opinion & debate

Psychiatric Bulletin (2000), **24**, 203–206

GRAHAM THORNICROFT

National Service Framework for Mental Health

The *National Service Framework for Mental Health* (NSF–MH) is a strategic blueprint for services for adults of working age for the next 10 years. It is both mandatory, in being a clear statement of what services must seek to achieve in relation to the given standards and performance indicators, and permissive, in that it allows considerable local flexibility to customise the services which need to be provided to fit the framework. This paper summarises the process by which the NSF was created, and its content, which became clear when it was published on 30 September 1999 (Department of Health, 1999).

Scope

The stated aims of the NSF–MH are to:

(a) help drive up quality;
(b) remove the wide and unacceptable variations in provision;
(c) set national standards and define service models for promoting mental health and treating mental illness;
(d) put in place underpinning programmes to support local delivery;
(e) establish milestones and a specific group of high-level performance indicators against which progress within agreed timescales will be measured.

The scope includes health promotion, primary care services, local mental health and social care services, those with mental health problems and substance misuse, and more specialised mental health services, including all forensic mental health services. The NSF–MH therefore encompasses a wide range of service activities including those provided by local authorities and health authorities, and it draws upon a review of the vast array of relevant evidence, including related information from other countries.

In reviewing the evidence in support of the standards, each part of the evidence base was graded according to the strength of the research in five categories:

Type I at least one good systematic review, including at least one randomised controlled trial;
Type II at least one good randomised controlled trial;
Type III at least one well-designed intervention study without randomisation;
Type IV at least one well-designed observational study;
Type V an expert opinion, including the opinion of service users and carers.

Before drafting the NSF for mental health, the Department of Health established an External Reference Group (ERG), which I chaired, to offer advice on the content of the framework. The ERG met from July 1998, and submitted its advice to ministers at the end of January 1999. The group included over 40 members, and also co-opted a further 30 members from a wide range of stakeholders including service users, managers, nurses, psychiatrists, national voluntary organisations, social care, primary care and national carers' organisations. To manage the task within six months much of the work of the ERG took place within eight working groups, namely (with chairs shown):

(a) population needs assessment, G.T. (psychiatrist);
(b) entry into health and social care, Huw Lloyd (general practitioner);
(c) crisis and short-term treatment, Marion Beeforth (Survivors Speak Out);
(d) longer term care, Cliff Prior (National Schizophrenia Fellowship);
(e) individual outcomes, Paul Lelliot (psychiatrist);
(f) outcomes at service level, Don Brand (National Institute of Social Work);
(g) managerial aspects, Chris Heginbotham (East Hertfordshire Health Authority);
(h) training and human resources, Matt Muijen (Sainsbury Centre for Mental Health).

At an early stage the ERG established seven critical issues facing services for adults with mental health problems, upon which the NSF–MH must impact if it is to succeed:

(a) insufficient involvement of users and carers;
(b) stigmatising public attitudes;
(c) poor agreement on service aims and boundaries;
(d) patchy and sometimes limited provision of services;
(e) lack of financial resources;
(f) workforce problems;
(g) lack of clear accountability.

https://doi.org/10.1192/pb.24.6.203 Published online by Cambridge University Press

opinion & debate

Core values and principles

The ERG also established a consensus on the fundamental values that should be used to guide practical service developments, namely that services should:

(a) show openness and honesty;
(b) demonstrate respect and offer courtesy;
(c) be allocated fairly and provided equitably;
(d) be proportional to their needs;
(e) be open to learning and change.

Upon this foundation services should also be guided by the following core fundamental principles, that users can expect services to:

(a) meaningfully involve users and their carers;
(b) deliver high quality treatment and care which is effective and acceptable;
(c) be non-discriminatory;
(d) be accessible: help when and where it is needed;
(e) promote user safety and that of their carers, staff and the wider public;
(f) offer choices which promote independence;
(g) be well coordinated between all staff and agencies;
(h) empower and support their staff;
(i) deliver continuity of care as long as needed;
(j) be accountable to the public, users and carers.

National standards

In the NSF–MH standards have been set in seven areas.

Standard 1: mental health promotion

Health and social services should:

(a) promote mental health for all, working with individuals and communities;
(b) combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Standard 2: primary care and access to services

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

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

Standard 3: primary care and access to services

Any individual with a common mental health problem should:

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

Standard 4: severe mental illness

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

(a) receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk;
(b) have a copy of a written care plan which:
  (i) includes the action to be taken in a crisis by the service user, their carer and their care coordinator;
  (ii) advises their general practitioner how they should respond if the service user needs additional help;
  (iii) is regularly reviewed by their care coordinator;
  (iv) be able to access services 24 hours a day, 365 days a year.

Standard 5: severe mental illness

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

(a) timely access to an appropriate hospital bed or alternative bed or place, which is:
  (i) in the least restrictive environment consistent with the need to protect them and the public;
  (ii) as close to home as possible;
(b) 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: caring about carers

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

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

Standard 7: preventing suicide

Local health and social care communities should prevent suicides by:

(a) promoting mental health for all, working with individuals and communities (Standard 1);
(b) delivering high quality primary mental health care (Standard 2);

https://doi.org/10.1192/pb.24.6.203 Published online by Cambridge University Press

opinion & debate

(c) 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);
(d) ensuring that individuals with severe and mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard 4);
(e) providing safe hospital accommodation for individuals who need it (Standard 5);
(f) enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard 6).

