ARTICLE

Government policy and the National Service Framework for Mental Health: modelling and costing services in England

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SUMMARY

The National Service Framework for Mental Health (NSF–MH), published by the Department of Health in 1999, set an ambitious 10-year agenda for improving mental healthcare for working-age adults in England, based on seven quality standards covering all major services. The NSF–MH was supported by a series of other policy documents published by the government. This article illustrates a means of modelling the government's policy for adult mental health services to produce figures for the necessary services, staffing and financial resources required to meet the policy objectives. The findings of a report recently published by the Sainsbury Centre for Mental Health, which undertook a detailed assessment of what needs to be done to deliver these standards in terms of service provision, staffing and funding, is summarised and its implications examined.

DECLARATION OF INTEREST

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Health policy and planning in the UK have been defined by the structure and function of the National Health Service (NHS) since 1948: free at the point of access and dominated by central planning. There have been many changes to the structure of the NHS over the years. Since the 1970s policy has been particularly concerned with how to manage the ever increasing demand for resources and how to address variations in population needs, availability of services and their quality across the country. A range of measures have been used to address these variations including, in recent years, an increasing use of market mechanisms. Staffing needs in the NHS have always proved difficult to predict and the numbers of professional staff have often swung between a shortage and a surplus. Such changes have occurred against a backdrop of rising expenditure, with NHS spending as a share of national income having more than doubled since 1948.

The general direction of mental health services has been clear since the inception of the NHS, moving away from large institutions to community-based services (Boardman 2005). These changes have been protracted and early predictions for the closure of asylums were widely optimistic (Tooth 1961). It was not until the last decade of the 20th century that asylums were finally closed in England and the first national plans for adult mental health services were created.

In this article we examine one example of mental health policy, the National Service Framework for Mental Health (NSF–MH), which set out the basis for a 10-year plan for adult mental health services in England. How might this national plan, its associated policies and projected services be turned into figures that give an indication of the human and financial resources required to deliver these policies? How can this framework and associated policies be understood in terms of their implications for service provision, staffing and funding of adult mental health services, and what are the implications for future policy and planning? We will consider these matters and illustrate how service resources can be modelled using as the starting point work that we undertook at the Sainsbury Centre for Mental Health, where we carried out a detailed assessment of what needs to be done to deliver the key objectives of current mental health policy using the seven standards of the NSF–MH. (This work is reported in more detail in Boardman & Parsonage (2007)). We will use this work to consider the overall progress that has been made in implementing the NSF–MH and how far there is still to go, and examine possible new directions in mental health policy and services as the 10-year programme set out in the NSF–MH enters its final years.

BOX 1 The seven standards of the NSF–MH

Standard 1: Mental health promotion and discrimination/exclusion

Health and social services should:

• promote mental health for all, working with individuals and communities

• combat discrimination against individuals and groups with mental health problems and promote their social inclusion

Standards 2 and 3: Primary care and access to services

Standard 2

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

• have their mental health needs identified and assessed

• be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it

Standard 3

Any individual with a common mental health problem should:

• be able to make contact around the clock with the local services necessary to meet their needs and receive adequate care

• be able to use NHS Direct, as it develops, for first-level advice and referral to specialist helplines or to local services

Standards 4 and 5: Services for people with severe mental illness

Standard 4

All mental health service users on a care programme approach plan should:

• receive care which optimises engagement, anticipates or prevents a crisis and reduces risk

• have a copy of a written care plan which:

  includes the action to be taken in a crisis by the service user, their carer and their care coordinator

  advises their general practitioner how they should respond if the service user needs additional help

  is regularly reviewed by their care coordinator

  be able to access services 24 hours a day, 365 days a year

Standard 5

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

• timely access to an appropriate hospital bed or alternative bed or place, which is:

  in the least restrictive environment consistent with the need to protect them and the public

  as close to home as possible

• a copy of a written aftercare plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care coordinator and specifies the action to be taken in a crisis

Standard 6: Services for carers

All individuals who provide regular and substantial care for a person on a care programme approach plan should:

• have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis

• have their own written care plan which is given to them and implemented in discussion with them

