medicine for managers

Knowing the business of healthcare
September 2013

Mental health services

An introduction to mental health services for finance managers

Foreword

This guide to mental health is the second briefing in the HFMA's Medicine for Managers series, following the publication of our popular guide to paediatrics in December 2012.

We have chosen to focus on mental health because mental health problems are among the most common health conditions, directly affecting about a quarter of the population in any one year.

The aim of our briefing is to enhance the knowledge of finance staff and help them to engage with their clinical colleagues with confidence in order to improve quality and efficiency in their organisation together. The objectives are to develop an awareness of:

- The background, role and structure of a specific specialty
- The staff involved in delivering the care
- The main conditions or diseases they treat
- The key financial facts and figures
- Current service challenges
- Potential service innovations and their likely impact.

The HFMA, along with others, has been a keen advocate of increasing the financial management knowledge of those delivering and managing healthcare. But while clinicians' understanding of financial management has improved, the HFMA is keen to ensure that its members' understanding of clinical practice keeps pace.

NHS accountants, particularly those supporting clinical directorates, have a key role in contributing to the delivery of high-quality, value-for-money services. They can only do this properly if they understand the services they support.

Finance staff can gain significant benefits from developing greater clinical awareness. This understanding – or 'knowing the business', as I have termed my theme for my year as HFMA president – goes beyond a familiarity with the specific language used and includes an appreciation of the key features of the day-to-day provision of services, the key challenges and inter-relationships with other services, and the likely impact of future clinical practice and innovations.

We hope you find the guide useful and would welcome your feedback and any suggestions you may have for future briefings.

Tony Whitfield, HFMA president

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Introduction to mental health services

What are mental health services?

Mental health is complex. Mental health services cover all ages with a wide range of conditions. Some service users will recover relatively quickly, while for others it is a long-term condition. Care is delivered in a wide range of settings by a mix of NHS, private and third sector organisations and multiple agencies are often involved in the care of individual service users. People often have a combination of physical and mental health problems, which require joint planning and delivery of care.

Mental health problems vary in nature and severity and in their impact on an individual over time. About half of people with 'common mental health problems', such as depression and anxiety, are no longer affected after 18 months.

Severe mental health problems can be long lasting and can have a serious impact on quality of life for individuals, their families and carers. Only a small proportion of people experience severe mental health problems such as schizophrenia or bipolar disorder. Other mental health problems include dementia, eating disorders, personality disorders and substance misuse.

The terms mental health problems, mental illness, mental disorder, mental wellbeing, and mental disability are often used interchangeably, even though they mean different things. Appendix A provides an explanation of the terms. This briefing uses the phrase 'mental health problem' as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorders.

Why focus on mental health services?

Mental health problems account for almost one quarter of the burden of ill health in England and are the largest single cause of disability[1]. The prevalence of mental health problems can increase during periods of economic recession and high unemployment, putting the NHS and other public services under increasing pressure[2]. The increase in the elderly population will result in a significant increase in the incidence of dementia in future.

In 2011, the government stated its commitment to parity of esteem between mental health and physical health services in its mental health strategy, *No health without mental health*[3]. The NHS Mandate[4], which sets out the government's priorities for NHS England between 2013 and 2015, includes a number of objectives to improve the support offered to people with mental health problems, and again reinforces the commitment to parity of esteem between mental and physical health services (*Box A*).

The *No health without mental health* strategy sets out six key objectives for better mental health and improved mental health care (*see Box B overleaf*).

Mental health problems, their symptoms and prevalence

In order to provide an overview to this briefing, the HFMA has been given permission to include information from the Mental Health Foundation's *Fundamental facts* document. This and other information about mental health can be found on the Mental Health Foundation's website[5].

Mental health problems are among the most common health conditions, affecting about a quarter of the population in any one year. Depression and anxiety are the most widespread conditions, and only a small percentage of people experience more severe mental illnesses.

Rates of mental health problems appear to be higher in minority ethnic groups than in the white population. Depression in ethnic minority groups is up to 60% higher, while black Caribbean people in

BOX A: DEFINING PARITY OF ESTEEM BETWEEN MENTAL HEALTH AND PHYSICAL HEALTH SERVICES

Parity of esteem is best described as valuing mental health equally with physical health. More fully, parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by:

- **Equal access to the most effective and safest care and treatment**
- **Equal efforts to improve the quality of care**
- **The allocation of time, effort and resources on a basis commensurate with need**
- **Equal status within healthcare education and practice**
- **Equally high aspirations for service users**
- **Equal status in the measurement of health outcomes.**

Royal College of Psychiatry 2013

FRONT COVER ILLUSTRATION: FOTOLIA

CONTENTS

FOOTNOTES

[1] World Health Organisation (2008) *Global burden of disease* report

[2] Dorling, D. (2009). *Unemployment and health: Health benefits vary according to the method of reducing unemployment.* BMJ, 338, b829

[3] Department of Health (2011) *No health without mental health: a cross government mental health outcomes strategy for people of all ages*

[4] Department of Health (2012) *The mandate: a mandate from the government to the NHS Commissioning Board: April 2013 to March 2015*

[5] www.mentalhealth.org.uk

BOX B: NO HEALTH WITHOUT MENTAL HEALTH

The strategy sets out six key objectives for better mental health and improved mental health care:

- **More people will have good mental health**

More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

- **More people with mental health problems will recover**

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

- **More people with mental health problems will have good physical health**

Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

- **More people will have a positive experience of care and support**

Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

- **Fewer people will suffer avoidable harm**

People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

- **Fewer people will experience stigma and discrimination**

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

the UK are twice as likely as white people to be diagnosed with a psychotic disorder.

Most mental health symptoms have traditionally been divided into groups called either 'neurotic' or 'psychotic' symptoms. Neurotic covers symptoms that can be regarded as extreme forms of normal emotional experiences, such as depression, anxiety or panic. Conditions once referred to as neuroses are now called 'common mental health problems'.

Common mental health problems

Mixed anxiety and depression is the most common mental disorder in Britain, with almost 9% of people meeting the criteria for diagnosis. About half of people with common mental health problems are no longer affected after 18 months, but poorer, long-term sick and unemployed people are more likely to be affected than the general population.

The term **depression** is used to describe a range of moods, ranging from low spirits to more severe mood problems that interfere with everyday life. Symptoms may include a loss of interest and pleasure, excessive feelings of worthlessness and guilt, hopelessness, morbid and suicidal thoughts, and weight loss or weight gain.

A depressive episode may be classed as mild, moderate or severe, depending on the number and intensity of associated symptoms. Between 8% and 12% of the population experience depression in any year.

Anxiety is a normal response to threat or danger and part of the usual human experience, but it can become a mental health problem if the response is exaggerated, lasts more than three weeks and interferes with daily life.

Anxiety is characterised by worry and agitation, often accompanied by physical symptoms such as rapid breathing and a fast heartbeat or hot and cold sweats.

Other common mental health problems include post-natal depression, seasonal affective disorder, obsessive compulsive disorder, phobias and post-traumatic disorder.

Severe mental health problems

Less common are psychotic symptoms that interfere with a person's perception of reality and may include hallucinations, delusions or paranoia, with the person seeing, hearing, smelling or feeling things no one else does. Psychotic symptoms – or psychoses – are often linked with severe mental health problems.

Psychosis describes a loss of touch with reality, which may include hearing voices, seeing something no one else sees, holding unusual personally derived beliefs, experiencing changes in perception or assigning personal meanings to everyday objects.

Psychosis is associated with schizophrenia, schizoaffective disorder, puerperal psychosis, severe depression and is often experienced during the highs of bipolar disorder. About one in every 200 adults experiences a probable psychotic disorder in a year. Less than a quarter of people who have distressing psychotic experiences at some time in their lives remain permanently affected by them. The average age of onset of psychotic symptoms is 22.

Bipolar disorder, which is also known as manic depression, is associated with severe mood changes that fluctuate from elation, overactivity and sometimes psychosis (together known as mania or hypomania) to a lowering of mood and decreased energy and activity (depression). A person usually recovers completely between bipolar episodes.

Schizophrenia is the most common form of psychotic disorder. The diagnosis of schizophrenia refers to a group of symptoms, typically the presence of hallucinations, delusions, disordered thought, and problems with feelings, behaviour, motivation and speech.

After a first episode, about 25% of people with schizophrenia make a full recovery and experience no further episodes. Between 10% and 15% will experience severe long-term difficulties and the remainder will experience recurrent acute episodes, with periods of remission or with only residual symptoms in between.

Other severe mental health problems include schizoaffective disorder and puerperal psychosis.