Primary care groups and primary care trusts

In future primary care groups (PCGs) and primary care trusts (PCTs) may take over the provision of what are currently known as secondary mental health services, including general adult in-patient units, if they can satisfy the following criteria of having:

(a) service user and carer involvement;
(b) advocacy arrangements;
(c) integration of care management and the CPA;
(d) effective partnerships with primary health care, social services, housing and other agencies including, where appropriate, the independent sector;
(e) board membership includes competent management of specialist mental health services;
(f) proportioned representation of mental health professionals on the executive of the PCT.

Implementation of the NSF–MH

The importance of such ambitious and far-reaching plans can be measured by the extent to which they are implemented. Already a concerted implementation strategy is being initiated, including:

(a) establishing a multi-agency NSF–MH national implementation team;
(b) starting regional implementation teams;
(c) bringing together local teams to produce, by April 2000, a strategic plan on how to implement the NSF–MH.

It is, therefore, clear that the Government is serious about putting this strategy into practice. It has also set a series of more specific milestones, with clear deadlines, including:

(a) *Saving Lives – Our Healthier Nation* (Department of Health, 1998) sets the target of a reduction in the suicide rate by at least one-fifth by 2010;
(b) NHS Direct will be rolled out to cover 60% of the country by the end of 1999 and the whole of England by the end of 2000;
(c) removing mixed gender accommodation in hospitals and no new mixed gender wards will be approved. By the year 2002, 95% of health authorities should have removed mixed gender accommodation;
(d) a reduction of 2% in the rate of psychiatric emergency readmissions by April 2002, from 14.3% to 12.3%;
(e) health improvement programmes (HIMP) should demonstrate linkages between NHS organisations and partners to promote mental health in schools, workplaces, and neighbourhoods for individuals at risk, for groups who are most vulnerable and to combat discrimination and social exclusion of people with mental health problems (April 2000);
(f) clinical governance reports (end of 2000);
(g) protocols agreed and implemented between primary care and specialist services for the management of depression and postnatal depression, anxiety disorders, schizophrenia and those requiring psychological therapies, drug and alcohol dependence (end of 2001);
(h) prescribing rates of antidepressants, antipsychotics and benezodiazepines monitored and reviewed within the local clinical audit programme (end of 2001).

In addition to this, additional work has been commissioned for the Department of Health over the next year on: finance, workforce planning, education and training, research and development, clinical decision support systems, and information and the introduction of a National Minimum Psychiatric Data Set from 2003.

Workforce planning

Since little of this framework can be practised without sufficient capacity of a competent workforce, a workforce action team has been set up:

(a) to review the current staffing position for psychiatry specialities, mental health nursing, child psychology, professions allied to medicine (therapies), social work, linkworkers and advocates and care and support staff;
(b) to establish the staffing profile in relation to the level of services needed by the population, service users and carers;
(c) to commission work on skill mix to inform future workforce planning. This should include an advisory group on the delivery of psychological therapies through the range of health and social care staff;
(d) to establish future workforce requirements for 2002 and 2005, and the planning assumptions to meet them;
(e) to verify the availability of suitably qualified staff and the timescale required to provide the necessary training.

Will the framework work?

This Government document is unlike many others of recent years, in that it is clearly built upon an evidence base, it has a very wide remit covering all services relevant to adults of working age who have mental health problems, and it has specific performance indicators with

https://doi.org/10.1192/pb.24.6.203 Published online by Cambridge University Press

opinion & debate

clear timescales, by which its implementation can be monitored. Some clinicians have responded to the framework by saying that its success depends upon sufficient additional investment in the service, and reinvestment in the workforce to motivate staff and to ensure that training is suitable for the purpose. Since its publication, health ministers have made it clear that the *National Service Framework for Mental Health* is a long-term strategic blueprint which may take up to 10 years to put into practice fully. It contains some elements which build upon current good practice, such as the recognition and treatment of common mental disorders in primary care, but it also includes new standards that are designed to effect a step-change in clinical practice, such as the requirement to formally assess the needs of carers, and the option for PCGs and PCTs to provide specialist mental health treatment and care. It is in this mix of extending the best of current practice and through adding new demands of mental health services that the NSF–MH is a challenge to practitioners to provide better in the future than in the past for the patients and families whom we serve.

References

DEPARTMENT OF HEALTH (1998) *Saving Lives – Our Healthier Nation. A Contract for Health. A Consultation Paper.* London: Department of Health.

— (1999) *The National Service Framework for Mental Health. Modern Standards and Service Models.* London: Department of Health.

The National Service Framework for Mental Health is available from: http://www.doh.gov.uk/nsf/mentalhealth.htm

Graham Thornicroft Professor of Community Psychiatry, Section of Community Psychiatry (PRiSM), Health Service Research Department, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF

https://doi.org/10.1192/pb.24.6.203 Published online by Cambridge University Press