Standard 7: Action necessary to reduce suicides

Local health and social care communities should prevent suicides by:

• promoting mental health for all, working with individuals and communities (standard 1)

• delivering high-quality primary mental healthcare (standard 2)

• ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an accident and emergency department (standard 3)

• ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (standard 4)

• providing safe hospital accommodation for individuals who need it (standard 5)

• enabling individuals caring for someone with severe mental illness to receive the support they need to continue to care (standard 6)

and in addition they should:

• support local prison staff in preventing suicides among prisoners

• ensure that staff are competent to assess the risk of suicide among individuals at greatest risk

• develop local systems for suicide audit to learn lessons and take any necessary action

(Department of Health 1999)

The National Service Framework for Mental Health (NSF–MH)

The National Service Framework for Mental Health (NSF–MH) was published by the Department of Health in 1999 and set out an ambitious 10-year agenda for improving mental healthcare in England, based on a set of quality standards covering all major services for adults of working age (Department of Health 1999) (Box 1). Subsequent policy documents, including the NHS plan of 2000 (Secretary of State for Health 2000), which linked the developments to additional funding and a series of policy implementation guides, supplemented the NSF–MH and clarified the nature and scale of the task. These policies were not to be implemented in isolation and the Department of Health set out a series of associated policies that had implications for the delivery of the NSF–MH. The main mental health policy documents along with other broader policy initiatives, all of which were considered in the modelling project, are listed in Box 2.

The establishment of the National Institute for Clinical Excellence for England and Wales in 1999 (Department of Health 1997, 1998d) and its evolution into the National Institute for

Health and Clinical Excellence (NICE) in April 2005 (Department of Health 2004h) also need to be considered. It provides guidance for the NHS on health technologies as well as national guidance on the promotion of good health and the prevention and treatment of ill health. How healthcare organisations should respond to NICE guidance is set out in *Standards for Better Health* (Department of Health 2004j) and the standards, which form the basis of the annual assessment by the Healthcare Commission, include requirements to conform to NICE guidance.

The National Institute for Mental Health in England (NIMHE) was set up in 2002 to implement and develop government mental health policy (Department of Health 2001e), and a 5-year review of the NSF–MH was published in 2004 (Department of Health 2004k).

Modelling the service, staffing and spending requirements of the NSF–MH

In a report published by the Sainsbury Centre for Mental Health (Boardman 2007), we sought to define and specify a set of mental health services

that would deliver all of the NSF–MH standards, taking into account subsequent policy statements and policy guidance, and to quantify the associated needs for staffing and expenditure. The services described by the project are intended to be available by 2010/11, in line with the 10-year timescale set at the release of the NSF–MH in 1999.

There were four main stages to the analysis (Box 3). However, the approach summarised in Box 3 is subject to a number of limitations, mainly reflecting shortages of relevant information at key stages in the analysis. For example, in specifying the type and configuration of services needed to deliver the NSF–MH standards, it was found that this is much more explicit in the published guidance for some areas of provision (e.g. assertive outreach teams) than for others (e.g. primary care). Where there were no explicit or agreed models in official statements of policy and guidance, alternative approaches had to be used: these included reference to NICE guidelines, current examples of good practice or a consensus of professional opinion. For this and other reasons, the service specifications should therefore be seen as representing only one

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BOX 2 Government policies associated with the NSF–MH

Policy before 1999

The New NHS: Modern, Dependable (Department of Health 1997)

Modernising Mental Health Services. Safe, Sound and Supportive (Department of Health 1998a)

Our Healthier Nation (Department of Health 1998b)

Modernising Social Services (Department of Health 1998c)

A First Class Service: Quality in the New NHS (Department of Health 1998d)

Policy in 2000

NHS plan in 2000 (Secretary of State for Health 2000; Department of Health 2004a)

Policy implementation guides

Mental Health Policy Implementation Guide (Department of Health 2001a)

Community Mental Health Teams (Department of Health 2002a)

Adult Acute Inpatient Care Provision (Department of Health 2002b)

Dual Diagnosis Good Practice Guide (Department of Health 2002c)

National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (Department of Health 2002d)

Support, Time and Recovery (STR) Workers (Department of Health 2003a)

