

**THE REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)**

A Strategic Framework for Adult Mental Health Services

Executive Summary

June 2005

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VISION, PRINCIPLES AND POLICY

1. The Strategic Framework for Adult Mental Health is part of the Northern Ireland Review of the whole system of provision for people with mental health problems and people with learning disability, embracing services, policy and legislation. The vision is common to the Review as a whole:
 - valuing those of us with mental health needs, including rights to full citizenship, equality of opportunity and self-determination;
 - addressing the challenges facing people with mental health needs;
 - a process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with mental health problems, to their carers and families.

2. The principles for the Strategic Framework draw on the vision of the Review:
 - partnership with users and carers in the planning, development, evaluation and monitoring of services;
 - partnership with users in the individual assessment process and all therapeutic interventions of care and support;
 - delivery of high quality, effective therapeutic interventions, care and support;
 - equity of access and provision of services, including the needs of people from minority cultures, people with disabilities, people subject to the criminal justice system;
 - provision of services which are readily accessible;
 - delivery of continuity of care and support for as long as is needed;
 - provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;
 - taking account of the needs and views of carers, where appropriate, in relation to assessment, therapeutic interventions, care and support;
 - provision of comprehensive and equitable professional and peer advocacy, where required or requested;
 - promotion of independence, self-esteem, social interaction and social inclusion through choice of services, facilitation of self management, opportunities for employment and social activities;
 - promotion of safety for service users, carers, providers and members of the public;

- provision to staff of the necessary education, training and support; and
- services subject to quality control, informed by the evidence.

3. The goals of this Strategic Framework are to:

- (i) provide better health outcomes and better outcomes for personal and social functioning for all people with mental health needs;
- (ii) ensure effective, accessible and safe services;
- (iii) guarantee service users and their carers significantly improved experience of and satisfaction with services; and
- (iv) give staff real and meaningful opportunities for professional development and job satisfaction.

Standards

4. The Strategic Framework envisages a broad and detailed reform and modernisation of services. Given the complexity of this process, clear signposts to mark out the highway of reform are essential. This is provided by 10 Framework Standards which, in turn, are underpinned by a detailed roadmap for change:

- Services must be person-centred;
- Service users must be assured;
 - effective community and primary care services;
 - effective community mental health services;
 - effective crisis services.
- Services must promote recovery;
- Services must sustain meaningful lives;
- Services must provide for people with special needs;
- Services must provide for the information and support needs of users and carers;
- The whole system of care must be supported by an effective information strategy; and
- The whole system of care requires an effective, competent and confident workforce.

A Blueprint for Reform and Modernisation

5. The Strategic Framework provides a blueprint for reform and modernisation of services based on the agreed principles and standards. It adopts a strong user and carer perspective and specifies evidence-based service models aimed at addressing the current problems and barriers to good practice. It is underpinned by programme recommendations for funding, human resources, information management, research, service evaluation and performance management.

PRESENT NEED AND CURRENT PROVISION

6. Consistent research evidence and information from service users, carers and service providers point to significant gaps and deficiencies in Northern Ireland's service provision for people with mental health needs. Present information on mental ill-health, needs for therapeutic interventions and care, together with economic evaluation, point to significant under investment and a requirement for prioritisation of Northern Ireland's mental health services.
7. A holistic and comprehensive approach to service provision and mental health practice is necessary to address the high prevalence and the wide spectrum of health, psychological and social needs of people with mental health problems throughout our community.

COMMUNITY AND PRIMARY CARE SERVICES

Strategy and Organisation

8. A fundamental principle of this Strategic Framework is that mental health and social care should be provided in the community unless there is good reason for not doing so. Community mental health care embraces the spectrum of mental health promotion, pre-primary (community) care through social networks, ill-health prevention, generic care, specific interventions by primary healthcare teams and specialist secondary services. The following key themes provide a rationale and foundation for the development of community (pre-primary care) and primary mental health care:
 - The principle of equity must underpin future community and primary care services;

- Much psychological and emotional distress can be resolved by the imaginative use of generic services, the voluntary sector and by community development approaches which provide support to people at times of need;
- Most people with mental health problems who receive health and social care services do so entirely in a primary care setting;
- Service users and their carers prefer primary care based services, which are accessible, responsive and work in partnership with service users and carers;
- Investment in primary care produces better healthcare outcomes in respect of activity in both primary and secondary care;
- Each individual with mental health problems should be given the opportunity to have their mental health needs addressed promptly within primary care settings;
- Commissioners of mental health services must carry out comprehensive needs assessments at population and community level; and
- Community and primary mental health care requires systematic efforts being directed towards mental health improvement. This is being examined by a separate Expert Working Committee.

Recommendations

1. Employers, educational establishments and community groups must promote and ensure the mental well-being of those for whom they have responsibility.
2. Commissioners of mental health services must seek to develop and expand the range of independent services in order to provide a planned and quality-assured profile of care available to service users at primary care level.
3. All community and primary care mental health services provided by and commissioned by statutory services must have service users, their carers and families involved in the development, delivery, monitoring and evaluation of services.
4. Community and primary care organisations must ensure that advocacy arrangements are developed within primary care settings.
5. Community and primary care organisations should facilitate person-centred planning.

6. Membership of the primary care team should be clearly defined and each team should have the full complement of professionals. Organisational barriers should not impede effective multidisciplinary working.
7. There should be targeted investment in the development of primary care teams to promote better recognition of common mental health problems and clear working arrangements for managing such problems.
8. Statutory mental health services must have seamless management arrangements between secondary and primary settings in order to maximise the efficiency and effectiveness of service delivery.
9. New working arrangements in primary care should seek to maximise treatment of mental health problems in primary care.

Therapeutic Interventions

9. The fundamental role for primary care is to ensure that individual needs are met in a timely, appropriate and accessible manner. In many cases this can be achieved by members of the primary care team such as social workers, offering social care and intervention, health visitors and community midwives giving advice about the emotional effects of pregnancy and childbirth, practice nurses giving lifestyle advice, community pharmacists managing concordance and the general practitioner prescribing for significant depressive illnesses. For assessment of more complex needs, appropriate expertise must be available at primary care level and appropriate referral to other agencies arranged, where necessary.

