Standards 4 and 5 as the Policy Implementation Guide is prescriptive in its description of the new community teams, but is more difficult in Standards 2 and 3 where no types of services are specified. In

our approach to describing a good mental health service we have not defined the actual philosophy and practice of teams and in some cases, for example in primary care, have not prescribed any model of service. In this latter case, only specific medication needs and the number of cognitive behavioural therapists required to improve access to psychological therapies for people with depression and anxiety have been examined. The actual delivery and organisation of these services for primary care have been left open to debate.

We have assumed that a multi-sector and multi-disciplinary model is required to deliver the range of services and skills necessary for a good mental health service; but training requirements have not been considered. The need for services has been based on epidemiological figures where available, but it is acknowledged that these may change over time and will certainly vary across the country. The actual staffing requirements for a 250,000 population will vary depending on local demographics and so numbers of staff will need to be modified to take this into consideration.

This document has been written with the intention of providing a platform for discussion, a SCMh 'Green' paper. Comments on the assumptions and calculations are welcome. The next stage will be to refine these figures and provide costings, but at this stage it is clear that to deliver the seven standards of the NSF-MH will require considerable investment in services, staffing and training; careful planning to specify modes and models of delivery and evaluation to assess outcomes.

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DEFINING A GOOD MENTAL HEALTH SERVICE

Summary of Consultation Questions

QUESTION 1: Overall approach

The suggested service specifications are variously derived from official guidance, epidemiological data, local examples of good practice and professional judgment.

a. Are you content with this general approach?

b. Are there any major sources of information that have not been taken into account?

QUESTION 2: Mental health promotion

In the absence of nationally accepted models for mental health promotion or guidance for these services, the suggested specifications for Standard 1 are based largely on existing practice.

a. Is this too conservative, particularly as the government's 5-year review of the NSF-MH notes that only limited progress has been made in delivering this standard?

b. What other evidence-based assumptions could be made?

QUESTION 3: NSF Standards 2 and 3

There is no clear model for mental health services at the primary care level, so the key specifications (relating to medication and psychological therapies) have been built up from a variety of sources.

a. Are you content with the main assumptions used, as summarised in boxes 4-6?

b. For reasons explained in the paper, the specifications are derived from data relating to the number of people with new onsets of anxiety and depression presenting to GPs. Is this the correct approach?

c. The numerical estimates relate mainly to depression and anxiety. Should more attention be given to other neurotic disorders (obsessive compulsive disorders, phobias etc)?

QUESTION 4: Community-based teams

- a. Are you content with the assumptions on caseloads and on staffing levels per team?

- b. What other assumptions would you make?

QUESTION 5: Support workers

Many areas of the country have support workers employed by voluntary sector organisations, which may also supply other community based services (e.g. day services).

- a. How many support workers may be required?

- b. What assumptions underlie the calculation of these numbers?

QUESTION 6: Inpatient and residential services

Estimates of numbers of places needed are taken from the National Beds Inquiry published in 2000.

- a. **Do any of the figures require modification in the light of subsequent developments?**

- b. **Are you content with the staffing assumptions, particularly for acute inpatient units?**

QUESTION 7: Day care and employment scheme

A wide range of assumptions is possible in this area and the figures used are based on a local example of good practice.

- **Is this appropriate as a model for national application?**

QUESTION 8: Forensic services

As with other inpatient services, the figure for medium-secure beds is taken from the National Beds Inquiry, but this looks particularly in need of revision because of the rapid growth in secure provision in recent years.

- **What other assumption might be used?**

QUESTION 9: Prison services

Prison in-reach services are undergoing major change.

- **Are there local examples of good practice which could be used to underpin the service specifications in this area?**

QUESTION 10: Sub-speciality services

The underlying estimates of prevalence for personality disorders are uncertain and may not reflect need.

- **We would particularly welcome comments on the appropriate level of provision for personality disorder services.**

QUESTION 11: Coverage

We want to ensure comprehensive coverage of the services that are required for delivery of the National Service Framework for Mental Health.

a. Has this been achieved?

b. Are there any important omissions?

QUESTION 12: Any other comments

- **Are there any other comments that you wish to make?**

**Please see overleaf for details
of how to return your form**

Please complete the following.
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Please send your responses to:

Dr Jed Boardman
Senior Policy Advisor
The Sainsbury Centre for Mental Health
134-138 Borough High Street
London
SE1 1LB
Email: costsconsultation@scmh.org.uk