Mainstreaming Gender and Women's Mental Health (Department of Health 2003b)

Fast-Forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers (Department of Health 2003c)

Fast-Forwarding Primary Care Mental Health: 'Gateway' Workers (Department of Health 2003d)

Community Development Workers for Black and Minority Ethnic Communities (Department of Health 2004b)

Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings (Department of Health 2004c)

Other aspects of mental health policy

Black and ethnic minority groups (Department of Health 2003e, 2005a)

Prisoners (Department of Health 2001b)

People with personality disorders (National Institute for Mental Health in England 2003)

Women (Department of Health 2002e, 2003b, 2006a)

Carers (Department of Health 2002f)

Mental Health Act (Department of Health 2004d,e, 2006b)

Future NHS workforce and recruitment (Department of Health 1998e, 2001c, 2004f, 2005b)

Social exclusion (Social Exclusion Unit 2004)

Employment, disability and benefit reform (HM Government 2005a,b, 2006)

Day services and vocational services (Department for Work and Pensions 2004; Department of Health 2006a,c,d)

Deafness (Department of Health 2002g; National Institute for Mental Health in England 2005)

Physical health (Department of Health 2006e)

Broader policy initiatives

Funding arrangements and commissioning (Department of Health 2003f,g, 2004g, 2006f)

Patient choice and patient and public involvement (Secretary of State for Health 2003; Department of Health 2004h, 2005c)

Focus on care outside hospitals (Department of Health 2005d; Secretary of State for Health 2006)

Management of chronic disease (Department of Health 2001d, 2005e,f)

Medicines management and prescribing (Department of Health 2000a, 2004i, 2005g)

NICE clinical guidelines and technology appraisals

possible version of a mental health service that might deliver the objectives of the NSF–MH and related policies. It should also be noted that, on the whole, a conservative approach was taken, avoiding the introduction of radical new models of service delivery or radical changes in staff roles (e.g. as indicated in *New Ways of Working for Psychiatrists*; Department of Health 2005b).

Another limitation is that the analysis did not explore in any detail the possible interaction between different types of service provision. For example, crisis resolution teams may over time reduce the need for in-patient services. The full analysis of such interactions requires detailed dynamic simulation studies with a more limited focus, such as Symmetric's mental health modelling (www.symmetricsd.co.uk/sdmodelling.asp).

Finally, the expenditure figures produced by the analysis should be regarded not as forecasts or projections, but rather as estimates of how much spending is needed to deliver the objectives of government policy. The analysis thus differs from conventional forecasting exercises, as exemplified by a recent study on mental health spending (McCrone 2008).

Key findings

Based on these methods of analysis, the main findings of the Sainsbury Centre report (Boardman 2007) on the specification of services and associated resource needs for each of the seven standards in the NSF–MH can be summarised as follows.

Standard 1: Mental health promotion and discrimination/exclusion

Little official guidance is available on the service and staffing requirements of standard 1. Current good practice indicates that, at minimum, a mental health promotion team of eight staff is needed for an average local population of 250 000 people. In practice, much of the provision associated with standard 1, particularly the promotion of the social inclusion of people with mental health problems, is likely to fall to non-healthcare agencies such as those concerned with education, employment and housing.

Standards 2 and 3: Primary care and access to services

For mental healthcare in primary care, the NSF–MH and associated guides provide relatively little by way of clear guidance on appropriate levels and methods of service delivery. In the absence of an agreed model for delivering mental health interventions in this setting, we used an approach that identified the main evidence-based types of

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BOX 3 Steps in the Sainsbury Centre project analysis

Step 1: Service specification

Detailed description of the type and configuration of services needed to deliver each of the NSF–MH standards, based wherever possible on published guidance.

Step 2: Service quantification

Assessment of the volume of services required to meet the needs for mental healthcare among working-age adults, calculated where possible by reference to population-based estimates of existing rates of mental health conditions.

Step 3: Staffing analysis

Conversion of the volumes of service provision as estimated in steps 1 and 2 into matching workforce requirements, disaggregated by type of staff.