Recommendations

10. All primary care teams must have access to a named mental health professional (a Link Worker) in order to provide timely, appropriate and accessible assessment and management of people with mental health problems.
11. Mental health services must be planned, integrated and accessible in order to provide timely, accessible and appropriate assessment and treatment in a manner valued by service users, their carers and by practitioners.
12. The means of access to out-of-hours mental health services should be stratified according to clinical need and to comprise face-to-face contact, telephone advice and arrangements for organisation of services during subsequent working days.

13. Formal screening tools should be used to support trained practitioners in a global assessment of at risk populations.
14. People receiving care at primary care level must have access to a high standard of psychosocial care and to specific psychological therapies delivered by people working in managed clinical teams.
15. All practitioners offering psychological therapies must have assured levels of qualification, experience, supervision and monitoring.
16. Those responsible for prescribing physical treatments in mental illness must be encouraged, within a multidisciplinary framework, to develop protocols for the prescribing, monitoring and review of treatment regimens according to evidence-based guidelines.
17. The Department of Health, Social Services and Public Safety (DHSSPS) must ensure that there are mechanisms to identify examples of good practice and to encourage widespread implementation of these.
18. Local statutory mental health providers must be funded for, and take responsibility for, the continued professional development of primary and secondary care staff by ensuring targeted and audited learning. The Review commends the use of multidisciplinary models of learning.

SECONDARY MENTAL HEALTH SERVICES

A Person-Centred Approach

10. The Strategic Framework provides a service blueprint for adults with more severe mental health problems and needs requiring the specialist skills and facilities of mental health services. This includes:
 - enhanced support for primary care services;
 - a range of services for people with acute needs;
 - support and interventions to promote recovery and address the residual effects of mental disorder which can significantly impact on the personal, domestic and occupational aspects of daily life;
 - the psychological, educational and training needs and aspirations of service users;
 - the management and prevention of relapse; and
 - the need for psychoeducational support for family members and carers.

11. A person-centred approach to service planning and provision is fundamental. The focus for strategic development is the individual service user and his/her family, person-centred and family-orientated services enabling and empowering the person with mental health needs and their family. Mental health services must reflect the multi-dimensional nature of service user and carer need. Recovery must be core to the vision for strategic development of services.
12. Central to the effectiveness of a person-centred, holistic approach is the integration of services – the relationships between different service elements and functions require careful planning, including sequencing, appropriate for local arrangements. The optimal shape of local community mental health services should, therefore, be the subject of careful planning and consultation including the involvement of representative service users and carers. Independent providers must be fully engaged, as appropriate, in planning, development and service delivery. Person-centred services must be needs driven considering both service users and their carers.

Recommendations

19. A person-centred approach to service planning and provision must be adopted with recovery core to the vision of strategic development.
20. Strategic reform and modernisation, including service configuration, must be considered for each local system of provision as a whole, based on whole populations of 200-300,000.
21. Each provider should adopt a planned approach, including sequencing, to the whole system of mental health service organisation and service development in their area:
 - all statutory and independent providers must be fully engaged and involved;
 - representative service users and carers must be involved in service planning, development, delivery and monitoring;
 - service vision, plans and strategy should be needs driven based on local assessment;
 - the needs of specific service users must be considered:
 - younger people and older adults;
 - adults with mild learning disability;
 - current long stay residents in mental hospital settings;
 - the mental health needs of people in general hospital settings; and
 - people requiring specialist services.

- the interface with Forensic, Alcohol and Substance Misuse Services, Services for Younger People and Older People must be included within service plans for Adult Mental Health.
22. Services must be underpinned by good managerial cohesion, information management, team working and communication.
 23. Provider units must have a comprehensive workforce strategy embracing recruitment, retention, training, support and supervision tailored to the specific needs of staff and work requirements. This must address specific training needs of specialist services and primary care mental health training. Training should be multidisciplinary and include team working and leadership skills, as well as therapeutic skills.

Living in the Community

13. For people whose mental health needs cannot be met within primary care, ready access to mental health services is essential. The Community Mental Health Team (CMHT), with its close links to primary care, forms the cornerstone of person-centred secondary services.

Recommendations

24. Community Mental Health Teams should be established so as to provide comprehensive coverage of each provider unit's population as an essential element of future mental health service provision. They must have, or be provided with detailed information on the numbers and needs of individuals in their area, particularly those with more complex and enduring needs.
25. CMHTs must be adequately staffed with a range of health and social care professionals. A minimum provision of 50 care staff/100,000 whole population, including community rehabilitation is recommended.
26. Where CMHTs are providing input to primary care, then the seamlessness of provision must be addressed, including the identification of a named individual on the CMHT for primary care staff. In addition to service support, such input has an important educational role. The relationship with primary care, A&E and Home Treatment services should be clearly defined and agreed by both provider and referring services.
27. CMHTs must have access to, and good interface arrangements with, a range of community facilities and services, including day hospitals, day activities, special accommodation including respite facilities, vocational and leisure services, independent and user-led facilities. Where other

community teams, for example, Home Treatment teams, are separate from CMHTs, then good interface arrangements are essential.

28. People with more complex and enduring mental health needs should be provided with yearly multidisciplinary review, including review of care plans, physical health and risk assessment. The participation of service users and, where appropriate, their key carer in the preparation and review of care plans is essential for person-centred care and leisure services, independent and user led facilities.

In Times of Crisis

14. People with more complex and enduring mental disorder often experience acute difficulty, or need which may arise through relapse of their mental disorder, or through problems in coping with the demands of their social and personal situation. Present evidence suggests that conventional community services, including CMHTs working within normal working day arrangements, are unable to respond adequately to the needs of people with severe mental health problems at times of urgent need. Research also suggests that up to one third of inpatients could have been provided with therapeutic interventions and care in more appropriate settings.

Recommendations

(i) Home Treatment (HT) Services

29. HT services must be available and accessible to each provider's catchment area, on a 24 hour basis subject to demand, accessible to general practitioners, A&E departments, CMHTs, social services and police.
30. There should be a single system of co-ordinated acute care, including step-up community residential care and inpatient provision. HT services must become the gatekeeper for hospital admissions.
31. HT teams must be appropriately resourced and skilled to deal with the range of healthcare and social situations for people in mental health crisis, their carers and families, including risk management.