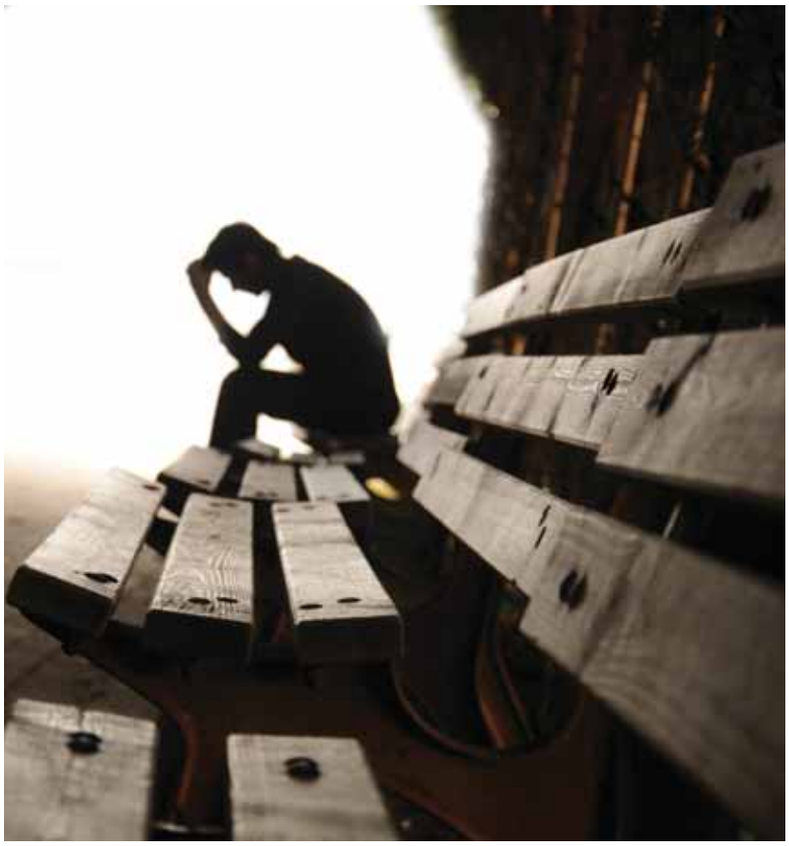
Other mental health problems

Other mental health problems include:

- Eating disorders
- Attention deficit hyperactivity disorder
- Personality disorder
- Dual diagnosis
- Dementia.

Dual diagnosis occurs when there is an overlap between substance misuse problems and other mental health problems. Definitions of alcohol and substance misuse vary. However, dependence is usually defined by preoccupation with use of the substance, inability to control use and failure to cut back despite life-damaging consequences. Between a third and half of people with severe mental health problems consume alcohol or other substances to levels that meet criteria for 'problematic use.' Some 51% of alcohol-dependent adults say they have a mental health problem.

Dementia is a progressive and largely irreversible condition that involves widespread damage to mental functioning. Someone with dementia may experience memory loss, language impairment, disorientation, change in personality, difficulties with daily living, self-neglect and behaviour that is out of character. Dementia affects 5% of people over the age of 65 and 20% of those over 80. About 60% of dementia cases are caused by Alzheimer's disease. About a fifth of cases of dementia are related to strokes or insufficient blood flow to the brain, these cases being known as vascular dementia.



FOTOLIA

The financial picture

It is difficult to estimate the overall spend on mental health, but the economic and social costs of mental health problems in England have been estimated to be £105bn, including £21.3bn in health and social care costs, £30.3bn in lost economic output and £53.6bn in reduced quality of life[6]. Health and social care costs include public expenditure, as well as private spending by individuals and the costs of informal care provided by family and friends.

Programme budgeting data for 2011/12 revealed that NHS commissioners spent £11.16bn (12% of expenditure) on mental health.

Mental health problems also have an impact on the costs of criminal justice, education and homelessness services. They are the most common reason for incapacity benefit claims, with around 43% of the 2.6 million people on long-term health related benefits having a mental or behavioural disorder as their primary condition[7].

FOOTNOTES

[6] Centre for Mental Health (2010) *The economic and social costs of mental health problems in 2009/10*

[7] Department for Work and Pensions 2010 statistical summaries

How mental health services are provided

Most core secondary mental health services, such as acute inpatient beds and community teams, are provided by mental health trusts. But non-statutory providers have a big share of the market for psychological therapy services and specialist inpatient services.

Non-statutory providers range from private companies to voluntary, community and user- and carer-led organisations. Private providers provide some non-specialist beds for mental health trusts if there is a capacity shortfall.

Commissioners

Clinical commissioning groups (CCGs) are responsible for commissioning most mental health services for their local area. In the past, common approaches have included joint commissioning between local authorities and primary care trusts (PCTs), lead commissioning where one PCT takes the lead for a number of PCTs, or commissioning by individual PCTs and local authorities. It is expected that CCGs will continue to use these types of arrangements.

Specialist services are commissioned by NHS England and include eating disorder services, forensic services (low, medium, high), services for the deaf, gender identity, perinatal mental health, Tier 4 child and adolescent mental health services (CAMHS), CAMHS secure and Tier 4 severe personality disorder (adults).

Primary care

Only a small number of people with mental health problems are referred to secondary care and even fewer are admitted to a psychiatric inpatient unit. More than 90% of people with mental health problems are managed entirely in primary care, including one in four people treated for psychosis[8].

There is no standard model for primary mental healthcare services and current patterns of service provision vary significantly across the country. Recent good practice guidance[9] suggests primary mental healthcare teams should include the core primary care team of GPs and practice nurses, primary care-based mental health specialists, third-sector providers (community organisations and networks), school nurses and health visitors.

The Improving Access to Psychological Therapies (IAPT) programme has significantly expanded access to psychological therapies in primary care settings for people with mild to moderate problems. Commissioners invested £213m in IAPT in 2011/12, 22% was with non-statutory providers[10]. Case study 1 sets out IAPT services provided by Nottinghamshire Healthcare NHS Trust in partnership with the charitable organisation Rethink Mental Illness.

FOOTNOTES

[8] Joint Commissioning Panel for Mental Health (2011) *Practical mental health commissioning*

[9] Joint Commissioning Panel for Mental Health (2012) *Guidance for commissioners of primary mental health care services*

[10] Mental Health Strategies (2012) 2011/12 *National survey of investment in adult mental health services*

[11] Department of Health 2011/12 *Programme budgeting*

[12] Mental Health Strategies (2012) *2011/12 National survey of investment in adult mental health services*

[13] Mental Health Strategies (2012) *2011/12 National survey of investment in mental health services for older people*

CASE STUDY 1: IAPT SERVICES IN NOTTINGHAMSHIRE

Simon Smith is executive director, local services, at Nottinghamshire Healthcare NHS Trust.

"The national IAPT programme was created to offer people a first-line treatment for depression and anxiety disorders, combined, where appropriate, with medication prescribed by GPs, which had traditionally often been the only treatment available. IAPT services are intended to provide early intervention to prevent the onset of more serious and longer-term mental health problems.

The evidence base shows that providing therapy can benefit both the individual and the nation, by helping people come off sick pay and benefits and stay in or return to work. Cognitive behavioural therapy (CBT) has been proven to be as effective as medication in helping people with depression and anxiety disorders and better at preventing relapse. Therapists provide high-intensity treatment to people with moderate depression or anxiety disorders, while psychological wellbeing practitioners offer guided self-help to people with mild to moderate depression.

IAPT services in Nottinghamshire are provided in partnership by Nottinghamshire Healthcare NHS Trust and the charity Rethink Mental Illness. We value the expertise, innovation and different approaches that Rethink have brought to the partnership. Unlike our core secondary mental health services, we had to compete on a commercial basis with other NHS and non-NHS organisations to win the IAPT contracts.

We use the nationally recommended model of seeing large numbers of people with minimal wait times for treatment. At a first assessment appointment, the therapist will plan a programme of support for a defined length of time. We offer a range of interventions, including computer-based CBT, group work and one-to-one sessions. Pre- and post-treatment outcome data is collected for every intervention.

To help combat the stigma of mental illness, our IAPT services have a different brand name from our secondary mental health services. They are known as Let's Talk – Wellbeing. Sometimes we offer therapy sessions for large groups of people in their local village hall, again with the aim of reducing stigma and improving access."

Secondary care

Some secondary mental health services are divided into distinct age-specific services:

- CAMHS
- Mental health services for working age adults
- Older people's mental health services.

Such services include a mixture of inpatient beds and community teams. Other services include forensic mental health services, liaison psychiatry services, drug and alcohol services and mental health services for people with learning disabilities. Within a particular geographical area, services may be provided by one mental health provider or by a number of different providers.

Child and adolescent mental health services

Annual spend on CAMHS was in the region of £710m in England in 2011/12[11]. Mental health services for children and young people are planned and delivered using a four-tiered model (*Table 1*).

Mental health services for working age adults

A total of £6.6bn was spent on specialist mental health services for adults of working age by the NHS and local authorities in England in 2011/12[12]. Some 83% of adult services were commissioned by the NHS and the remaining 17% by local authorities. The highest area of spend (*Table 2*) was secure services and psychiatric intensive care units (PICU). The majority of adult services were provided by the NHS, but just over a quarter were provided by non-statutory providers (*Figure 1*).

Table 3 (*overleaf*) describes the traditional model of services based on the Department of Health's 1999 framework, *A national service framework for mental health*. More recently, mental health trusts have been redesigning services to reduce the reliance on in-patient services, offer a single point of access to service users and provide a range of treatments, including recovery colleges that offer training in skills and techniques to empower service users, carers and staff to more effectively manage their mental health.

