

Putting NICE guidance into practice

Costing report: Antenatal and postnatal mental health: clinical management and service guidance

Implementing the NICE guideline on antenatal and postnatal mental health (CG192)

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This costing report accompanies [Antenatal and postnatal mental health: clinical management and service guidance](#) (NICE guideline CG192)

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This report is written in the following context

This report represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting with healthcare professionals. It should be read in conjunction with the NICE guideline. The report and template are implementation tools and focus on the recommendations that were considered to have a significant impact on national resource utilisation.

The cost and activity assessments in the report are estimates based on a number of assumptions. They provide an indication of the likely impact and are not absolute figures. Assumptions used in the report are based on assessment of the national average. Local practice may be different from this, and the template can be amended to reflect local practice.

Implementation of the guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this costing tool should be interpreted in a way that would be inconsistent with compliance with those duties.

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Executive summary

This costing report looks at the resource impact of implementing the NICE guideline on [antenatal and postnatal mental health](#) in England.

The costing method adopted is outlined in appendix A; it uses the most accurate data available. It was produced in conjunction with clinical experts, members of the Guideline Development Group (GDG) and the National Collaborating Centre for Mental Health, and reviewed by clinical and financial professionals.

The guideline is an update of NICE guideline CG45 (published 2007) and replaces it. The costing work for the updated guideline focuses on recommendations published in 2007 that have not been implemented and are still recognised as changes to current practice. The new costing work replaces the costing work relating to NICE guideline CG45.

Specialised perinatal mental health services, which include mother and baby units will be commissioned by NHS England under specialised commissioning arrangements (see section 5). Mother and baby units are provided by mental health trusts and specialist (tertiary care) services.

Perinatal networks will also be commissioned by NHS England, however some of the care provided for women during pregnancy and the first year after giving birth, will be commissioned by clinical commissioning groups (CCGs). Providers will include GPs in primary care, community mental health teams and secondary mental health services.

Significant¹ resource-impact recommendations

This report focuses on the recommendations that are considered to have the greatest resource impact nationally, and therefore require the most additional resources to implement. They are:

- Clinical networks should be established for perinatal mental health services **[recommendation 1.10.3]**
- Each managed perinatal mental health network should have designated specialist inpatient services **[recommendation 1.10.5]**

Net resource impact

The annual change in resource use arising from implementing the recommendations considered in the costing analysis is summarised below.

Cost impact of recommendations for total number of births for population of England per annum

Recommendation	Recommendation number	Cost impact £(million)
Establishing clinical networks for perinatal mental health services	1.10.3	2.2
Establishing specialist perinatal inpatient services	1.10.5	8.6
Total cost impact (£ million)		10.8

Costs

Following discussions with clinical experts, members of the GDG and the National Collaborating Centre for Mental Health, it was felt appropriate to devise a template containing the core network staff needed to manage a perinatal clinical network. We have also included the facility to allow for extra staff costs to be included depending on local area needs.

¹ The following impacts have been defined as significant:

- where the number of people affected by the guideline recommendations is estimated to be over 300 (equivalent to 1 person per 170,000; in practice, smaller populations may have no people affected or possibly more than 1, particularly if it is a disease that runs in families and there is a cluster in 1 area)
- where initial costing work indicates that the national cost is more than £1 million (equivalent to £2000 per 100,000 population).

The core network staff are estimated to have an annual cost impact of £2.2 million for England. Local organisations will need to identify their needs against the recommendations in the guideline to calculate local costs; these could be lower if services are already established.

The annual cost impact for establishing specialist perinatal inpatient services is £8.6 million. The total annual cost impact of this guidance is therefore £10.8 million for England.

There may also be some non-recurrent costs in establishing the inpatient services. Non-recurrent costs may include building costs or additional bed costs, but these will vary depending on local provision and have not been included in the costing model.

The government has announced a number of changes to promote and sustain good mental health for everyone, with a particular focus on mental health problems during the perinatal stage. The aim is to provide enough training to ensure there are specialist staff available for every birthing unit by 2017. According to the Department of Health's 2014 report, [Closing the gap: priorities for essential change in mental health](#), there are more than 5,000 new midwives now in training and the health visitor workforce is to expand by over 50% by 2015.

Training may also be needed within Improving Access to Psychological Therapies (IAPT) services. IAPT services should ensure they have professionals appropriately trained in perinatal mental health issues.

Other costs relating to specific mental health problems and to adverse impacts on children can be found in [Costs of perinatal mental health problems](#) (Centre for Mental Health 2014).