(ii) Day Hospitals

32. Within each Trust, consideration should be given to providing day hospital provision as an alternative to acute admission and complementing HT teams.

(iii) Inpatient Services

33. Acute inpatient services should be based in well-designed facilities and close to the community they serve such as general hospital sites.
34. The quality of inpatient services should be the subject of both regional and local review. Services must be of high quality and provide an appropriate range of assessments, therapeutic interventions and services including intensive nursing services. They must deliver a therapeutic and safe atmosphere and be sensitive to gender and cultural needs.
35. Each provider must designate a lead clinician or manager to take overall responsibility for inpatient services.

Promoting Recovery

15. For people with more complex and enduring mental health needs, a diverse range of services is required to promote recovery, tailored to individual circumstances. They have, by definition, greatest need and should be afforded the highest priority. Services are also required to give carers the information, skills and support necessary to assist them in their caring role and to minimise the stress associated with that role.

Recommendations

36. The service requirements of people with complex and enduring mental health needs should be given the highest priority and clearly defined for each Trust's catchment area.
37. Identifiable services promoting recovery should be established within each Trust for people with complex needs and providing comprehensive coverage of the Trust area. Care plans embracing risk assessment should be provided based on a multidisciplinary and, when required, a multi-programme approach. Risk assessment should include accommodation needs. Users and, where appropriate, carers must be involved in care planning.
38. A comprehensive range of community services must be available to facilitate recovery for people with complex needs. The introduction of step-down facilities should be considered to facilitate discharge from acute inpatient care.
39. Every effort must be made to destigmatise and normalise, making maximum appropriate use of mainstream facilities and resources.

40. Assertive Community Treatment (ACT) should be provided for service users with highest levels of disability and greatest vulnerability, particularly those who have difficulty maintaining links with existing services.
41. ACT teams must be adequately resourced – an optimal individual caseload for delivering care is 10-12.

People with Specific Service Needs

16. Some people have special needs including needs arising from challenging behaviour, co-morbid substance misuse, or growing older.

(i) Younger People with Mental Health Needs

17. The Review envisages a substantial development in young people's services. Nevertheless, there is a need for flexibility and, where appropriate, joint working appropriate for the needs of individuals. It is essential that there are seamless transitional arrangements for people whose mental health problems arise in childhood and extend into adult life.

Recommendation

42. Separate age-appropriate services for younger people with a first episode of psychosis should be established. Services should be gender and culture sensitive.

(ii) Adults with Mild Learning Disability

18. The majority of people who have a mild learning disability live in society without formal additional support and may be well integrated into their communities. While not necessarily disabled in their daily functioning by their intellectual impairment, they are at increased risk of mental disorder. Mental disorder in addition to pre-existing intellectual impairment may be disabling. Adults with mild learning disability and their carers wish to access health services as other adults including, where appropriate, adult mental health services.

Recommendations

43. Adults with mild learning disability should be facilitated in accessing adult mental health services as a first preference. The preferences of people already within either adult mental health services or learning disability services should be respected.

44. Adult mental health services should be resourced to include people with mild learning disabilities. Additional time and expertise are required for assessment, and for consultation between professionals, within and across programmes of care. Co-operative working, sharing of facilities and expertise between adult mental health services and learning disability services must be established in each Trust area.

(iii) People Becoming Older with Enduring or Relapsing Mental Illness

19. With increased life expectations generally, more people with major mental disorders such as schizophrenia, bipolar affective disorder, organic brain disease, severe depression, are living into later life. Given the separate development of health and social service services for older people, it is essential that there are locally agreed arrangements for service provision for people within adult mental health services who reach 65 years of age.

Recommendations

45. Local arrangements for meeting the needs of people who enter old age with enduring or relapsing mental disorder must be agreed. Where individuals graduate from adult mental health services to services for older adults, therapeutic and care needs should be the subject of review.
46. Local population needs of people entering older age and their carers should be assessed.

(iv) People with Challenging Behaviour

20. Within adult mental health a number of people who are suffering from a serious mental illness have, in addition, a range of challenging behavioural problems, such as aggression, violence, repeated self-harm, extreme self-neglect. Their needs must be addressed.

Recommendations

47. Service providers must plan for the needs of people with challenging behaviour:
- community mental health services with the capacity to provide intensive support;
 - specialist accommodation with appropriately skilled staff;
 - local intensive care; and
 - low secure inpatient services with a rehabilitation ethos and links to Assertive Outreach services.

48. Low secure units can function as 'step-down' services from the Regional Secure Unit.
49. Longer term high quality hospital provision is likely to prove necessary for a small group of people whose behavioural problems are often chronic and severe.

(v) People with Forensic Needs

21. People with mental health problems may become subject to the criminal justice system. Adult mental health services must co-ordinate with forensic services to ensure individual needs are met.

Recommendation

50. Service providers must ensure co-ordinated development of adult mental health and forensic services.

(vi) People with Co-existing Substance Misuse and Mental Health Problems (Dual Diagnosis)

22. Comprehensive services must be provided for those with a dual diagnosis of concurrent mental health problems and substance misuse – alcohol and/or drugs.

Recommendations

51. Trusts should make provision for people with mental health problems and co-existing alcohol or drug misuse. Local prevalence and needs of people with dual diagnosis should be assessed.
52. People with co-existing substance misuse and mental health problems should ideally be treated using an integrated treatment model within a single service:
 - The needs of those with complex, enduring and relapsing mental disorders can best be met by adult mental health services.
 - The needs of those with less severe mental health problems, whose main difficulties are directly related to substance misuse, can best be met by substance misuse services.
 - Agreed arrangements need to be established between any specialist services for people with personality disorder and substance misuse services.
 - There should be systems of liaison between substance misuse and other mental health services to ensure that people with a dual diagnosis have access to the full range of the most appropriate treatment services.

- Physical health problems associated with substance misuse need to be identified and addressed.

53. The needs of people with co-existing substance misuse and mental health problems in contact with the criminal justice system should be identified and addressed.

(vii) People in General Hospital Settings

23. A multidisciplinary Liaison Mental Health Service (LMHS) provides the best means of ensuring effective methods of dealing with the mental health needs of service users in a general hospital setting. Liaison Teams are also suitably placed to provide education and to improve the knowledge and skills required to treat people with mental health problems and learning difficulties in general hospital settings, regardless of whether or not they need to be referred to specialist services.