Mental health services for older people

A total of £2.8bn was spent on older people's mental health services in 2011/12 in England by the NHS and local authorities in 2011/12[13]. Some 62% of services were commissioned by the NHS and the remaining 38% by local authorities. The highest area of spend related to care homes (*Table 4 overleaf*). Slightly less than half of services were provided by

TABLE 1: THE FOUR-TIERED CAMHS MODEL

Tier 1	Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers) who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and make referrals to more specialist services.
Tier 2	Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.
Tier 3	Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.
Tier 4	Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

TABLE 2: MENTAL HEALTH SERVICES FOR WORKING AGE ADULTS – INVESTMENT BY SERVICE CATEGORY 2011/12

Secure services and PICU	19%
Community mental health teams	14%
Acute inpatients	12%
Continuing care	12%
Access and crisis services	11%
Accommodation	10%
Psychological therapy services	7%
Other	15%

FIGURE 1: ADULT MENTAL HEALTH SERVICE PROVIDERS 2011/12

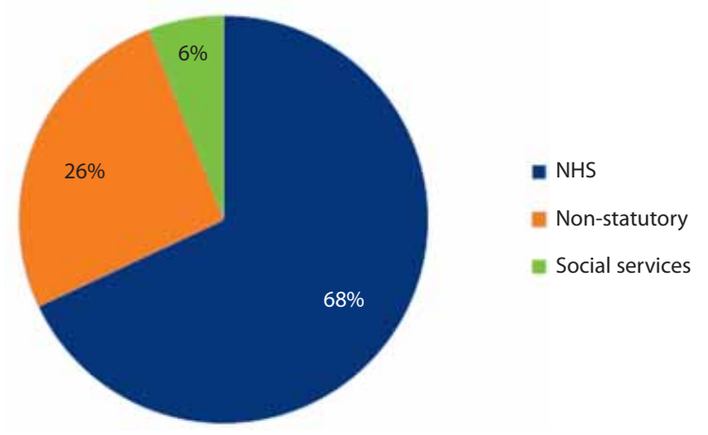


TABLE 3: MENTAL HEALTH SERVICES FOR WORKING AGE ADULTS – TYPES OF SERVICE	
Acute adult inpatient ward	Acute wards provide care with intensive medical and nursing support for users in periods of acute psychiatric illness.
Psychiatric intensive care unit (PICU)	PICU are locked wards for compulsorily detained patients who are in an acutely disturbed phase of a serious mental health problem. Staff ratios are higher than on acute inpatient wards.
Adult community mental health team (CMHT)	Multi-disciplinary CMHTs provide treatment and support to service users in the community. Staff include psychiatrists, mental health social workers, community psychiatric nurses, psychologists and occupational therapists. How teams operate varies across the country – some provide a generic service, while others focus on specific areas, for example, recovery, assessment, treatment. Some have fully integrated working arrangements with the local authority.
Assertive outreach team (AOT)	AOTs provide intensive support in the community for people with severe mental health problems, who are difficult to engage in more traditional services. Many have been in contact with the criminal justice system and have a dual substance misuse and mental health problem. Services aim to maintain contact and increase engagement and compliance.
Early intervention in psychosis (EIP)	EIP teams give treatment and support in the community for people who are having symptoms of psychosis for the first time.
Crisis resolution and home treatment team (CRHT)	CRHTs aim to reduce both the number and length of hospital admissions. They act as a gatekeeper to acute mental health services, by assessing all those at risk of hospitalisation and deciding on their care. They provide intensive support at home for people experiencing an acute mental health crisis.
Rehabilitation services	People who do not recover sufficiently after an acute mental health admission to be able to be discharged home are referred to rehabilitation services. These services also provide 'step-down' for patients moving on from secure mental health services who have longer term and complex mental health needs. Rehabilitation services aim to work with people to help them acquire or regain the skills and confidence to live in the community. They include inpatients, community teams and supported accommodation services.

TABLE 4: MENTAL HEALTH SERVICES FOR OLDER PEOPLE INVESTMENT BY SERVICE CATEGORY 2011/12	
Care homes	43%
Acute inpatients	16%
Community mental health teams	14%
Continuing care	9%
Other	18%

FIGURE 2: OLDER PEOPLE'S MENTAL HEALTH SERVICE PROVIDERS 2011/12

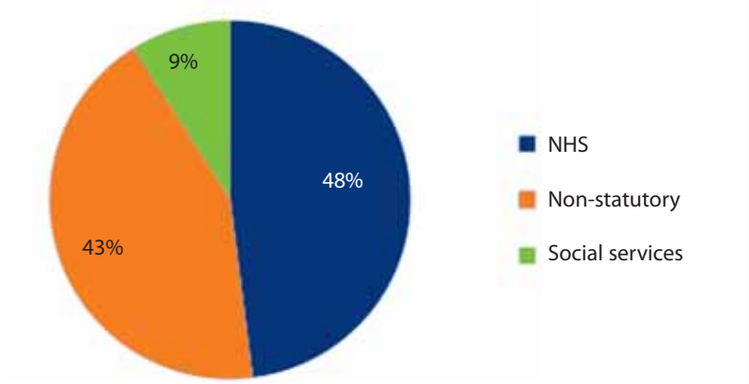


TABLE 5: MENTAL HEALTH SERVICES FOR OLDER PEOPLE	
Older adult acute inpatient wards	These wards provide assessment, treatment and rehabilitation of older people with mental health problems.
Memory assessment services	These services aid the early detection and diagnosis of dementia. Investment in these services has increased from £9m in 2006/07 to £35m in 2011/12.
Older adult CMHTs	Multidisciplinary CMHTs provide specialist assessment, treatment and care in the community.
Care homes	Care homes provide residential care for older people with mental health problems. Some also provide nursing care.

the NHS and 43% of services by the non-statutory sector (*Figure 2*). Table 5 describes some of the standard services found in an older people's mental health service. Case study 2 describes the memory clinic services at Southern Health NHS Foundation Trust.

Forensic mental health services

Forensic mental health services work mainly with people who have a mental health problem and have been through the criminal justice system. They provide treatment in hospital (in particular, secure hospitals), prison and community settings.

There are three different levels of secure hospitals: low, medium and high security. Low-secure services care for patients who demonstrate challenging or disturbed behaviour in the context of a serious mental health problem, usually with complex co-morbidities and who require the provision of security.

Medium-secure services provide inpatient treatment and care for adults with complex mental health problems who have been in contact with the criminal justice system and who present a serious risk to themselves or others, combined with the potential to abscond. There has been a significant increase in the level of investment in both low and medium secure services over the

past decade[14]. In 2011/12 PCTs invested about £1bn in low- and medium-secure services, with about a third of the investment in the non-statutory sector[15].

High-secure services are designed for patients detained under the Mental Health Act 2007 who pose a grave and immediate danger to the public. All high-secure beds are provided by the NHS at Ashworth, Broadmoor and Rampton hospitals.

Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem[16]. The mental health services across prisons vary, but all prisons have a healthcare team and some have an in-reach team, similar to a CMHT.

Prisons have access to a psychiatrist who can refer a prisoner to hospital if their mental health condition cannot be safely and effectively managed within the prison system.

Community forensic mental health services aim to help individuals who no longer require secure care make the transition back to the community.

Liaison psychiatry services

Liaison psychiatry services address the mental health needs of people who are being treated primarily for physical health problems or symptoms. The prevalence of mental and physical health co-morbidities is high among patients in general and acute hospitals. Older people account for 65% of all inpatients in general and acute hospitals at any one time and the overall prevalence of mental health conditions among this group is estimated at around 60%[17].

Liaison psychiatry services can improve the detection rates of mental health problems by acute staff in emergency departments and on wards.

They also improve access to mental health services in acute hospitals and train acute staff in the care of patients with mental health problems. The provision of liaison psychiatric services varies significantly across England[18].

Drug and alcohol services

Drug and alcohol services are generally provided by NHS trusts or voluntary sector services. A large proportion of people with mental health problems have co-occurring problems with drug or alcohol misuse. The complexity of issues can make diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide[19]. The Department of Health's guide on dual diagnosis[20] states that integrated care should be the norm for this group of people. However, support for people with a dual diagnosis, including those with a range of multiple needs, is often inadequate[21].

Mental health services for people with learning disabilities

Service models for mental health services for people with learning disabilities vary across England. These include jointly provided services where local mental health and learning disability services share facilities, teams and expertise; services where there is little joint working between mental health and learning disability services; poorly developed local services with a high reliance on out-of-area inpatient placements; or high reliance on mainstream mental health and older adult services, but sometimes without sufficient learning disability expertise to meet the mental health needs of the client group[22].

NHS England has an objective to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care.

Working with other agencies

The cross-government mental health strategy *No health without mental health* reinforces the fact that

FOOTNOTES

[14] Mental Health Strategies (2012) *Review of the provider market for mental health services*

[15] Mental Health Strategies (2012) *2011/12 National survey of investment in adult mental health services*

[16] Department of Health (2011) *No health without mental health*

[17] Centre for Mental Health (2012) *Liaison psychiatry in the modern NHS*

[18] Centre for Mental Health (2012) *Liaison psychiatry in the modern NHS*

[19] Joint Commissioning Panel for Mental Health (2013) *Guidance for commissioners of drug and alcohol services*

[20] Department of Health (2002) *Mental health policy and implementation guide – dual diagnosis good practice guide*

[21] Centre for Mental Health, DrugScope and UK Drug Policy Commission (2012) *Dual diagnosis: a challenge for the reformed NHS and for Public Health England*

[22] Joint Commissioning Panel for Mental Health (2013) *Guidance for commissioners of mental health services for people with learning disabilities*

CASE STUDY 2: FAREHAM AND GOSPORT MEMORY CLINIC, SOUTHERN HEALTH NHS FOUNDATION TRUST

Associate specialist, Dr Jo Taylor, runs a memory clinic in Gosport:

"There are different models of memory clinics across the country. We carry out the initial assessment of a patient with suspected dementia in their home, to see how they are coping in their usual environment. The assessment is normally carried out by a community mental health nurse, but it can be a psychiatrist.

Patients diagnosed as having Alzheimer's are referred to our memory clinic. There they are seen by a psychiatrist who will confirm the diagnosis, check the results of blood tests and agree with the patient and carer whether medication should start. Medication cannot cure Alzheimer's, but it can slow the progression of the disease in some people. If medication is prescribed, the patient is seen by the psychiatrist once a month for two more appointments, and then again after three months, when the memory test is repeated to measure any deterioration.