Benefits and savings

Implementing the guideline may result in the following benefits and savings:

- There is evidence to prove that early detection, assessment and management could prevent the development of postnatal mental health

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problems and improve the mother's quality of life during pregnancy and prevent adverse effects on children ([NICE guideline CG192](#)).

- Early interventions could result in savings in additional interventions, support and pharmacological treatments and to improvements in a woman's quality of life ([Costs of perinatal mental health problems](#) Centre for Mental Health 2014).
- Perinatal mental health networks will help identify clear care pathways and lead to more cost-effective use of inpatient services.
- Perinatal mental health networks can also play a key role in training, education and raising awareness of perinatal mental health illnesses.
- Further benefits and savings can be found in costing reports and templates relating to other NICE guidance on mental health problems.

Local costing template

The costing template produced to support this guideline enables organisations in England, Wales and Northern Ireland to estimate the impact locally and replace variables with ones that depict the current local position. A sample calculation using this template showed a minimum additional cost of £1.7 million could be incurred per 100,000 births.

1 Introduction

1.1 *Supporting implementation*

1.1.1 The NICE guideline on antenatal and postnatal mental health is supported by the following implementation tools:

- costing tools
 - a costing report; this document
 - a local costing template; a spreadsheet that can be used to estimate the local cost of implementation
- clinical audit tool; measure current practice against the guidance and identify areas in which practice can be improved
- baseline assessment tool; assess your baseline against the recommendations in the guidance in order to prioritise implementation activity, including clinical audit.

1.2 *What is the aim of this report?*

1.2.1 This report provides estimates of the cost impact arising from implementing the guideline on antenatal and postnatal mental health in England. These estimates are based on assumptions made about current practice and predictions of how current practice might change following implementation.

1.2.2 This report aims to help organisations plan for the financial implications of implementing NICE guidance.

1.2.3 This report does not reproduce the NICE guideline on antenatal and postnatal mental health and should be read in conjunction with it.

1.2.4 The costing template that accompanies this report is designed to help those assessing the resource impact at a local level in England, Wales or Northern Ireland.

1.3 *Epidemiology of mental health problems in pregnancy and the postnatal period*

- 1.3.1 The NICE guideline on antenatal and postnatal mental health is relevant for women with a mental health problem in pregnancy or the postnatal period (from childbirth to the end of the first postnatal year). It covers the care provided by healthcare professionals in the primary, community, secondary and tertiary care settings.
- 1.3.2 The guideline covers a broad range of mental health problems, including depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental health problems.
- 1.3.3 The Office for National Statistics (2013) indicates there were around 642,000 maternities in England in 2013.
- 1.3.4 Depression and anxiety are the most common mental health problems during pregnancy. The Royal College of Psychiatrists estimates that between 10% and 15% of pregnant women experience depression and anxiety ([Mental health in pregnancy](#) Royal College of Psychiatrists 2012). It also thought between 20% and 30% of women experience a mental health problem during the perinatal period. Examples of these mental health problems include obsessive compulsive disorder, post-traumatic stress disorder and postpartum psychosis ([Perinatal mental health curricular framework](#) NHS Education for Scotland 2006).

1.4 *Current service provision*

- 1.4.1 The provision and uptake of services varies across England. This reflects variation in the recognition of mental health problems and also the presence or absence of specialist multidisciplinary and multi-agency services.
- 1.4.2 Women with mental health problems during pregnancy and the year after giving birth are treated in a variety of NHS settings, including primary care services, obstetric and gynaecological
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services, general mental health services and specialist secondary care mental health services. Most mental health problems that arise during pregnancy and the postnatal period will be mild to moderate, and treated and managed within primary care.

- 1.4.3 The previous NICE guideline on antenatal and postnatal mental health (published in 2007) recommended offering brief psychological treatment and social support for women who have had a previous episode of depression or anxiety. In the 2014 guideline this recommendation ([recommendation 1.8.1](#)) was updated to provide facilitated self-help as described in recommendation 1.4.2.2 of the NICE guideline on [depression in adults](#).
- 1.4.4 The 2007 guideline also recommended establishing perinatal mental health networks and specialist perinatal inpatient services. In most areas this has not been done. The Joint Commissioning Panel for Mental Health's [Guidance for commissioners of perinatal mental health services](#) (2012) states that there are only 19 mother and baby units and 168 mother and baby beds throughout England. This recommendation remains in the 2014 guideline. Therefore we have looked at the current resource impact of implementing the recommendation.
- 1.4.5 NICE has produced other guidance that supports the recommendations within the antenatal and postnatal guideline. For further information please see appendix C, references.