Recommendations

54. Appropriate education should be provided to general hospital staff:

- to prevent people with mental health needs feeling stigmatised; and
- to provide basic psychosocial assessments and support.

55. Acute hospitals should ensure that appropriate liaison services are established:

- clear referral protocols should be in place;
- general ward staff should, where necessary, have access to appropriately trained and experienced mental health professionals on a 24 hour basis;
- Liaison Services should provide prompt same day assessment and advice on therapeutic interventions, risk management and follow-up; and
- confidential, comfortable and safe accommodation must be provided to interview service users in A&E environments and general hospital settings. Policies outlining the support procedures from security staff should be established.

56. Liaison Services must be able to access addiction services promptly for service users willing to avail of them.

57. Liaison Services to A&E departments should be appropriate for user needs:

- all people with deliberate self-harm should be offered psychosocial assessment and appropriate after care plans;
- people with problems relating to addiction attending A&E should be able to avail of prompt access to community addiction services; and

- young people attending A&E with mental health problems should be seen by those with appropriate expertise. Clear protocols should be in place between Liaison Teams and Child and Adolescent Mental Health Service teams.

Therapeutic Interventions

24. From a health perspective, services are but vehicles to promote recovery and underpin optimal delivery of specific therapeutic interventions, care and support. Optimal holistic therapeutic interventions and care depend fundamentally on collaborative working between persons with mental health needs, their families, carers and the professionals and organisations involved. In addition to specific intervention skills, health and social care professionals require a range of general skills including interpersonal skills, team working and communication skills.

Recommendations

58. The choice of therapeutic interventions should be made jointly by the individual and the clinician responsible for treatment.
59. Medication, psychological and social interventions must be integrated within a complete package of treatment, care and support.
60. Therapeutic interventions must be provided within a multidisciplinary framework, according to evidence-based guidelines.
61. Psychological therapy services must be organised in ways that promote the use of psychological interventions in routine practice.
62. A workforce strategy developing psychological therapy services must be addressed as a matter of urgency.
63. A Northern Ireland-wide training strategy to improve access to psychological therapies and psychosocial interventions must be developed as a matter of priority.

Physical Health

25. People with mental health problems are at increased risk of having physical health problems. Many of the excess deaths of people with more complex and enduring mental disorder are potentially preventable by better medical treatment and attention to lifestyle, including diet and smoking.

Recommendations

64. The assessment of people with more complex mental health needs must include assessment of physical health needs. Local providers of services

should agree which service (primary or secondary) will take responsibility for monitoring physical health.

65. Registers should be established of people with severe mental health needs at primary care level.

Education, Training, Occupation

26. Education and training relates to activities compatible with both vocational outcomes and personal development. Occupation is a basic human need, which is directly related to the meaning and quality of one's life and important for both physical and mental well-being. Everyday occupations play a significant part in maintaining structure, meaning and social inclusion. Mental disorder often results in a disruption of occupational balance, with lack of meaningful occupation limiting social connections and increasing stress and isolation. Service users report lack of a job, loneliness, health problems, looking after self and lack of leisure activities as priority areas in relation to quality of life. The Labour Force Survey of 2002 Great Britain found that only 21% of adults with mental illness were in employment. Three issues are important for the Strategic Framework – assessment, barriers to employment and employment models.

Recommendations

66. People with severe mental health needs should be offered an early opportunity to participate in a full occupational assessment. This should be reviewed on an annual basis as part of the service user's review. Assessment should be conducted by an occupational therapist with the emphasis on quality of life, time management and occupational issues.
67. More straightforward and flexible social security benefits should be introduced to facilitate the transition from benefits to work.
68. A comprehensive range of occupational services must be provided within each Trust area and should include access to voluntary work, educational and leisure opportunities.
69. Day care services should provide a comprehensive range of activities and opportunities to support the different needs of service users.
70. Vocational specialists with mental health expertise and the flexibility to work on an interagency basis should be commissioned to enhance the rehabilitative function of CMHTs.

Accommodation

27. Suitable accommodation is a fundamental element of effective services to support people with mental health problems. A number of principles need to be considered in order to ensure an appropriate range of accommodation and support:
- as far as possible, people with mental health problems should have a choice of the type of accommodation in which they wish to live. This has to be balanced in relation to the degree of risk posed to themselves or others;
 - assessment of accommodation needs should be a component of an overall assessment;
 - support for people receiving mental health services should be available to people with mental health problems regardless of where they are accommodated; and
 - providers of accommodation should receive training and should be supported regardless of whether the accommodation is statutory or independent.

Recommendations

71. Providers should ensure that a complete range of accommodation is available to meet the needs of people with mental health problems. Supporting People partnership between Trusts, Boards, Northern Ireland Housing Executive and the independent sector should be sufficiently flexible to make timely responses to the accommodation needs of people with mental health problems.
72. Service users should have choice of accommodation appropriate to their needs and given maximum independence through appropriate levels of support. Care environments and practices should be designed to maximise personal autonomy and reduce the risks of institutionalisation. Service principles must underpin the development of standards and must focus on the needs and rights of individuals.
73. Discharge protocols should ensure that people leaving mental health facilities have appropriate accommodation.
74. Staff working in residential settings should have adequate support and training including, where appropriate, training in the management of people with challenging behaviour.

75. Statutory services should provide support to residents and staff to optimise community living, prevent unnecessary hospital admission and to reduce the risk of homelessness in people with mental health needs.
76. Monitoring and evaluation of services should be a continuous process and involve users and carers.

Social Security Benefits and Support

28. In Northern Ireland, more than a third of Incapacity Benefit claimants have a mental disorder. The key issues facing people with mental health problems are:
 - inadequate levels of benefit, for example, personal expenses payments for people in residential/institutional care, help with the cost of prescriptions, problems with the Social Fund;
 - assessment – the prevalence of medical examinations that are often seen as intimidating; many of those conducting assessments have limited experience of mental illness;
 - easing the transition to work; there is much of a gap between incapacity and getting back to work. The current rules and financial incentives to move from benefit to work are complex and fragmented and there is a need for simpler, more flexible and improved financial incentives to allow people to return to work without the fear of penalties if unsuccessful; and
 - delivery – there is a need to take greater account of mental health issues in the administration of social security benefits. Awareness training, increased user involvement in training and planning, improved claim forms and tailored independent advice and advocacy services are all needed.
29. The social security system should support and enable people with mental health problems to live independently, with dignity and a good quality of life, both in and out of work.