Patients are then seen for yearly follow-ups by a community mental health nurse at the memory clinic. We tell our patients that if they have any concerns between appointments, they can phone whenever they like. Patients and carers are also offered information and support and have access to memory courses and carer support groups."

FOOTNOTES

[23] Centre for Mental health (2009) *Individual placement and support into employment*

[24] Johnson R, Griffiths C, Nottingham T (2006) *At home? Mental health issues arising in social housing*

[25] Social Exclusion Unit (2004), *Mental health and social exclusion*

[26] Johnson R, Griffiths C, Nottingham T (2006) *At home? Mental health issues arising in social housing*

[27] Joint Commissioning Panel for Mental Health Cases for change – severe problems

caring for and supporting people with mental health problems requires partnership working between many agencies.

Social services

Social services play a key role in the provision of mental health services. Adult and older people social services work closely with NHS mental health services and multi-disciplinary community teams include clinical staff and social workers. Children's services' responsibilities include working with vulnerable children and their parents, large proportions of whom need mental health support.

Employment

Employment or meaningful activity is regarded as an essential element of recovery from mental ill health. People who experience severe and enduring mental health problems have one of the lowest employment rates in the UK[23]. Individual placement and support programmes work with people to secure paid competitive employment, as demonstrated in case study 3 below.

Housing

Good housing is critical for good mental health. People with mental health problems are less likely to be homeowners and far more likely to live in unstable environments[24]. Mental ill health is often cited as a reason for tenancy breakdown[25] and housing problems are frequently given as a reason for a person being admitted to inpatient care[26]. Around a third of adults with severe mental health problems (about 60,000 people) reside in supported accommodation provided by health and social services, voluntary organisations, housing associations and other independent providers[27].

Police

The police are often the first point of contact for a person in a mental health crisis (*Box C*).

If someone is suspected of having a mental health problem and is in immediate need of care and control, the police can use Section 136 of the Mental Health Act 2007 to take the person from a 'public place' to a 'place of safety' for up to 72 hours. Where the person is not in a public place, the police may use Section 135 of the Act to gain access to a person's home by force, following the granting of a court warrant.

Police and court diversion liaison services aim to ensure that individuals with a mental health problem are identified quickly when they come into contact with the police and the courts. Where appropriate, they are diverted to care and support, and if the individual is remanded or sentenced to prison, their mental health needs are communicated to the prison.

CASE STUDY 3: VOCATIONAL SERVICES - NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST AND EMPLOY-ABILITY

Raza Ahmed manages Vocational Services for North Essex Partnership University NHS FT:

"The trust considers it has a key role to play in helping people who use their services to access and retain employment as part of the recovery process. These people's needs fall into four groups:

- **People who are currently ready to work and need support to gain access to competitive employment**
- **People who want to work now or in the near future but do not have the qualifications and skills required and therefore need access to vocational training or work placements**
- **People not currently considering paid employment who need extra longer term vocational support to develop their skills through social enterprise/firms, voluntary work, training or education**
- **People who are currently in employment and need help to retain their employment.**

Our community mental health teams all include employment specialists, who are fully integrated members of the CMHT. In West Essex we work in partnership with the charity Employ-Ability, while in Mid and North East Essex the employment specialists are employees of the trust. The employment specialists actively engage with local employers to create job opportunities and educate employers about the advantage of inclusive employment practices.

The employment specialists meet with service users to find out what kind of work they would like to do and what previous experience they have. They provide them with advice and support in looking for a job, completing application forms and interview techniques. Once the service user has found a job, the employment specialist continues to support them for as long as they need. We have helped people get a wide range of jobs – for example, in teaching, nursing, accountancy and catering.

As well as supporting people to find competitive employment, our employment specialists help people to access work placements, voluntary work and training. Work placements within our trust have led to several people getting permanent jobs with us. Sometimes people already in employment need support to retain their job. Our employer specialists are there to provide that support."

Who is involved in providing mental health services?

Most mental health services are based on specific community teams, as well as inpatient services. Each team will have several types of mental health workers with different knowledge and skills, so that they can support service users with the range of problems people with mental health problems face.

Psychiatrists

Psychiatrists are medically qualified doctors who specialise in the care of patients with mental health problems. They usually specialise in a particular branch of psychiatry and tend to work with people who have more severe disorders that may require some sort of medical treatment. This often, but not always, involves the prescription of medication. Most psychiatrists work in community-based teams, outpatients and hospital wards (*Box D*).

Clinical psychologists

Clinical psychologists have a degree in psychology and a doctorate in clinical psychology. Clinical psychology applies the scientific knowledge base of psychology to 'clinical' problems. The psychologists aim to reduce psychological distress and to enhance and promote psychological wellbeing. A wide range of psychological difficulties may be dealt with, including anxiety, depression, relationship problems, learning disabilities, child and family problems and serious mental illness.

To assess a client, a clinical psychologist may undertake a clinical assessment using a variety of methods – psychometric tests, interviews and direct observation of behaviour. Assessment may lead to therapy, counselling or advice. Therapies include cognitive and behavioural therapies, psychoanalytic/psychodynamic therapy, humanistic therapies and systemic therapies.

There are different types of practitioner psychologists, including clinical psychologists, counselling psychologists and health psychologists. Psychologists are based in hospitals, outpatient clinics and work in community-based teams.

Mental health nurses

Mental health nurses specialise in mental health during their training. They work in community-based teams, psychiatric wards, day hospitals and outpatient departments. When they work in community-based teams, they are called community psychiatric nurses (CPNs) or community mental health nurses (CMHNs). Some nurses can prescribe medication. The role of a CPN can be wide and may include counselling or anxiety management, and working with people who have had severe mental health problems for years and need long-term support and psychiatric drugs.

Mental health social workers

Mental health social workers have a degree in social work and post-qualifying awards in mental health. They are usually employed by local authority social service departments, but often work within a community-based team run by a mental health trust. They are involved in the management and planning of care, and may help service users with practical issues such as benefits, housing, respite

BOX C: LEGAL FRAMEWORK

Under the Mental Health Act 2007 a person can be admitted, detained and treated in hospital against their wishes. There are strict legal guidelines to using the Mental Health Act in this way, usually involving the agreement of two doctors, an approved mental health professional (AMHP) and consultation with a family member. When someone is admitted to hospital under compulsion, this is commonly known as being 'sectioned'. Supervised community treatment allows someone who has been detained under certain sections of the Mental Health Act to be discharged from hospital under a Community Treatment Order.

AMHPs are approved by a local authority social services department to carry out duties under the Mental Health Act. These duties involve assessing, in collaboration with other mental health professionals, whether someone should be compulsorily treated under the Act. An AMHP can be a specially trained social worker, mental health nurse, occupational therapist or psychologist.

The Mental Health Act 2007 is not to be confused with the Mental Health Capacity Act 2005, a framework for acting and making decisions on behalf of individuals who lack the mental capacity to make decisions themselves. It contains provision for assessing whether people have the mental capacity to make decisions, procedures for making decisions on behalf of people who lack mental capacity and safeguards. The Act covers decisions relating to an individual's property, financial affairs, and health and social care, and decisions on personal care.

BOX D: TRAINING TO BECOME A PSYCHIATRIST

- **After gaining a medical degree, graduates enter a two-year Foundation Programme, which exposes them to a range of competencies across a broad range of specialities. It can include a placement in psychiatry.**
- **Specialist training in psychiatry is a minimum of six years – three years at core training level, and three years at higher training level.**
- **Core trainees undertake four- to six-month posts in various psychiatric specialities. They must obtain at least 12 months' experience in general psychiatry. They also sit the MRCPsych exam.**
- **After completing core training, trainees can apply for higher training in one of six specialties: CAMHS, forensic psychiatry, general psychiatry, learning disability psychiatry, medical psychotherapy and old age psychiatry.**
- **Trainees in general psychiatry can undertake additional training in liaison, rehabilitation and substance misuse psychiatry. Higher training normally involves three 12-month posts.**

care and personal budgets. They may also assess the needs of carers of people with serious mental health problems and plan packages that can help them.

Occupational therapists

Occupational therapists support people with mental health problems to get on with daily life, helping them to live independently and safely. They work in hospitals and community-based teams, and can support employment, social and leisure activities.

Other therapists

A range of other therapists also support people with mental health problems, such as art, music and drama therapists. Some community-based teams include a support, time and recovery worker (STR worker). Support may include promoting independent living, helping someone return to education or to travel independently. Some mental health trusts are starting to train and employ peer support workers with experience of mental distress. They work alongside others with mental health problems to facilitate recovery by promoting hope and support based on common experience.

IAPT services employ high-intensity therapists trained in CBT and other therapies recommended by the National Institute for Health and Care Excellence (NICE). They also employ psychological wellbeing practitioners trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression.

Graduate mental health workers also work in primary care settings to improve the capacity of primary care to manage common mental health problems. They are usually graduates in psychology and are offered postgraduate training as they work.

Case study 4 describes the roles and functions of staff in a community mental health team.

CASE STUDY 4: ANDOVER COMMUNITY TREATMENT TEAM, SOUTHERN HEALTH NHS FOUNDATION TRUST

Carol Adcock is team leader for the Andover community treatment team:

“ The trust reorganised adult community mental health services in 2012. Instead of traditional CMHTs, we now have a range of other services to support people in the community. Our access and assessment teams provide a single point of access, acting as the front door for all planned and unplanned mental health referrals. Where intervention of less than 12 weeks is required, it is provided by the access and assessment team. IAPT services support some people who used to be cared for by the CMHTs. Individuals who need support and treatment for periods of more than 12 weeks are allocated to the community treatment teams (CTTs).