2 Costing methodology

2.1 Process

- 2.1.1 We use a structured approach for costing guidelines (see appendix A).

- 2.1.2 We have to make assumptions in the costing model. These are tested for reasonableness with members of the GDG and key clinical practitioners in the NHS.
- 2.1.3 Users can assess local cost impact, using the costing template as a starting point, and update assumptions to reflect local circumstances.

2.2 *Scope of the cost-impact analysis*

- 2.2.1 The guideline offers best practice advice on the recognition and management of mental health problems in pregnancy and the first year after giving birth.
- 2.2.2 The guideline does not cover the exclusions below. Therefore, these issues are outside the scope of the costing work.
- The needs of infants, other children and partners of women who have developed mental health problems in pregnancy and the postnatal period.
 - Configuration of services for the provision of effective care for women and their children.
- 2.2.3 We worked with the GDG and other professionals to identify the recommendations that would have the most significant resource-impact (see table 1). Costing work has focused on these recommendations.

Table 1 Recommendations with a significant resource impact

Recommendation	Recommendation number	Guideline key priority?
<p>Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:</p> <ul style="list-style-type: none"> • a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams • access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding • clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care • pathways of care for service users, with defined roles and competencies for all professional groups involved. 	1.10.3	✓
<p>Specialist perinatal inpatient services should:</p> <ul style="list-style-type: none"> • provide facilities designed specifically for mothers and babies (typically with 6–12 beds) • be staffed by specialist perinatal mental health staff • be staffed to provide appropriate care for babies • have effective liaison with general medical and mental health services • have available the full range of therapeutic services • be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay. 	1.10.5	

- 2.2.4 Eleven of the recommendations in the guideline have been identified as key priorities for implementation and one of these are among the 2 recommendations considered to have significant resource impact.
- 2.2.5 Two of the key priorities for implementation (recommendations 1.2.1 and 1.4.6) relate to discussing with women who have a mental health problem, contraception, risks of relapse and the effect of a mental health problem and providing them with information. Both these recommendations are likely to be current practice in most cases and so will not have significant additional costs to the NHS.
- 2.2.6 Four of the key priorities for implementation relate to pharmacological treatments (recommendations 1.2.3, 1.4.10, 1.4.15 and 1.4.16). Following discussions with experts, it is felt the change in prescribing patterns will not have a significant resource impact.
- 2.2.7 It is considered that recommendations 1.3.5 and 1.7.1 will be covered by the establishment of specialist perinatal networks so no extra costing work was needed. Women will be seen by professionally trained specialists within the networks who will share information with all services and all interventions will be delivered in a timely manner.
- 2.2.8 The recommendation on discussions with a woman whose baby is stillborn or dies soon after birth (recommendation 1.9.7) is not expected to generate any significant additional costs to the NHS.
- 2.2.9 We have limited the consideration of costs and savings to direct costs to the NHS that will arise from implementation. We have not included consequences for the individual, the private sector or the not-for-profit sector. If applicable, any realisable cost savings arising from a change in practice have been offset against the cost of implementing the change.

2.3 *General assumptions made*

- 2.3.1 Based on expert clinical opinion, it has been assumed within the costing template that the core multidisciplinary team needed to coordinate and manage the clinical network will consist of a psychiatric consultant for 8 sessions each month, a whole-time-equivalent band 7 network manager and a whole-time-equivalent band 5 coordinator.
- 2.3.2 The average annual cost of a bed has been established on the assumption that inpatient beds are mainly provided in specialist mental health services or general adult services. However, these services do not meet the needs of mother and baby. There is therefore an incremental cost of providing specialist services for mother and baby to meet the guideline.

3 *Significant resource-impact recommendations*

3.1 *The establishment of perinatal mental health networks*

Background

- 3.1.1 The structure of perinatal mental health services varies in different parts of the country depending on local factors, including the organisation of existing mental health services, the demographic profile of the local population and geographical issues. The guideline recommends (recommendations 1.10.2 to 1.10.5) how the components of services may be adapted to meet local needs and deliver integrated care, to ensure the effective provision of high-quality clinical services.
- 3.1.2 A key task of the clinical perinatal network will be to determine the need for all levels of care, including inpatient care, in light of the local epidemiology and current service provision and configuration.