Step 4: Expenditure analysis

Conversion of the projected staff numbers into expenditure terms, using appropriate pay rates, combined with estimated levels of spending on non-pay inputs to give a figure for total required expenditure in 2010/11.

(Boardman 2007)

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treatment for common mental health disorders – medication and psychological therapies. As summarised in NICE guidelines, there is a good evidence base for drug treatments in anxiety and depression and for a range of psychological therapies, particularly cognitive–behavioural therapy (CBT) (National Institute for Clinical Excellence 2004a,b).

Drawing on epidemiological evidence, it is estimated that in a typical local population of 250 000 people (all ages), there will be around 13 200 new onsets of depression and anxiety among working-age adults in any one year. If treatment is given to all those for whom antidepressant medication or CBT are judged suitable in line with NICE guidelines and if all these cases are detected by general practitioners, a total of nearly 9000 people should receive antidepressants and 4400 should receive a course of CBT (12 sessions on average). The provision of CBT on this scale would require about 55 therapists per 250 000 population, corresponding to a requirement in 2010/11 of 11 400 therapists for England alone. The estimates for required levels of medication are broadly in line with current levels of provision, but those for improving access to psychological therapy are far higher.

Standards 4 and 5: Services for people with severe mental illness
Community-based teams

The services required for people with severe mental illness are more clearly defined in official guidance. This particularly applies to the services provided by community-based teams (community mental health teams and the new specialist functional teams providing crisis resolution, assertive

outreach and early intervention services). Analysis suggests that, relative to the numbers employed in 2005/06 (taken as the reference year in the Sainsbury Centre report), nearly 18 000 additional community team care staff are needed by 2010/11, if the NSF–MH standards are to be implemented. This is an increase of nearly 80%. The staffing gap is particularly large in the case of early intervention teams, where the numbers employed in 2005/06 were only about a fifth of the required level.

There is also a need to diversify the types of staff traditionally seen in community teams, including for example more pharmacists, dual diagnosis workers, employment specialists and support workers for people from Black and minority ethnic groups. Other forms of community provision are required to augment the core community teams and the voluntary sector might supply many of these, including advice and information services, advocacy services, befriending and voluntary schemes, self-help and mutual aid groups, and service user groups.

In-patient services

Community services must be backed up by good-quality acute in-patient services, together with a range of residential accommodation and rehabilitation facilities. Projections for numbers of beds and residential places in 2010/11 were mainly taken from the National Beds Inquiry published in 2000 (Department of Health 2000b). In the absence of official norms, associated staffing requirements were based on a consensus of professional opinion. This suggested, for example, that a 20-bed acute ward would require a complement of 32 nurses to cover the ward for a 7-day period, taking into account paid leave, training and sickness absence. The total number of care staff required for in-patient and residential units (excluding forensic units) in 2010/11 is estimated at around 85 000.

As with community teams, there is a need to diversify the types of staff employed in these units, for example to improve medicines management and physical care for patients, to increase the therapies and activities available, and to improve the social component of care.

Day care and employment services

Day services are in need of reorganisation and should be closely allied to employment schemes. Service specifications and staff needs were based on recent official guidance on day services and also on cross-departmental initiatives such as the report on social exclusion and mental health (Social Exclusion Unit 2004). About 3500 staff were employed in day care and employment services in 2005/06, which is only about a third of the required level.

Forensic services

Forensic services were assessed separately. Because the capacity requirement for in-patient services is not well defined, current numbers of secure beds were used as the basis of the calculations, implying provision of 820 high secure beds and around 4430 medium secure beds, based on the numbers in use in 2005/06. Outside the hospital setting, community forensic teams are in their infancy and need developing for the community management of offenders and those discharged from secure in-patient units.

Staffing needs for mental health services in prisons were also examined and it is estimated that in a typical category B prison of 550 inmates, an in-reach team of around 14 whole-time equivalent staff is required.

Subspecialty services

A series of subspecialty services are needed to provide services for working-age adults in addition to the core community and in-patient services. These include general hospital liaison services, perinatal services, services for people with personality disorders, services for deaf people and services for people with eating disorders. Staffing levels vary according to the underlying epidemiological base and it is estimated that provision for a representative local population of 250 000 people will require complements of around 11 staff for general hospital liaison services and around 18 staff for local personality disorder services.