Andover CTT is comprised of consultant psychiatrists, a junior doctor on rotation, clinical psychologists, a psychological advanced practitioner, social workers, nurses, support time recovery workers and administrative staff. We receive 16 to 25 new cases a month and have about 270 cases at a time. Most fit into one of three categories:

- **People with psychotic disorders who may stay on our caseload for three to five years. If they require an anti-psychotic depot injection, they may stay longer on our caseload as many GPs do not undertake this treatment**
- **People with moderate to severe depression, or whose depression is treatment resistant, will stay on our caseload for about 12 months**
- **People with emotionally unstable personality disorder (previously known as borderline personality disorder) may be on our caseload for 12 to 18 months.**

All service users are allocated to a member of my team, who becomes that person’s care co-ordinator and is responsible for overseeing the person’s care and support. If the care co-ordinator feels someone on their caseload needs to be seen at least once a week (the individual is experiencing a psychotic relapse, say, or developing suicidal thoughts), we put the person on ‘shared care’ .

Shared care describes a team approach to care, with primary and secondary care practitioners working in a coordinated way to deliver care to ensure the patient’s care is as seamless as possible. Each day a member of the team is responsible for the shared care patients. If someone is discharged from hospital, they are assigned to shared care for three weeks, while they are at greater risk of relapse. Once a week we have a multi-disciplinary team meeting, where we discuss all patients on shared care and any other urgent cases.

I am a psychiatric nurse. As well as managing the team, I have a small caseload of complex cases. When someone is on my caseload, my activities could include care-coordination (liaising with other agencies including the family), carrying out an assessment of a patient over time, encouraging the person to engage with services, monitoring the effectiveness of medicine and its sides effects, CBT or emotional coping skills work, and providing carer support.

As well as working directly with service users, we spend a considerable amount of time working with other agencies:

- **Andover MIND Wellbeing Centre provides one-to-one specialist support for some of our service users to prevent social exclusion and social isolation. For example, they might support someone to enrol at the local college or join a local gym. They attend our weekly multi-disciplinary team meetings.**

Models of care

The principles of the recovery approach in mental health are recognised as applying to all age groups and conditions. Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems. [30] This approach emphasises the importance of good relationships, education, employment and purpose, alongside reductions in clinical symptoms.

The care programme approach (CPA) is used to co-ordinate the care and support from secondary mental health services for people who have severe mental health problems and complex needs. A person eligible for CPA should get a full assessment of their health and social care needs, a care plan and regular reviews. A named care co-ordinator (usually a community psychiatric nurse or social worker) is responsible for overseeing that care and support.

Risk management is a core component of mental healthcare. The three main areas of risk are violence (including antisocial and offending behaviour), self-harm/suicide and self-neglect. Clinicians assess the likelihood of risk events, and then work with the service user to identify ways of reducing the likelihood of them happening.

People with a diagnosed mental health problem are among those at the highest risk of committing suicide. In 2010, about 4,200 people died by suicide. The suicide rate is highest among men aged 35-49 years and overall men are three times more likely than women to take their own life.[31]

The government launched a suicide prevention strategy in September 2012 with six areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups

FOOTNOTES

[28] MARAC is a meeting where information is shared on the highest risk cases of domestic abuse between criminal justice, health, child protection, and other specialists. A safety plan for each victim is created.

[29] MAPPA are the arrangements for the 'responsible authorities' tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.

[30] Shepherd, Boardman and Slade, Sainsbury Centre for Mental Health (2008) *Making recovery a reality*

[31] Department of Health (2012) *Suicide prevention strategy*

- **The Princess Royal Trust for Carers provides a wide range of support services for carers. They also attend our weekly multi-disciplinary team meetings.**
- **Housing provider Stonham is a significant provider of mental health supported accommodation in the local area.**
- **We attend the monthly Hampshire County Council housing panel to discuss the housing needs of the most vulnerable people.**
- **We carry out joint visits with probation services.**
- **We work closely with local alcohol and drug services Hampshire Operational Model for Effective Recovery, creating joint care plans**
- **We attend Multi Agency Risk Assessment Conference[28] and Multi Agency Public Protection Arrangements[29] meetings.**

Dr Mishra is one of the two consultant psychiatrists on the team:

"The team aims to promote independence rather than dependence on mental health services, using a recovery model. My role is assessment and diagnosis. If a person requires a diagnosis, they are referred to one of the two consultants. We then formulate a management plan. Providing activity for a person is an important aspect of treatment, and some people are referred to Andover MIND Wellbeing Centre. If the person is prescribed medication, we will provide follow-up in the clinic. Once the person is stable, they are allocated a care co-ordinator with a recovery plan. If the co-ordinator is concerned the person's condition is deteriorating, I will see them for a medical review."

Amanda Gunn is one of the senior social workers on the team:

"I am the care co-ordinator for about 30 service users with a range of disorders. I monitor the mental state of people with severe depression and liaise with the consultant about medication. I provide therapeutic sessions for people with emotionally unstable personality disorders. I see people with long-term psychotic illnesses every three to four weeks to monitor their mental state, and ensure their social support network and housing status remain stable. I also monitor from a commissioning perspective a number of people in residential placements. I have a smaller caseload than some of the other care-coordinators, because half of my time is spent performing functions as an approved mental health professional under the Mental Health Act."

Clinical psychologist Laura Dannahy works with service users in both Andover and Winchester:

"I tend to work with the most unwell. I have individual and group sessions. The type of therapy will depend on the person's mental health problem. We provide CBT for people who have a psychotic illness, treatment-resistant depression or complex post-traumatic distress disorder. CBT focuses on how a person thinks about the things going on in their life, and how this impacts on how they behave and deal with emotional problems. It looks at how a person can change negative patterns of thinking or behaviour, which may then change the way the person feels. Dialectical behaviour therapy (DBT) is for people with emotionally unstable personality disorder, especially those with self-harming behaviour or suicidal thoughts. DBT aims to stop such behaviours and improve their quality of life. A DBT programme – individual weekly therapy, weekly group therapy and 24-hour telephone crisis coaching with the psychologist – lasts a year. Other therapies include acceptance and commitment therapy for people who have been stuck in services for a long time, and cognitive analytic therapy for people with a range of personality disorders."

TABLE 6: NICE STEPPED-CARE MODEL FOR DEPRESSION

Focus of intervention	Nature of intervention
Step 4 Severe and complex depression; risk to life; severe self-neglect	Highly specialised treatment – medication, high-intensity psychological interventions, combined treatments, multi-professional and inpatient care, crisis services, electroconvulsive therapy
Step 3 Persistent sub-threshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression	Cognitive behavioural therapy (CBT), interpersonal psychotherapy, behavioural couples therapy, counselling, short-term psychodynamic psychotherapy, antidepressants, combined interventions, collaborative care, self-help groups
Step 2 Persistent sub-threshold depressive symptoms or mild to moderate depression	Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support programmes, non-directive counselling delivered at home, antidepressants, self-help groups
Step 1 Known and suspected presentations of common mental health problems	Identification, assessment, psychoeducation, active monitoring, referral for further assessments and interventions

CASE STUDY 5: TYPICAL CARE PATHWAY FOR SCHIZOPHRENIA AT CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

Consultant psychiatrist, Dr Mo Zoha, works with the assessment and brief treatment team in Kensington and Chelsea:

"A GP with concerns about possible psychotic symptoms in a patient can refer them to the local assessment and brief treatment team. These teams work with service users who are new to mental health services. If the assessment diagnosis is schizophrenia and the service user is aged under 35, the person is then referred on to an early intervention in psychosis (EIP) Team. Early engagement with the person is recognised as being very important. The EIP team adopts an assertive outreach model – they don't expect the person with schizophrenia to come to them, but rather they go out to see the person at home, or at a place they feel more at ease. This helps to build up engagement with the person and encourages them to accept treatment.

Normal treatment consists of developing a care plan drawn up under the care programme approach and covering a range of interventions, including pharmacological, psychological, social, occupational and educational. A person with a first episode or first presentation of schizophrenia usually remains under the care of the EIP team for three years.

About 10% of people with diagnosed schizophrenia have no further episodes of psychosis. The remaining 90% will continue to have episodes of psychosis. After three years with the EIP team, some patients can be discharged back to the care of their GP.

Patients who continue to have high levels of need are likely to move to the caseload of a community recovery team (previously known as a community mental health team), where they will continue to receive a similar set of interventions.

The community recovery team is multi-disciplinary, with input from occupational therapy, social work, nursing, vocational workers, psychology and psychiatry. People in the team will often receive care from a number of different non-NHS agencies. This care will be coordinated by the recovery team. Social care will be a big aspect of the care received by this group. The team also works with the carer and may signpost the carer to support provided by other agencies such as the local authority or voluntary sector.

Some people with schizophrenia have co-morbidities – for example, substance misuse or depression. This is actively addressed by the community recovery team, as well as other appropriate services, such as substance misuse services. People who find it difficult to engage with services may be cared for by the assertive outreach team. Such people may be homeless, have drug and alcohol difficulties, have been involved with the criminal justice system or have complex difficulties. They usually have a history of admissions to hospital, possibly detained under the Mental Health Act and often encounter problems with medicinal treatments.

People with schizophrenia tend to experience periods when their symptoms become more intense and they need acute mental health services to help them to return to stability. These services consist of home treatment teams (HTT) and inpatient wards. HTTs help avoid admission by visiting people in their homes daily. They also help people who have been discharged from hospital make the transition back into the community. If the risk is too high, or the person is unwilling to engage, the person is admitted to an acute ward, as a voluntary patient or under the Mental Health Act."

- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring.

NICE has published guidelines for the treatment and care of people with mental health problems. This briefing describes typical care pathways for three conditions: depression, schizophrenia and dementia.

Care pathways for common mental health issues

There is no standardised model for primary mental health care services and current patterns of service provision vary greatly[32]. NICE recommends a stepped-care model for common mental health problems (*Table 6*). In stepped care the least intensive intervention appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment.

It states electroconvulsive therapy (ECT) should be considered for the acute treatment of severe depression that is life-threatening and when a rapid response is required or other treatments have failed. It is unlikely to help with mild to moderate depression or most other psychiatric conditions. It has no role in the general treatment of schizophrenia. Between 1985 and 2002 use of ECT in England more than halved, possibly because of better psychological and drug treatments[33].

Care pathway for schizophrenia

NICE's *Clinical Guideline 82 (CG82)* covers treating and managing schizophrenia in adults. Recommendations are listed for the phases of schizophrenia experienced: first episode (presentation of psychotic symptoms); promoting recovery (ongoing psychosis); and acute episode (psychotic crisis). Case study 5 sets out a care pathway for someone with schizophrenia at Central and North West London NHS Foundation Trust.

Care pathway for dementia

NICE's *Clinical guideline 42 (CG42)* recommends how people with dementia and their carers should be supported and stresses the importance of integrated health and social care. As far as possible, dementia care services should be community-based, but psychiatric inpatient admission may be required. Case study 6 (*overleaf*) describes a typical care pathway for someone with dementia at Central and North West London NHS Foundation Trust.

Current service and financial issues

Improving the quality of mental health services

There have been several recent reports highlighting the need to improve the quality of mental health services. The national mental health strategy *No health without mental health* focuses on improving outcomes in mental health. The accompanying *Implementation framework* sets out what local organisations can do to implement the strategy and improve mental health outcomes (*Box E*).

The latest Care Quality Commission (CQC) Mental Health Act report[34] notes that while some providers demonstrate excellent practice, this is not the case in all areas (*Box F*).

Following the Winterbourne View Hospital failings in 2012, the Department requires CCGs and local authorities to have a locally agreed joint plan by April 2014 to ensure high-quality care and support services for all children, young people and adults with learning disabilities or autism, as well as mental health problems or behaviour described as challenging. Services should be local, to let people remain in their communities. It is anticipated that there will be a substantial reduction in hospital placements for this group of people[35].

FOOTNOTES

[32] Joint Commissioning Panel for Mental Health (2012) *Guidance for commissioners of primary mental health care services*

[33] Royal College of Psychiatrists website

[34] Care Quality Commission (2013) *Monitoring the Mental Health Act in 2011/12*

[35] Department of Health (2013) *Transforming care: a national response to Winterbourne View hospital*

BOX E: NO HEALTH WITHOUT MENTAL HEALTH IMPLEMENTATION FRAMEWORK

What mental health service providers can do:

- **Ensure equality of access and outcomes**
- **Assess and improve service user and carer experience**
- **Ensure service design is based on humanity, dignity and respect**
- **Keep people safe**
- **Improve the physical health/wellbeing of people with mental health problems**
- **Improve the mental health/wellbeing of people with long-term physical conditions**
- **Consider the power of information to transform services**
- **Focus on choice, recovery and personalisation**
- **Develop protocols for sharing information with carers**
- **Tackle stigma and discrimination.**

BOX F: MONITORING THE MENTAL HEALTH ACT IN 2011/12 – CARE QUALITY COMMISSION FINDINGS

- **Services are under pressure, for example issues relating to the provision of AMHPs and transport to hospital, high bed occupancy, increased workloads and access to psychological therapies**
- **Most of the concerns highlighted in previous reports remain, particularly in respect of care planning, patient involvement and consent to treatment**
- **There is a significant gap between practice and the ambitions of the national mental health policy. The CQC observed that the *No health without mental health* strategy was not being observed in many wards and trusts that were visited**
- **Cultures persist where control and containment are prioritised over treatment and support of individuals.**

CASE STUDY 6: TYPICAL CARE PATHWAY FOR DEMENTIA AT CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

Consultant psychiatrist Dr Pramod Prabhakaran works in the Harrow Memory Clinic:

"Detection rates of dementia are very low nationally. There are a number of ongoing initiatives to raise awareness of dementia. Not all boroughs within the trust have a fully commissioned memory service, although we are working with commissioners to address this.

People may need assessment for possible dementia if they are:

- Having difficulty remembering day-to-day things
- Forgetting conversations and repeating questions
- Missing appointments
- Finding that they are losing things around the house
- Getting in a muddle with finances, paying bills and so on
- Their carer is having difficulty coping.

Many people with dementia may not be aware of their own difficulties and it is often family members that notice changes. If either a patient or a family member expresses concern about a patient's memory to the GP, the GP will usually carry out initial cognitive screening and blood tests. If the GP thinks the person may have dementia, they refer the person to the multi-disciplinary memory service.

The memory service carries out a comprehensive assessment to establish the likely diagnosis. This includes history-taking, a cognitive and mental state examination, appropriate physical examination, a review of medication and often a brain scan. There are several conditions that cause dementia, the most common ones being Alzheimer's disease, vascular dementia and Lewy Body disease.

Once the diagnosis is made, the memory service supports the individual in understanding and coming to terms with the diagnosis and provides useful strategies and treatments to help them minimise their memory difficulties. Counselling is offered for those having difficulty in coming to terms with the diagnosis.

Current medical treatments are effective in about two thirds of patients with Alzheimer's disease by slowing down the worsening of the symptoms. There is no cure or disease modifying medication at present, although trials are under way.

Many patients benefit from structured mental stimulation often done in groups called cognitive stimulation therapy (CST), which helps the patient develop cognitive strategies and can positively impact on their quality of life. CST is a brief treatment for people with mild to moderate dementia. Group sessions are held for about 14 weeks.

Drugs currently used in dementia belong to two types. The first group, Acetylcholinesterase (AChE) inhibitors, includes three similar medications that are recommended by NICE as options for managing mild to moderate Alzheimer's disease.

Memantine is recommended as an option for managing Alzheimer's disease for people with moderate Alzheimer's disease who are intolerant of AChE inhibitors or for people with severe Alzheimer's disease. If people are prescribed medication, we monitor them to optimise the dose and to assess whether they are benefiting from the medication. Our aim is to refer patients stabilised on medication back to the care of their GP for follow up care.

As part of the assessment and care planning process, social and psychological needs for the patient as well as the carer are identified. The care plan addresses these needs, and often includes referral to social services for a full needs assessment and carer's assessment. Some services are integrated with social services, which means social care needs assessments and care plans can be managed in-house without needing a referral.

About 30% of our older adult inpatient wards are occupied by people with dementia. We try to avoid admitting patients with dementia, but examples of when admission may be necessary include when a person is suffering with severe psychosis or severe depression, when there is significant risk, or when there is carer breakdown in the context of such challenges. Inpatient admission is also used to comprehensively assess someone with very complex behavioural and psychiatric needs.

It is very important to consider the needs of carers. As mentioned earlier, carers have the right to receive an assessment of needs by social services. Carers of people with dementia are at increased risk of experiencing mental and physical morbidity themselves. When we see carers, we offer them the opportunity of attending the Carers' Information Programme, which runs once weekly for six weeks. Often, carers are offered individual therapy such as CBT or the opportunity of attending a carers' support group.

Although there are some reversible causes of dementia, generally dementia tends to be progressive, with worsening cognition and the ability to function independently. In the later stages, the person will become dependent on others for care, and may need long term residential or nursing home care. Our memory services receive referrals from residential and nursing homes, for example to provide advice regarding diagnosis and in managing behavioural difficulties."

Increasing pressure on resources

The requirement to improve the quality of services is set against a backdrop of increasing pressure on resources. The NHS is required to save £20bn in the four years to 2014/15 (the current spending review period), while local authority funding is being reduced by £7.6bn (26%) between 2011 and 2015.

A recent National Audit Office report on the financial sustainability of local authorities notes evidence that some local authorities are reducing services in adult social care, and at the same time demand for high-cost services, such as adult and children's social care, is increasing[36]. People with mental health problems are also experiencing the impact of changes to benefits as a result of the Welfare Reform Act 2012[37].

In seeking to deliver these levels of savings there are particular challenges that mental health providers and their commissioners face regarding information and structure.

Information

Income is currently earned on a block contract basis, where providers are paid a pre-determined financial sum for providing a range of contracted services. Typically, this financial sum has built up over several years and there may be no clear link to individual services or activity levels. Yet without this it is hard to assess the profitability of individual services or how they will be affected by big changes in activity. Data quality is a concern, as historically the accuracy of activity data recorded has been mixed, particularly in relation to community based services. This is improving with the move to payment by results.

TABLE 7: PRODUCTIVITY WITHIN MENTAL HEALTH SERVICES

Action across the care pathway	• Improve assessment processes • Reconfigure community services • Reduce unnecessary use of acute beds • Improve discharge and step-down arrangements
Effective responses to complex needs	• Reduce out-of-area treatment • Respond effectively to substance misuse • Improve secure services
Changing ways of working	• Build peer support • Maximise workforce productivity

Structure

Mental health trusts will typically cover a much larger area than acute trusts. To ensure services are accessible to the whole population, services are often provided from multiple locations. This can conflict with the wish to centralise services to achieve economies of scale. Typically, trusts will have large estates, and suitability can vary greatly. A key part of the service modernisation programme can be to rationalise and improve the estate. These types of changes will take time and the ability to reduce overhead costs in the short term will be limited.