Recommendations

77. The Social Fund should be reviewed with a view to ending loans as the main form of discretionary financial support. An exemption to the single room rent should be made for people with mental health difficulties. People with severe mental health problems should be exempt from prescription charges.

78. Trusts must ensure that people with mental health problems have access to independent dedicated advice and advocacy services to provide assistance in dealing with social security problems.
79. Returning to work: people with mental health problems wishing to work and who have been on benefit for long periods should be provided, as necessary, with intensive support. Rules encouraging a return to work should be made more flexible and easier to understand.
80. Staff Training and Development. All frontline benefit advisers, social security decision-makers, medical referee service staff and appeal tribunal members should receive mental health awareness training, part of which should involve interaction with people directly affected by mental-ill health. Medical assessors must have appropriate skills in assessing the mental health needs of applicants. Consideration should be given to greater use of mental health specialists (medical and non-medical).

Personal Life, Family Life and Culture

30. Mental ill-health and the accompanying distress can affect all aspects of one's social life and relationships – within the family, with friends, with work colleagues. The sense of feeling isolated and stigmatised is a very real experience of many sufferers. There is also a sense of disempowerment and the distress arising from this – “my life will never be the same again”. Acknowledgement of these issues and concerns can be of particular importance in promotion of recovery and needs to be recognised by professionals.
31. Within a multi-cultural society, the service user's specific cultural, spiritual and religious needs need to be recognised and addressed. With the emphasis on community based care and treatment, the religious and spiritual dimension of an individual's life should be considered as part of holistic assessment. Mental health services must be sensitive to these issues and to the particular needs of ethnic minorities.

Recommendations

81. Information. Service users and, where appropriate, carers, family and friends should be provided with relevant information in clear and simple terms. The information and communication needs of service users in situations of non-voluntary admission require special attention. Priority must be given to improved methods of communication and information

for people from ethnic minorities, including the use of interpreters and translators.

82. Services must be sensitive to the cultural needs of people from ethnic minority communities. Within a multi-cultural society, the service user's specific communication, cultural, spiritual and religious needs must be recognised and acknowledged.
83. Advocacy services should be sensitive and appropriate for the needs of people from ethnic minority communities.
84. Staff training and awareness. The distress accompanying mental illness and its impact on an individual's personal life, including a sense of stigma, need to be recognised and acknowledged by mental health professionals. The importance of the relationship between service providers and service users in the maintenance of self-esteem, hope and self-worth needs to be recognised and valued by providers.

Advocacy

32. The purpose of advocacy is to ensure maximum preservation of each service user's personal autonomy and self determination. Service users must have access to local advocacy service.

Recommendations

85. Independent Advocacy services ensuring maximum preservation of each service user's personal autonomy and self determination must be established in all Trusts providing mental health services.
86. Advocates should be involved in service planning and development, be given access to appropriate service information and receive support, as necessary, from Trust staff.

Carer and Family Needs

33. The inter-relationship between service user, carer and other family members is important for each person's well-being. The carer who is a spouse may have to assume new roles and responsibilities. The carer who is a mother may concentrate on the ill family member to the neglect of others. A child whose parent is unwell may become a 'young carer' and may suffer adverse consequences. Individuals within a family who lives are affected by these circumstances must be identified and offered support. Their health needs must be met.

Recommendations

87. Boards and service providers must fully implement existing policy and legislative obligations relating to carers.
88. The needs of carers, children and other relevant family members should be identified at assessment.
89. Key carers should be provided with appropriate support, education and information to carry out their role, as partners with the service user.
90. Agencies should accord carers equal status with other providers of care.
91. Key carers should be offered an annual assessment and a written care plan.
92. Family interventions should become an integral part of mental health practice.
93. Training programmes for dealing with mental health problems should be made available to all carers.
94. Service providers should ensure that a range of support services, in the form of helplines, self-help groups, directories of services, help with social security benefits and respite opportunities, is provided for carers and families. Providers should make available dedicated carer and family workers. The services of appropriately trained professionals should be made available for key carers.
95. Service users who are parents should be supported in their parenting role.
96. Children of people with mental health problems should be provided with appropriate support in their day-to-day lives and measures taken to support them in times of crisis, including the availability of a confidante.
97. Hospitals must ensure there are suitable visiting arrangements for families.
98. Agreed protocols must be established between child and adolescent services and mental health services, where children may require protection.
99. Staff training must include engagement with carers and the assessment and management of their needs as carers.

A Model Service Configuration

34. Provider unit service configuration is considered for a community of 250,000 people. While the details of service configuration must be informed by the local context, the following is presented as a model of good practice. As service providers advance towards their goals of comprehensive person-centred services, the following configuration of the key building blocks of provision are recommended, based on present evidence and on the principles informing the Strategic Framework.
35. **(i) CMHTs Supporting Primary Care**
Present evidence suggests that the optimal model of CMHT configuration is 5 teams, each of approximately 11 staff, supporting primary care services, each servicing a population of approximately 50,000. Teams should provide Tier 2 level services for deaf people with mental health problems and women with perinatal mental health needs.
36. **(ii) Recovery Service CMHTs**
Sectorised services are required for people with enduring and recurring mental disorder. Three CMHTs are recommended, each underpinning Recovery Services for approximately 85,000 people. As a short-term goal the staff complement for each team should be approximately 23 with a multidisciplinary composition appropriate for the needs of recovery services. These CMHTs should provide Tier 2 level services for the mental health needs of people with acquired brain injury or progressive brain disease, Asperger's Syndrome or High Functioning Autism (AS/HFA), also services for people with challenging behaviour, dual diagnosis, first episode of psychosis and mild learning disability. HT and ACT teams should be closely associated with each Recovery CMHT.
37. **(iii) Home Treatment and Assertive Community Teams**
In order that HT teams can provide 24/7 services it is recommended that the complement for a provider for 250,000 should be 24 staff, configured as 3 teams of 8 staff, each team linked with a Recovery CMHT. Three ACT teams should also be created in close association with Recovery CMHTs.
38. **(iv) Psychological Therapy Services**
Psychological therapy services should be consolidated into a single unit from which support, supervision and training can be provided for all CMHT staff. They should be responsible for specialist services for people with psychological trauma, people with eating disorders and people with personality disorders.