Standard 6: Services for carers

Services for carers are at present poorly provided. For example, in 2005/06 there were about 800 carer support workers in England, but it is estimated that more than double this number are needed in order to implement standard 6 by 2010/11.

Standard 7: Action necessary to reduce suicides

It is noted in the NSF–MH that the service models to address standard 7 are seen by the Department of Health to be those set out in relation to standards 1–6. In line with this official view, it was therefore not necessary to make separate staffing estimates in this case.

Staffing and expenditure

The service specifications required to deliver the NSF–MH standards and the associated workforce requirements were assessed across the full range of mental health services for adults of working

age. Pulling together the findings, Table 1 shows estimates for 2010/11 of the required number of staff in selected clinical groups and compares these with the numbers employed in 2005/06.

Overall, these figures indicate that numbers in the groups shown need to increase by nearly 40% from 2005/06 levels in order to deliver the NSF–MH by 2010/11.

The final stage in the analysis was to convert the estimates of staff numbers into global expenditure terms. This entailed a number of further calculations, including allowing for non-pay inputs (building costs, drugs) and also allowing for real increases in pay, where it was assumed that pay rates in health and social services would increase over and above general inflation at 2.4% a year, in line with historical trends. Taking into account these and other adjustments, the report estimated that for full implementation of the NSF–MH, total spending on adult mental health services would need to increase between 2005/06 and 2010/11 by 53% in real terms (i.e. on top of general inflation), equivalent to an average increase of 8.8% a year. In absolute terms, the required increase in expenditure at constant 2005/06 prices is from £4.9 billion in 2005/06 to £7.5 billion in 2010/11.

Implications of the Sainsbury Centre model

The modelling adopted a direct approach to the process of examining the service, staffing and financial implications of government policy for adult mental health services using the NSF–MH as the central component of policy. The process made the boundaries of the exercise clear (government mental health policy for adults of working age) and if the services were not specified in published policy documents then they were not included in the modelling exercise. Staffing estimates were based, as far as possible, on estimates of need from epidemiological studies, but failing this, from demand figures or accepted good practice, making every effort to be as explicit as possible. Cost estimates were based directly on staffing figures. Owing to the methods used, the resulting estimates for staffing numbers were inevitably conservative.

The cost of government policy objectives was included in the analysis and it was possible to assess the additional resources necessary to deliver these aspirations and the progress made towards them. What are the main implications of the findings?

Funding

As noted earlier, to deliver the NSF–MH in full, spending on adult mental health services needs to increase between 2005/06 and 2010/11 at an

TABLE 1 Number of staff employed in 2005/06 and required in 2010/11

Clinical group	Staff employed in 2005/06, *n*	Staff required in 2010/11, *n*
Consultant psychiatrists	2689	4075
Other medical staff	4446	6844
Qualified nurses	51 928	70 790
Social workers	6124	10 211
Clinical psychologists, psychotherapists and counsellors	13 623	16 320
All of the above groups	78 180	108 240

Source: Boardman (2007).

average rate of 8.8% a year in real terms. How likely is it that extra resources will be made available on this scale in light of past and prospective trends in government spending?

Looking first at the historical record, an analysis of past spending shows that between 1999/2000 (when the NSF–MH was published) and 2005/06 expenditure on adult mental health services increased in real terms by 47%, equivalent to an annual rise of 6.7% a year. About a third of the additional money went on the development of community-based mental health teams, particularly the new specialist functional teams described in the NSF–MH. These increases for mental health occurred at a time when overall expenditure on the NHS and social services was rising particularly quickly by historical standards and the share of mental health in the total remained broadly constant. The rate of increase in spending on mental health was nevertheless substantial and allowed considerable progress to be made in improving services along the path set by the NSF–MH. On the other hand, even if expenditure continues to grow at this rate, it will not be sufficient for the full implementation of the policy by 2010/11, given a growth requirement of 8.8% a year.