The King's Fund and Centre for Mental Health report *Mental health and the productivity challenge*[38] provides examples of where there is scope to improve productivity in mental health services (*Table 7*). An example of a change in practice is the host family scheme developed by Hertfordshire Partnership University NHS Foundation Trust, which can provide both improved outcomes for service users whilst reducing cost (*case study 7*).

FOOTNOTES

[36] National Audit Office (2013) *Financial sustainability of local authorities*

[37] The Hardest Hit (2012) *The Tipping Point – The human and economic costs of cutting disabled people's support*

[38] Chris Naylor and Andy Bell, The King's Fund and Centre for Mental Health (2010) *Mental health and the productivity challenge*

[39] Department of Health (2013) *Mental health clustering booklet 2013/14*

[40] Mental Health Network NHS Confederation/ Mental Health Strategies (2011) *Mental Health Payment by Results Readiness Review*

[41] Monitor/NHS England (2013) *How can the NHS payment system do more for patients?*

CASE STUDY 7: HOST FAMILY SCHEME AT HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Hertfordshire Partnership University NHS Foundation Trust (HPFT) has recruited families who are willing to take service users into their homes as an alternative to them being admitted to an acute ward.

The crisis assessment and treatment team (CATT) provides home treatment to the service users. Without the host families, the service users would not have been able to stay in the community due to unstable home environments.

The scheme is based on one in Lille, France. HPFT invited a host family from Lille to a recovery conference to discuss host families and launch it within HPFT. A host family's steering committee was formed with representatives from all HPFT's key stakeholders. The host families were recruited and service users on acute wards placed with them. Currently, there are four host families and HPFT are in the process of recruiting more host families across the county.

HPFT has found that the scheme has many advantages including:

- **Maintaining living and social skills and community connections during an acute episode**
- **Providing a non-stigmatising and normalising environment**
- **Promoting and maintaining self-management**
- **Providing community education and normalisation among host families and their social and community networks**
- **Reducing pressure on inpatient beds**
- **Reducing out-of-area treatments.**

Qualitative evaluation has been conducted by fellow service users (whose mental state is currently stable) through the HPFT's peer experience listening project. The service users who have been placed in host families have given positive feedback and they said that it enhanced their experience of mental health services. They felt much better being in a host family than being on the acute ward.

The development of mental health payment by results has been under way for several years. The first stage of implementing a workable payment system is to determine what is being paid for

Mental health payment by results

The development of mental health payment by results (PBR) has been under way for several years. The first stage of implementing a workable payment system is to determine what is being paid for – what is the unit of healthcare? This unit of healthcare is often referred to as the currency.

Mandatory from April 2012, the currency used for mental health services for working age adults and older people is outlined below.

What is the currency?

- PBR currencies for mental health services for working age adults and older people are called clusters. Care clusters are based primarily on the characteristics of a service user, rather than on diagnosis alone.
- Care clusters fit within three broad super clusters: non-psychotic, psychotic and organic. There are a number of subcategories within each of the main categories. The care clusters are numbered 0 to 21 (cluster 9 is currently a blank cluster). Appendix B describes the clusters in more detail. The *Mental health clustering booklet*[39] provides detailed information on each care cluster.
- Service users have to be re-assessed periodically to ensure they remain allocated to the right cluster. The *Mental health clustering booklet* states the maximum length of time between reassessments – for example, the maximum cluster review period for cluster 1 is 12 weeks, while the maximum cluster review period for cluster 11 is 12 months. These maximum cluster review periods are the contract currencies.

How are service users allocated to a cluster?

- Mental health professionals assess the clinical need of each service user using secondary mental healthcare services via the mental health clustering tool.
- The mental health clustering tool has 18 scales – for example, depressed mood, non-accidental self-injury, problems with activities of daily living. Each scale is given a rating from 0 (no problem) to 4 (severe to very severe problem).
- Mental health professionals allocate service users to a care cluster, using the rating scales and the *Mental health clustering booklet*.

What are the care packages?

- Mental health providers are required to specify the types of care interventions that they will offer service users in each cluster, basing these on NICE guidance and other best practice.
- The care package for a service user will typically include multiple different interactions, with a range of clinicians and different types of interventions, and may cover lengthy periods, such as several years.

How is the tariff calculated?

Having agreed the currency, the price to be paid for the currency has to be determined. This price is referred to as the tariff. Progress on the development of mental health tariffs is detailed below.

- During 2012/13 most providers had not yet been able to agree local cluster prices with their commissioners. Mental health contracts remained in the form of block contracts.
- 2013/14 PBR guidance requires as a minimum that all contracts for working age adults and older people should be agreed based on the clusters, and a price should be agreed for each cluster review period based on the current contract 'value'.
- Many providers will have a different cluster price associated with the contract with each commissioner due to historical funding levels and variation in commissioning requirements.

What needs to happen before a national tariff could be introduced?

The Department of Health recognises that a number of building blocks need to be in place before a national tariff could be introduced:

- Complete and accurate data, for both clusters and costs
- Defined packages of care for each cluster
- The ability to measure and understand the quality of services being delivered.

In addition, there needs to be greater understanding of the variation in care packages provided to users within one cluster and the impact this will have on cluster costs and tariff [40].

From April 2013, NHS England and Monitor have joint responsibility for the payment system for NHS funded care. Their May 2013 discussion paper *How can the NHS payment system do more for patients?* states that they are reviewing the rules governing mental health reimbursement[41]. The 2013/14 PBR guidance updates the rules governing mental health local price-setting and emphasises the importance of collecting quality and cost data.

Case study 8 (*following page*) describes the role of a finance manager working in Northumberland, Tyne and Wear NHS Foundation Trust.

Future challenges

Mental health has a high profile in the government's mandate for NHS England 2013/15. The government has identified priority areas where it expects particular progress to be made, including:

- Delivering a service that values mental and physical health equally
- Supporting people with multiple long-term physical and mental health conditions
- Preventing premature deaths from the biggest killers
- The diagnosis, treatment and care of people with dementia.

Access to mental health services

NHS England's mandate is to put mental healthcare on a par with physical healthcare, so that people requiring mental health services have timely access to the best treatment. The most recent national psychiatric morbidity surveys show that only a minority of people with mental health problems receive any intervention. This is in stark contrast to other disease areas such as cancer where almost all receive intervention.

People with mental health problems have lower levels of access to evidence-based or recommended treatment. For example, NICE recommends that psychological therapies are offered to a wide range of people with depression, but these services are not universally commissioned and people can face long waits to access services.

There is also evidence that people with mental health problems can wait a long time for secondary care services, even when they are in a crisis[42]. The Royal College of Psychiatrists recommends: 'People who are in crisis because of a mental health problem should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems.'

The mandate states: 'By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services'. The government proposes to add other objectives for NHS England[43]:

- To ensure acute and emergency care for people in mental health crisis is as accessible and high quality as for physical health emergencies. This will include close cooperation with accident and emergency services as well as working with police and other key partners to ensure people get the care they need in the most appropriate setting.
- To ensure that there is adequate liaison psychiatry services to support effective crisis care.
- To work with the Department and other stakeholders to develop costed options for funding

FOOTNOTES

[42] Royal College of Psychiatrists (2013) *Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health*

[43] Department of Health (2013) *Refreshing the mandate to NHS England: 2014/2015 consultation*

[44] NICE (2009) *The treatment and management of depression in adults with chronic physical health problems*

[45] Department of Health, 2013

[46] Department of Health, 2013 *Refreshing the Mandate to NHS England: 2014/2015 Consultation*

CASE STUDY 8: FINANCE MANAGER AT NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST

Head of finance and costing, Chris Cressey, works in the finance department of Northumberland, Tyne and Wear NHS Foundation Trust:

"The trust is one of the largest mental health and learning disability trusts in England, employing more than 6,000 staff, serving a population of 1.4 million, providing services across an area totalling 2,200 square miles. Staff work across 100 sites throughout Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland, and we have a budget of more than £300m.

My career started as a graduate finance trainee in an acute trust, and prior to moving into mental health, I worked at the children's hospital in Manchester and a large acute trust in Durham.

While I enjoyed my time in the acute sector, I have found that working in mental health finance requires a more flexible skill set as the landscape changes. A number of factors make it an exciting and rewarding time to be working in a mental health trust. I feel we have a real opportunity to make a difference.

The work being done to support the implementation of PBR means that we now have a much better understanding of the case mix of the patients we care for, so we can have a far more informed discussion with clinicians about how we use our resources to care for them. Like all trusts we have to make efficiency savings (£11m in 2013/14). We need to take cost out and we know we can't do it by just simply slicing at the edges.

The trust is committed to transforming services to improve the service user experience. For example, we plan to treat more people in the community rather than as inpatients, which will also support delivery of the trust's requirement to cut costs. Transforming services is about changing how we work. Our primary cost driver is staff time. Our transforming programme is led by clinical colleagues committed to redesigning care pathways to improve the quality and to maximise the use of staff time.

Mental health PBR is not just about costs, it is also about measuring outcomes. This year's emphasis is on developing quality indicators and outcome measures for mental health PBR, further encouraging accountants and clinicians to work closely together."

and implementing new access and/or waiting time standards for mental health services by the end of March 2015, and be prepared and committed to introducing those standards as they are agreed.

- To continue to extend and offer more open access to IAPT including, particularly for children and adults of working age, planning for country-wide service transformation.

Long-term conditions

Depression is about two to three times more common in patients with a chronic physical health problem than in people who have good physical health, and occurs in about 20% of people with a chronic physical health problem[44].