39. **(v) Inpatient Provision**
Acute inpatient services should be provided as part of an integrated model of crisis services with locally accessible units, utilising where possible the facilities of general hospitals. Acute inpatient services can be complemented by step-up and step-down houses in close collaboration with HT teams. As the goals of the Strategic Framework are achieved, then the requirement for acute inpatient provision should reduce to approximately 20 places per 100,000, their location recognising the advantages of general hospital settings.
40. In addition, inpatient facilities for people with challenging behaviour, with approximately 25 places for a population of 250,000 people, will be required. The requirements for inpatient provision will turn critically on the adequacy and comprehensiveness of alternative community provision, including residential facilities.
41. The model is predicated on all of the service elements specified above for secondary services, including the skill level of staff, being successfully implemented to high fidelity with the recommendations. Monitoring and evaluation of their implementation will, therefore, be essential.

PEOPLE WITH SPECIAL NEEDS

42. Most people with mental health problems receive services exclusively at the primary care level. For people with more complex and more enduring mental health needs mental health services are required. There are, however, a number of specific mental health problems which cannot be fully addressed at either the primary or secondary care levels, usually because interventions are necessary which require specialist skills and specialist services. In this section of the Strategic Framework, the needs of people requiring such specialist services are addressed. We have identified eight specific areas:
- People with eating disorders;
 - People with acquired brain injury or progressive brain disease;
 - Deaf people with mental health needs;
 - People with mental health needs arising from psychological trauma;
 - People with personality disorders;
 - People with Asperger's Syndrome or High Functioning Autism;
 - People with disorders of gender and sexuality; and
 - Women with perinatal mental health problems.

43. While forensic services and services for people with substance misuse or alcohol related health problems are also specialist services, these are already established services and are, therefore, the subject of specific independent reviews, to be reported on separately.
44. A common aspect to the service requirements of people with special needs is a tiered approach to provision. That is, there are needs that can be met at a local level, whether community or primary care (Tier 1). Other needs can be met within local community mental health services (Tier 2). However, for some individuals, some or all of their needs can only be met through highly specialised services (Tiers 3 and 4).

Services for People with Eating Disorders

45. Services for people with eating disorders must be able to respond to the multidimensional nature of the problems presented, the different levels of severity and complexity and be able to cater for the needs of service users across the age range.

Recommendations

100. The Regional Eating Disorders Working Group needs to continue its work of overseeing the strategic planning and practical implementation of eating disorders service development.
101. DHSSPS and service providers should establish Tier 3 teams; and
 - Tier 3 teams should define local operational policies and form a regional network enabling expertise and resources to be shared across the Province; and
 - Tier 3 teams should support Tiers 1 and 2 through training, supervision and shared care arrangements.
102. Strategic planning should continue for longer term needs such as Tier 4 services and the further development of specialist child and adolescent mental health services.

Services for People with Acquired Brain Injury or Progressive Brain Disease

46. A four tier model should be adopted to plan comprehensive service provision to meet the mental health needs of people with acquired brain injury (e.g. arising from trauma, haemorrhage, anoxia, infections, toxins including alcohol, nutritional deficiency, epilepsy) and progressive brain disease (e.g. Multiple Sclerosis, Parkinson's Disease, Huntington's Disease, early onset dementia).

Recommendations

103. Planning and Development. Services should be developed to address the psychological and mental health needs of people with acquired brain injury or progressive brain disease, their carers and families. Partnerships are required across statutory and independent sectors. Service planning must involve clinical leaders, users and carers. Local information on needs must inform planning and development of services:

- local primary care and secondary care physical disability and mental health services should be strengthened;
- priority should be given to the ongoing development of community brain injury teams throughout Northern Ireland;
- service planning for those with progressive brain disease must address the cognitive, emotional, social, behavioural and mental health needs of this group. An emphasis should be placed on multidisciplinary team working within community based services for people with progressive brain disease;
- development of day care, respite, residential and supported living options are required for those who present with cognitive, emotional, social, behavioural and other mental health problems associated with acquired brain injury and progressive brain disease;
- a specialist regional mental health team is required to offer expertise in the assessment, diagnosis, treatment and management of mental health problems in acquired brain injury and progressive brain disease;
- Maine Neurobehavioural Unit should be enabled to develop fully as a regional specialist service. This might provide services on an all-Ireland basis; and
- the development of care pathways is required to develop links and networks between different services and service components for both brain injury and brain disease.

104. Partnerships. Partnership between statutory and independent sectors and within statutory sector organisations (health, housing, education, employment and training) should be pursued, to ensure a comprehensive range of service provision.

105. Workforce. A workforce strategy is required to ensure that there are sufficient numbers of appropriately qualified staff, across the range of

disciplines required to enable service developments to address the mental health needs of both acquired brain injury and progressive brain disease:

- attention to skill mix and the development of new job roles is required;
- attention to the training and ongoing development needs of specialist staff is required; and
- specialist services should provide training and support to local community services and to care staff working in acute hospital, residential and day care settings.

Services for Deaf People with Mental Health Needs

47. With the introduction of the Disability Discrimination Act 1995 and the modernisation of mental health services, particularly the development in community based provision, there is an opportunity to address issues of equality of access, and the needs of minority and excluded groups. The Department of Health consultation document “Sign of the Times” outlines proposals for future developments for deaf mental health services. There should be a tiered approach to the provision of mental health services for deaf people.

Recommendations

106. There should be a tiered approach to the provision of mental health services for deaf people. A regional plan for services should be developed with service user and carer involvement and should include audit, research, teaching and health promotion. There should be effective interfaces and liaison between primary care, social services, voluntary organisations and the deaf community. Protocols for effective joint working between local CMHTs and services and the specialist mental health service for deaf people should be developed.
107. Long-term plans should be developed for the local establishment of inpatient facilities, possibly on an all-island basis.
108. The deaf service user must be given full information about his or her rights and referred as soon as possible to specialist services, if they are required.
109. For deaf people being assessed for inpatient admission, protocols must be developed for the use of interpreters and other relevant professionals, such as social workers with deaf people, in addition to the Approved Social Worker. During an admission period, appropriate and accessible communication support must be provided within a maximum of 24 hours.