Looking ahead, it seems unrealistic to assume that spending will in fact continue to rise as rapidly as in the recent past. This is for two main reasons. First, taking 2005/06 as the starting point, it is already clear from data put into the public domain since publication of the Sainsbury Centre report that spending on mental health services slowed down substantially in 2006/07 and 2007/08, reflecting wider financial pressures in the NHS. Thus, an annual survey of investment in mental health services has shown that aggregate expenditure on these services increased by just 2.3% in real terms between 2005/06 and 2006/06 and by 3.7% between 2006/07 and 2007/08 (Mental Health Strategies 2007, 2008). These increases are well below the average rise of 6.7%

a year recorded between 1999/2000 and 2005/06 and even further below the average rise of 8.8% a year that is needed between 2005/06 and 2010/11 for full implementation of the NSF–MH.

Second, the government's pre-budget report and comprehensive spending review was published in October 2007 and included detailed spending plans for all major public expenditure programmes, including the NHS and social services, covering the three financial years 2008/09, 2009/10 and 2010/11 (HM Treasury 2007). These show that over the period in question, total spending on the NHS is planned to increase at an average rate of 4.1% a year in real terms, while the corresponding planned increase in total spending on local authority social services is 2.1% a year. Assuming that the share of mental health in both these programmes remains constant and also taking into account that current spending on adult mental health services divides roughly 80:20 between the NHS and social services, it can be calculated that expenditure on mental health is likely to increase by around 3.7% a year in real terms over the 3 years covered by the new public spending plans. This is well below the required rate of 8.8% a year.

Bringing together the above figures, it is estimated that by 2010/11 aggregate financial provision for adult mental health services will be over 20% short of the level required for full implementation of the NSF–MH. Notwithstanding the substantial extra resources that have been made available since the NSF–MH was published, these are very unlikely to deliver the policy in full within the 10-year timescale originally envisaged, and by 2010/11 funded capacity for adult mental health care is likely to be at around 77.5% of its required or target level.

Services

The specifications for services outlined in the NSF–MH and associated policy documents have varied in the extent of their detail. Some services, particularly those in standards 4 and 5, such as assertive outreach and crisis resolution teams, had detailed specifications but others, for example those required for health promotion (standard 1), were not well defined. The model of services for primary care (standards 2 and 3) was also not specified, although the government's 5-year review of the NSF–MH aspired to improve access to psychological therapies (later taken up by the Improving Access to Psychological Therapies (IAPT) pilots; Department of Health 2008a). In-patient units, although prominent in the NSF–MH, have made limited progress and remain areas of unacceptable levels of violence (Royal College of Psychiatrists 2008).

These variations in specifications are mirrored in the degree to which progress has been made in achieving the NSF–MH standards. Assertive outreach teams and crisis resolution teams have been set up across the country (although early intervention teams are less well established), but health promotion initiatives are mainly lacking. This may also reflect the fact that health promotion activities cut across government departments, but nevertheless there is a need to develop specific initiatives in health and social care.

Some forms of secondary care provision were not included in the NSF–MH. For example, there are no current policy initiatives for the development of rehabilitation services. Another neglected area is 'interface services' for individuals at points of transition or overlap with general adult services: they include adolescents and young adults, older adults, people with learning difficulties or autism-spectrum disorders, and individuals with drug or alcohol use disorders in addition to mental illness.

Research and development

At the time of the Sainsbury Centre study, monitoring of the staffing of services related to the NSF–MH was carried out by the Centre for Public Mental Health at Durham University (Centre for Public Mental Health 2006) and financial monitoring was undertaken by an independent company, Mental Health Strategies (Mental Health Strategies 2006, 2007). (Both service and financial monitoring are now carried out by Mental Health Strategies.) There was no other systematic overview or analysis of the implementation or progress of the NSF–MH. This may have been a wasted opportunity. For example, the community-based teams may be considered to be the hub of local secondary services, dealing at some point with the majority of the population of people with severe mental illness. The creation of new community teams may be considered to be a live experiment requiring an evaluation of their efficacy. Community mental health teams and new teams could be placed in the context of other mental health services for working-age adults, including in-patient units, specialist services (e.g. forensic and rehabilitation), primary care and services provided by the independent sector. This would imply the need for a rigorous national review before the final implementation date of 2010/11.