The mandate requires NHS England to coordinate improvement in the integration of care across different services, including services provided to those with long-term conditions. It describes the need for improvements in the way care is coordinated around the needs of patients rather than the interests of organisations, ensuring 'people experience smooth transitions between care settings and organisations, including between primary and secondary care, mental and physical health services … and health and social care'.

Preventing premature mortality

People suffering from serious mental problems tend to have a life expectancy that is 10 to 15 years lower than the UK average. This is thought to be due to a combination of factors:

- Some medications increase appetite, and therefore can cause excessive weight gain
- People with severe mental health problems have poorer diets, take less exercise and smoke more than general population
- Poor access to healthcare and lack of clarity about who is in charge of the physical health of service users mean they are less likely to get access to appropriate physical interventions.

NHS England aims to close the health gap between people with mental health problems and the population as a whole, and has set as an improvement area reducing 'excess under 75 mortality in adults with severe mental illness'.

Improving the diagnosis, treatment and care of people with dementia

There are about 800,000 people with dementia in the UK. By 2040, the number of people affected is expected to double. The diagnosis rate in England is only 45%[45]. The Government's goal is that the diagnosis, treatment and care of people with dementia should be among the best in Europe. NHS England is required to make measurable progress towards achieving this by March 2015, in particular ensuring timely diagnosis and the best available treatment for everyone who needs it, including carers. The government proposes updating this objective[46] so that 'by 2015 two-thirds of the estimated number of people with dementia in England should have a diagnosis, with appropriate post-diagnosis support'.

Changes in commissioning structures

The recent changes in commissioning structures may lead to different decisions about the provision of mental healthcare. There is already evidence of CCGs reviewing local mental health services to inform decision-making, and changes in specialised commissioning could also have an impact on the delivery of services. Such changes generate new business opportunities for mental health providers, but may also mean providers lose some of their business if commissioning intentions change.

Public mental health

Local authorities became responsible for public health from April. Public mental health focuses on the wider prevention of mental health problems and the promotion of mental health for all ages. *No health without mental health* emphasises the importance of public mental health, stating: 'More people will have good mental health'.

Public mental health interventions are wide-ranging and include interventions to improve parental health, school-based mental health promotion, prevention of suicide, addressing social inequalities, housing interventions and reduced stigma and discrimination. ■

APPENDIX A: DEFINITIONS

The terms mental health problems, mental disorder, mental illness, mental wellbeing and mental disability are often used interchangeably, but mean different things. The first four definitions below have been taken from *No health without mental health:*

Mental health problems

We have used the phrase 'mental health problem' in this document as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder, following the example of *No health without mental health*. The strategy notes: 'Mental health problems may be more or less common, may be acute or longer lasting and may vary in severity. They manifest themselves in different ways at different ages and may (for example in children and young people) present as behavioural problems. Some people object to the use of terms such as 'mental health problems' on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative.'

Mental disorder

A broad term covering mental illness, learning disability, personality disorder and substance misuse. It is more formally defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'.

Mental illness

A term generally used to refer to more serious mental health problems that often require treatment by specialist services, including depression and anxiety (which may also be referred to as common mental health problems), schizophrenia and bipolar disorder (also sometimes referred to as severe mental illness). Conduct disorder and emotional disorder are the commonest forms of childhood mental illness.

Mental wellbeing

A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.

Mental disability

The Equality Act 2010 prohibits discrimination against people with the protected characteristics that are specified in the Act.
Disability is one of the specified protected characteristics.
A person has a disability for the purposes of the Act if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

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APPENDIX B: MENTAL HEALTH PBR CARE CLUSTERS

Cluster	Cluster label	Description
0	Variance	Despite careful consideration of all the other clusters, these service users are not adequately described by any of their rating profiles or descriptions, but do need mental healthcare and will be offered a service.
1	Common mental health problems (low severity)	This group has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any distressing psychotic symptoms.
2	Common mental health problems (low severity with greater need)	This group has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.
3	Non-psychotic (moderate severity)	Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)
4	Non-psychotic (severe)	This group is characterised by severe depression and/or anxiety and/or other increasing complexity of needs. May experience disruption to function in everyday life; increasing likelihood of significant risks.
5	Non-psychotic disorders (very severe)	This group will be experiencing severe depression and/or anxiety and/or other symptoms. Will not present with distressing hallucinations or delusions but may have unreasonable beliefs; may often be at high risk for non-accidental self-injury and may present safeguarding issues and severely disrupt life.
6	Non-psychotic disorder of over-valued ideas	Moderate to very severe disorders that are difficult to treat; may include treatment resistant eating disorder, OCD etc, where extreme beliefs are strongly held, some personality disorders and depression.
7	Enduring non-psychotic disorders (high disability)	Moderate to severe disorders that are very disabling. Patients will have received treatment for years and, although they may have improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.
8	Non-psychotic chaotic and challenging disorders	Wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.
9	Blank cluster	
10	First episode psychosis	Presenting to the service for the first time with mild to severe psychotic phenomena; may also have depressed mood and/or anxiety. Drinking or drug-taking may be present but not be the only problem.
11	Ongoing recurrent psychosis (low symptoms)	History of psychotic symptoms that are currently controlled and causing minor problems if any at all; currently experiencing a sustained period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.
12	Ongoing or recurrent psychosis (high disability)	History of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.
13	Ongoing/recurrent psychosis (high symptom and disability)	This group will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with a major impact on role functioning.
14	Psychotic crisis	They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.
15	Severe psychotic depression	Suffering from an acute episode of moderate to severe depressive symptoms; hallucinations and delusions; likely to present a risk of non-accidental self-injury and have disruption in many areas of life.
16	Psychosis and affective disorder (high substance misuse and engagement)	Enduring, moderate to severe psychotic or bipolar affective symptoms with unstable, chaotic lifestyles and co-existing problem drinking or drug taking. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.
17	Psychosis and affective disorder – difficult to engage	Moderate to severe psychotic symptoms with unstable, chaotic lifestyles; may be problems with drugs or alcohol not severe enough to warrant care associated with cluster 16. This group have a history of non-concordance, are vulnerable & engage poorly with services.
18	Cognitive impairment (low need)	People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.
19	Cognitive impairment or dementia complicated (moderate need)	People who have problems with their memory, and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.
20	Cognitive impairment or dementia complicated (high need)	People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.
21	Cognitive impairment or dementia (high physical or engagement)	People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

APPENDIX C: FURTHER INFORMATION

This briefing has drawn on various sources of information. The most important sources are set out below.

British Psychological Society
www.bps.org.uk
The British Psychological Society (BPS) is the representative body for psychology and psychologists in the UK. The BPS promotes excellence and ethical practice in the science, education and practical applications of psychology. A range of information is available on the society's website.

Centre for Mental Health
www.centreformentalhealth.org.uk
The Centre for Mental Health is a charity that delivers research and training in mental health. Its main areas of focus are criminal justice, employment, recovery, children and workplace training. Information on these topics, together with reports on research and analysis, can be found on its website.

Department of Health – Mental health policy
www.gov.uk/government/policies/making-mental-health-services-more-effective-and-accessible--2
The cross-government strategy *No health without mental health* sets the shared objectives to improve people's mental health and wellbeing and improve services for people with mental health problems. A new suicide prevention strategy was launched in September 2012.

Department of Health – Investment in mental health 2011/12: Working Age Adults and Older Adults
www.gov.uk/government/publications/investment-in-mental-health-in-2011-to-2012-working-age-adults-and-older-adults
The two reports, prepared by Mental Health Strategies on behalf of the Department of Health, provide details of the level of investment in secondary mental health services for working age adults and older adults by service type.

Department of Health – payment by results
www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14
The website provides the components of the mental health PBR package for 2013/14, including the guidance, the mental health clustering booklet and the clustering support tool algorithm.

Joint Commissioning Panel for Mental Health
www.jcpmh.info
The Joint Commissioning Panel for Mental Health (JCPMH) is a collaboration between 17 organisations, co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners. JCPMH publications include a practical mental health commissioning guide for CCGs, as well as guidance for commissioners on what good services should look like for specific mental health services – for example, primary mental health care, dementia services and mental health services for young people.

Mental Health Care
www.mentalhealthcare.org.uk
This website, created by the Institute of Psychiatry and South London and Maudsley NHS FT, contains information about psychosis. It is designed for family members and friends of people who have a diagnosis of schizophrenia, bipolar disorder or another illness that may result in the symptoms of psychosis. It includes information on diagnoses, treatment and care, services and mental health law, and support for carers.

Mental Health Foundation
www.mentalhealth.org.uk
The Mental Health Foundation is a charity that aims to help people survive, recover from and prevent mental health problems. It does this by carrying out research, developing practical solutions for better mental health services, campaigning to reduce stigma and discrimination and promoting better mental health for everyone.

Mind
www.mind.org.uk
The charity Mind campaigns on behalf of people with mental health problems, provides support for the independently run local Mind associations, and provides direct information through telephone helplines, publications and website.

National Institute for Health and Care Excellence (NICE)
www.nice.org.uk
NICE provides recommendations for the NHS about the treatment and care of people with specific conditions, based on the best available evidence.

Rethink Mental Illness
www.rethink.org
The charity Rethink provides information, advice, support and services to people with severe mental health problems, as well as their families and carers. It also campaigns for high-quality care, including both acute and long-term services, and aims to improve and spread understanding about severe mental health problems.

Royal College of Psychiatrists
www.rcpsych.ac.uk
The Royal College of Psychiatrists is the professional body responsible for education, training, setting and raising standards in psychiatry. Factsheets for the general public about all aspects of mental health are available on its website.

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