All service users should be enabled to give fully informed consent for their treatment, or to appeal against it.

110. Primary care teams should be provided with appropriate information about mental health and deafness services to enable them to refer service users for specialist assessment.
111. Deaf awareness training, appropriate technology and access to communication support, especially interpreters, are essential for those working with the deaf community.
112. Staff in CMHTs and services must be provided with knowledge and skills to enable them to work, if necessary through interpreters, with deaf people, including staff in day services and out-of-hours services.
113. Specialist mental health services for deaf people must:
 - develop a multidisciplinary team which should include deaf professionals;
 - provide assessment and treatment for service users at clinics in all the Health and Social Services Boards and in the community;
 - work jointly with primary care, local mental health teams and other specialist mental health services, including learning disability, older adult forensic and psychological therapy services; and
 - carry out preventative work including with provision for deaf children, adolescents and their families, rehabilitation programmes for people with acquired deafness.
114. Specialist mental health services for deaf people should work with other agencies including education, social services, the independent sector, deaf community organisations, employment and housing.

Services for People with Psychological Trauma

48. Northern Ireland (CREST) guidance on the management of Post Traumatic Stress Disorder (PTSD) in adults was issued in 2003. This followed the guidance issued by the International Society for Traumatic Stress Studies (2000) and the Department of Health, which, on the basis of available research evidence, pointed to the treatments of choice for (inter alia) PTSD. In 2004, The National Institute for Clinical Excellence (NICE – England & Wales) issued draft guidance on the treatment of PTSD in both adults and children (with a final version of this guidance expected in 2005). The CREST guidance is a key element in the development of an evidence-based approach to the understanding, recognition, treatment of PTSD and related conditions. It forms a key building block in the development of a response to this area of need and should form the basis for the development of policy, services and training.

Recommendations

115. The development and expansion of evidence-based services, including CREST guidelines, to address psychological trauma and including adult survivors of childhood trauma should be taken forward as a priority. The expertise developed in the non-statutory sector should inform the development of the overall trauma network.
116. To facilitate progress, a coherent tiered strategy should be developed, based on a managed service network:
- service planning must involve clinical leaders, users and carers and clinical managers;
 - an audit of what is currently available (i.e. resources and skills), tested against the CREST guidance (2003), should be undertaken;
 - future service configurations should build upon the experience and expertise that has been developed in both the statutory and non-statutory sectors; and
 - standards should be developed to support the development of and access to services.
117. Primary care staff (and other front line services), in line with CREST guidance, should be provided with the necessary guidance, training and support in the detection, preliminary intervention and appropriate referral of people with trauma-related needs.
118. A workforce plan, which addresses staff levels and qualifications, training and re-training, should be developed:
- Training. Pre-professional training for health and social care professions should include appropriate content on the conceptualisation, recognition and treatment (including referral) of psychological trauma; and
 - Advanced training for the treatment of PTSD (and related conditions) should follow current evidence-based guidance on the management and treatment of psychological trauma.
119. Health promotion programmes to address the specific needs of those affected by traumatic events should be developed in line with evidence-based practices and principles.
120. Organisations which employ people who, in the course of their work, may be exposed from time to time to traumatic experiences should put in place measures relevant to the nature of the work and risks.

Services for People with Personality Disorders

49. In line with guidance in other parts of the UK, people with a personality disorder who experience significant distress or mental illness as part of their disorder and the mentally ill who suffer from co-morbid personality disorders are part of the business of mental health services. The needs of personality disordered offenders within the criminal justice system are considered separately by the Forensic Services Expert Working Committee. Services for people with personality disorders should be accessible and bring discrete components of care together including psychotherapy, medication, housing and social care.

Recommendations

121. Specialist services for people with personality disorder must be established to augment secondary care services. Service planning must involve clinical and service leaders, users and carers and the independent sector:
- service requirements should be the subject of needs assessment;
 - residential and day treatment services for people with personality disorders should be established in Northern Ireland; and
 - specialist multidisciplinary teams should be established to provide assessment, education and support to other services who may come into contact with people with personality disorders.
122. Specialist services for people with personality disorder should co-ordinate with other mental health services such as forensic services, substance misuse and with learning disability services.
123. Training. Specialist services must provide education and support for staff in the diagnosis and management of people with personality disorders. In primary and secondary care, awareness training of the needs of those with personality disorders should be provided for such services as primary care, A&E, perinatal services, medical and surgical staff.
124. User and carer initiatives to support service users and carers of those with personality disorders should be facilitated.

Services for People with Asperger's Syndrome or High Functioning Autism (AS/HFA)

50. A tiered service including the service needs of people with AS/HFA is recommended. The initial priority is the formation of a core team (Tier 3) in each Board area, with the necessary expertise to provide training and support

for local providers. Based on current evidence, such a team should include professional input from clinical psychology, occupational therapy, psychiatry, family support co-ordinators and intervention therapists to assess and support housing and employment. Services for people with AS/HFA must be identified at local provider level (Tiers 1 and 2) in response to local assessment of need and with the support of Tier 3 services. Adequate information systems must be developed to assess need and inform service planning.

Recommendations

125. A needs assessment of people with AS/HFA and their families should be completed as a priority.
126. The mental health programme of care should assume overall responsibility for ensuring the development of services across health and social services for all people with ASD including Asperger's Syndrome/High Functioning Autism. Service planning must involve users and carers, clinicians, relevant statutory and voluntary organisations.
127. Assessment. Multidisciplinary teams should be established for each provider area for specialist assessment services (Tier 3) with clear pathways to service access.
128. Appropriate, timely person-centered interventions should be provided based on best available evidence:
 - clear referral pathways to mainstream services (Tiers 1 and 2);
 - specialist interventions by appropriately trained specialists (Tier 3).
129. Individual and family support. Emotional and practical support and resources must follow assessment in a timely fashion and is especially required at times of transition (eg leaving school). Appropriate respite services must be developed. Access to leisure and meaningful activity should be assured. Social inclusion including opportunities for further and higher education and employment should be supported. A range of supported accommodation should be developed.
130. Training. Provider units should ensure the provision of training for parents and staff. Staff training specific for the service needs for people with ASD should be assured within the workforce training strategy at regional and provider levels (Recommendations 23 & 62), including awareness training and specialist training.
131. A senior manager in each provider unit should have overall responsibility for the development and delivery of services for people with ASD.