Although a crucial opportunity has been missed in creating a continuous evaluation of the implementation and progress of these teams, it is not too late to provide a retrospective view of their implementation or a prospective evaluation over the next few years.

Other uses of the model

As Box 3 shows, the end-product of the analysis is a quantified model of the mental health system. A feature of the model is that it can readily be re-calibrated to incorporate changed assumptions or data and so can be used, for example, to assess the workforce and expenditure implications of different levels or methods of service delivery. Similarly, the model can be adapted using demographic and other data relating to a specific locality and thus serve as a local planning tool. As an example of such uses, a workforce capacity tool has been developed by the Care Services Improvement Partnership drawing on the Sainsbury Centre model, which is intended to help commissioners plan the expected number of new staff needed to manage demand for psychological therapies and other services in their areas (www.mhchoice.csip.org.uk/psychological-therapies/workforce/workforce-capacity-tool.html).

New challenges and future priorities

The 10-year lifespan of the NSF–MH is drawing to a close. There are new and emerging challenges to confront and new priorities in policy and services for the years after 2010/11.

New challenges

Challenges include the slower growth in NHS spending and the implications of wider NHS reforms.

On the basis of the government's public expenditure plans announced in October 2007, spending on mental health services is likely to grow at around 3.7% a year in real terms over the next 3 years. It would also seem prudent to assume that growth at or even below this rate, rather than above it, will persist over the longer term. By historical standards, this is a more than respectable rate of increase. For example, it has been estimated that between 1984/85 and 2003/04 mental health spending grew by 3.3% a year on average (Parsonage 2005). It is also faster than the long-run rate of growth in the economy as a whole, which is around 2.5% a year, implying that mental healthcare will account for a steadily rising share of national income over time. It is, however, much slower than the average annual increase of 6.7% enjoyed during the first 6 years of the NSF, a time of particularly rapid expansion in the availability of resources that is unlikely to be repeated in the foreseeable future. One implication of a more constrained resource environment is that continuing improvements in services must increasingly be financed by efficiency savings rather than new money.

The current round of reform in the health service centres on a linked set of initiatives aimed at delivering more personalised and responsive care at a local level, much of which is focused on general health services (Department of Health 2008b). These include patient choice, practice-based commissioning, payment by results and diversity of supply (including foundation trusts and greater use of the independent sector). All are intended to apply throughout the NHS, but their scope and impact will vary greatly from one sector to another, as will their ease of implementation. For example, payment by results (Department of Health 2003f) has now been established for some years as a method of remuneration for hospital services in the acute sector in England, but a system for mental health will not be introduced until 2010/11.[†] The slower implementation of reform in this area reflects genuine difficulties in designing a new payment system that fits the particular characteristics of mental health and its care. In the meantime, concern has been expressed that mental health budgets are increasingly vulnerable to demands from the acute sector to finance higher levels of activity driven by payment by results.

Future priorities

When the NSF–MH was published, there was no associated analysis of the implications for staffing and other resources. The Wanless report (Wanless 2002) examined the financing of the NHS, including the projected costs for implementing the then five NSFs and produced similar figures for the NSF–MH as we have presented here. The figures published in the Wanless report were not sufficiently detailed to reveal how they were derived and there were no associated details of services and staffing resources.

There have been calls to look at the plans for mental health services after 2010/11 (Future Vision Coalition 2008) and the Department of Health has responded by creating the New Horizons project to help develop a new vision to replace the existing NSF–MH, but this vision has not yet been published. What is required is the creation of a clear view of the future direction, standards, delivery and structure of 21st-century mental health services, along with a published analysis of the implications for staffing and other resources.

Two priorities for this future direction include the creation of plans for the areas of the NSF–MH that have been insufficiently developed and the development of recovery-oriented services.