Services for People with Disorders of Gender and Sexuality

51. In the past year, a strategy group has been established by the DHSSPS, with representatives from the four Area Boards to examine the provision of psychosexual services and in particular, those for transpeople. There is a general view that, as individuals with sexual dysfunctions often have comparatively less complex problems and usually require shorter periods of intervention often with simpler interventions, their needs usually should be addressed locally. This would mean that individuals with more complex cases (in particular disorders of gender and sexual preference) would be referred to the more specialist services in Belfast (and, where appropriate, Omagh). This would also facilitate more of a focus in the Belfast service on the needs of transpeople and individuals with disorders of sexual preference.

Recommendations

132. People with disorders of gender and sexuality in Northern Ireland should be offered the full range of services which have been shown to produce positive therapeutic outcomes. Service planning must involve clinical leaders, users and carers and clinical managers:

- as contact with services is often long-term, the majority of provision should be local and community based, with appropriate access to regional specialist services when this is required;
- services should be community based and person-centred; and
- regional services should be targeted at individuals with the most complex needs.

133. There is a need to evaluate the workforce requirements for service changes and for training.

Services for Women with Perinatal Mental Health Problems

52. Perinatal mental health problems need to be addressed with a clear regional strategy focused on the different levels of services required and ensuring that all staff involved receive adequate training and support.

Recommendations

134. A regional specialist mental health service should be established for women with mental health problems occurring in the perinatal period. The requirement for inpatient mother and baby facilities should be the subject of a regional needs assessment.

135. Protocols for the management of women who are at risk of a relapse or recurrence of a serious mental disorder during the perinatal period must be in place in every provider unit with maternity services:

- comprehensive assessment of maternal health must include mental health.

136. Women who have a past history of serious non-postpartum mental disorder, should be offered assessment by a psychiatrist in the antenatal period and a management plan instituted regarding the high risk of recurrence following delivery:

- substance misuse services should be accessible throughout antenatal care.

SUPPORTING CHANGE

53. The Strategic Framework provides a road map for major reform of mental health services for adults. It will take 10-15 years to achieve and depends on a number of underpinning elements and processes.

Developing the Workforce

54. The capacity to deliver the vision turns on having an adequate workforce, appropriately trained and working effectively together and in partnership with service users and their carers, to achieve meaningful change in the quality and standards of care delivery throughout Northern Ireland. A Workforce Strategy for Mental Health should be established, to include a Workforce Development Group.

Information and Information Management

55. Good information is at the heart of high quality mental health care and decision-making. A comprehensive Regional Information Strategy for Mental Health and an implementation plan must be established.

Research and Development

56. While the work of the Review has been founded on the best current research evidence on clinical and service effectiveness, there are many gaps in our knowledge base. High quality research and information is needed on mental health, and mental ill-health and their determinants, effectiveness of interventions and on closing the gap between research information and service

implementation of new research evidence. A Research and Development Strategy must be established to underpin the Review as a whole and its implementation.

Resourcing the Changes

57. The proposed Strategic Framework provides major challenges at both regional and local levels. The proposals have major implications for future HPSS mental health revenue and capital investment programmes and for future estate requirements. With anticipated reorganisation and reconfiguration, local providers must ensure that resources follow service users. These changes cannot occur without protected investment from Government to drive local service development. The Review recommends the establishment of a Mental Health Modernisation Programme that brings together the service recommendations of the Strategic Framework and matches them with both the necessary funding streams and the performance milestones that will guide local investment.

IMPLEMENTING THE STRATEGIC FRAMEWORK

Regional Support for Local Implementation

58. Implementation of the Strategic Framework should be directed by an Implementation Team which must include user and carer representation. Within HPSS organisations, the new Duty of Quality will drive the quality agenda, underpinned by Health & Social Care Governance. The DHSSPS must ensure engagement of other Government Departments so that those elements of the Strategic Framework outwith health and social care are delivered both successfully and on time. The Implementation Team with the support of the Department have an important role in facilitating the processes necessary for engagement and communication with all stakeholder groups and for the broad agenda of change management.

Local Providers

59. Local providers will ultimately be responsible for ensuring the implementation of the Strategic Framework and must translate it into local delivery plans. This, in turn, requires local partnerships with all relevant statutory and independent providers and a shared vision. Successfully harnessing the energies and resources of the independent sector and of users and carers will be pivotal in realising the vision.

60. The Strategic Framework brings a new opportunity for change, with a clear statement of what has to be done and firm performance management. It provides a sound evidence base for action together with examples of good practice.
61. Translating the regional Strategic Framework into effective local implementation arrangements will present significant challenges for professional staff, management and local service leaders. It envisages a broad-based and complex reform of mental health services. It is also occurring in the context of anticipated substantial reorganisation and re-configuration of health and social services and local administration. A major challenge is the change in culture necessary to deliver this Strategic Framework, a culture of partnership, collaboration and empowerment.
62. Keeping the perceptions and needs of service users and carers at the centre of our vision will be most important throughout the change process. The involvement of service users and carers can greatly assist the realisation of a new vision and a new culture at local level. Barriers to change must be recognised, identified and overcome. The current interest, commitment and skill of professional staff, service managers and service leaders provide a sound foundation on which to build the local implementation of the Strategic Framework. The Strategic Framework provides a unique opportunity to consider the use of learning networks, “communities of practice”, self assessment and peer review as models of organisational change and development. Self-assessment combined with external validation by peer teams provide valuable learning opportunities and facilitate multidisciplinary professional development.

Ensuring Progress – Performance Assessment

63. The Strategic Framework represents an ambitious agenda for change within adult mental health services aimed at driving up quality across all aspects of services. Each of the 10 Standards for service development provides a central pillar of the Strategy around which succinct areas of service development and improvement must be built. To ensure progress in each of the 10 areas, Performance Indicators have been specified and against which progress on implementation can be measured. The strategic vision, standards and framework within this Review of Adult Mental Health, underpinned by a clear implementation plan, together provide a coherent basis for the necessary reform and modernisation of services.