Those areas of the NSF–MH that require further development include: mental health promotion, particularly the reduction of ignorance, prejudice

[†] For a discussion of payment by results for NHS mental healthcare in England and Wales see: Fairbairn A (2007) Payment by results in mental health: the current state of play in England. *Advances in Psychiatric Treatment*, **13**: 3–6; Oyebode F (2007) Payment by volume (not results). *Advances in Psychiatric Treatment*, **13**: 7–9. Ed.

and discrimination, and the improvement of well-being; the establishment of improved primary care mental health services; and improved access to psychological therapies, which builds on the IAPT pilots (Department of Health 2008a). For secondary services, the neglected fields have been the interface areas highlighted above and the quality of in-patient care and units, including forensic facilities and prison healthcare. Services for carers is another area for continued attention.

The concepts of recovery have consequences for the organisation of mental health services and the approaches adopted by those who work in them, and recovery is likely to be the central organising principle for mental health services in the next 25 years (Shepherd 2008). The central ideas behind recovery-oriented practice and services are consistent with current policy strands relating to health and disability management, for example 'choice', 'social inclusion' and the self-management of chronic illness. Two particular policy implications of recovery are the need to develop a clear national policy that seeks to implement recovery-oriented principles in the design and delivery of all adult mental health services, and to transform the current workforce by employing a higher proportion of mental health workers and other members of the trust workforce who have a 'lived experience' of mental health problems.[‡] Recovery-based services should promote social inclusion and challenge marginalisation and stigmatising views/behaviours within our own services and in wider society.

A vision for future services has been set out by others (Rankin 2005; Sainsbury Centre for Mental Health 2006; Future Vision Coalition 2008). Nevertheless, there is a vision of services implicit in a policy that promotes social inclusion, citizenship and rights, principles that are not merely abstract, but are central to the lives of current and potential service users. Concerns still to be resolved are the availability of sufficient resources to match the vision and the nature of our longer-term strategy to secure an equitable distribution of these resources. Our modelling exercise has considered the resource inputs necessary to deliver the policy aspirations related to the NSF–MH, which have to some degree been met, but a clear policy direction for mental health services needs to be developed and maintained. At present there seems to be a lacuna at the heart of mental health policy that needs to be filled with a clear view for the future direction, standards, delivery and structure of 21st-century mental health services, along with a published analysis of the implications for staffing and other resources. Some form of successor to the NSF–MH is needed to maintain the momentum of recent years.

[‡]A series of four articles and commentaries offering a collaborative dialogue on recovery-oriented care between providers and consumers of compulsory psychiatric services appeared in a recent issue of *Advances*, beginning with Roberts G, Dorkins E, Wooldridge J, et al (2008) Detained – what's my choice? *Advances in Psychiatric Treatment*, **14**: 172–80. Ed.

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MCQ answers				
1	**2**	**3**	**4**	**5**
a f	a f	a t	a f	a f
b f	b f	b f	b f	b t
c f	c f	c f	c t	c f
d f	d t	d f	d f	d f
e t	e f	e f	e f	e f

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MCQs

1 The National Service Framework for Mental Health:

a was published in 2000

b set out the financial arrangements for mental health service funding

c defined the plans to close the large asylums in England

d covered policy for England, Wales and Scotland

e set seven standards for mental health services for adults of working age.

2 The National Service Framework for Mental Health:

a was the only National Service Framework to be published by the Department of Health

b set out a 20-year agenda for adult mental health services ending in 2020/21

c was backed by a comprehensive evaluation programme

d was supported by a number of policy implementation guides

e is assessed annually by the Healthcare Commission.

3 In the National Service Framework for Mental Health:

a standard 4 covers written care plans

b standard 1 covers the implementation of new day services

c standards 2 and 3 delineate standards for social care services

d standard 5 covers in-patient services for carers

e prevention of suicide is covered by standard 6.

4 In standards 4 and 5 of the National Service Framework for Mental Health:

a the plans for suicide prevention were clearly laid out

b the staffing implications for acute in-patient services were precisely delineated

c the types of care programme approach care plans were specified

d access to NHS Direct was considered to be important

e mental health promotion was regarded as integral to combating stigma.

5 The funding for adult mental health services:

a has steadily risen between 2000/01 to 2006/07 by an average of 8.8% per year

b rose between 1999/2000 and 2005/06 by 47%

c has been monitored by Durham University

d is mainly spent on social service provision

e is likely to be sufficient to fully implement the National Service Framework for Mental Health by 2010/11.