- 3.1.3 Local organisations will need to assess the requirements of the network against their own locality's baseline. Multidisciplinary teams may need to be established to support staff training and education, to integrate services, to establish protocols and procedures to support the identification of mental health problems in women during pregnancy and the postnatal period and give expert advice to support women in the community.
- 3.1.4 Discussions with clinical experts suggested a multidisciplinary team could consist of a number of different professionals such as a consultant psychiatrist or obstetrician, a GP, a clinical lead, a network manager, a midwife, a health visitor, a psychiatric nurse and a coordinator. However, the make-up of the team would depend on availability of services and local area need.

Assumptions made

- 3.1.5 The guideline recommends that a perinatal mental health network should have designated specialist inpatient services and typically provide for a population of between 25,000 and 50,000 live births depending on the local population morbidity rates. This suggests that, based on approximately 642,000 maternities per year, there should be between 13 and 26 perinatal mental health networks established in England.
- 3.1.6 The costing template has allowed for the establishment of 20 perinatal mental health networks.
- 3.1.7 Although a number of mother and baby units are available in England, there is little evidence to confirm how many are linked to a perinatal clinical network. Therefore it has been assumed there are no current costs for any perinatal mental health networks.
- 3.1.8 The core staff expected for the network includes: a consultant psychiatrist for 8 sessions a month, each session costing around £400 including on-costs, a yearly cost of around £38,800 (Curtis

2013); a whole-time-equivalent band 7 network manager costing £43,300 including on-costs and a whole-time-equivalent band 5 coordinator costing £29,400 including on-costs (NHS Agenda for change, 2013–14).

3.1.9 Additional costs may need to be considered for non-clinical aspects of consultant work plans, for example administration time. The structure within each network may differ locally and the costing template allows for extra staff or different providers of care to be included if needed.

3.1.10 In establishing the network, investment may be needed depending on local arrangements in the following areas (not included in the costing template):

- recruitment of staff
- reimbursement of expenses
- venue hire for meetings and day-to-day office expenses
- marketing of perinatal mental health networks
- IT communications hardware and ongoing upkeep.

Cost summary

3.1.11 The estimated cost of this recommendation is £2.2 million for England, to provide a core network team for 20 perinatal mental health networks.

3.1.12 Not all costs may be applicable to each network and costs could vary greatly depending on what services are already in place. Perinatal mental health networks will be commissioned by NHS England.

3.2 *Establishment of specialist perinatal inpatient services*

Background

3.2.1 Specialist perinatal inpatient services should:
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- provide facilities designed specifically for mothers and babies (typically with 6–12 beds)
- be staffed by specialist perinatal mental health staff
- be staffed to provide appropriate care for babies
- have effective liaison with general medical and mental health services
- have available the full range of therapeutic services
- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

Assumptions made

3.2.2 The guideline suggests that across England there is a need for between 60 and 80 additional inpatient beds suitable for mother and baby. Using a midpoint of 70, we have calculated the cost of 70 additional beds occupied for a full year.

3.2.3 It is thought the average cost of a bed for these women would be £124,800 a year (Cost code MHCC99, NHS reference costs 2012-13).

3.2.4 The average cost of a bed in a mother and baby unit will be £247,500 a year (Cost code SPHMSMBUAPC, NHS reference costs 2012-13).

Cost summary

3.2.5 In calculating the cost of this service it is assumed that these mothers and babies are currently cared for by inpatient services provided by mental health trusts and specialist (tertiary care) services. The costing tool details the average cost of 1 bed day and an incremental cost for providing a specialist inpatient bed. See table 2.

Table 2 Cost impact of specialist inpatient service

Service description	Annual cost (£000)	Total annual cost for 70 beds (£000)
Mother and baby units, admitted patient	247	17,300
Standard inpatient bed	125	8,700
Cost impact	122	8,600

3.2.6 The estimated cost of implementing this recommendation is therefore £8.6 million for England. Mother and baby units will be commissioned by NHS England.

Other considerations

3.2.7 Local organisations will need to review the availability of services and access to capital investment that will be needed to implement this recommendation.

3.3 *Treating specific mental health problems in pregnancy and the postnatal period*

3.3.1 The costing tool for the previous [NICE guideline CG45](#) on antenatal and postnatal mental health produced in 2007, calculated it would cost £1.1 million to provide psychological therapy for pregnant women that did not meet diagnostic criteria (recommendation 1.3.1.1).

3.3.2 This recommendation has now been updated in the 2014 guideline (recommendation 1.8.1) and interventions for depression should be delivered as described in recommendation 1.4.2.2 of the NICE guideline CG90 on [depression in adults](#).

3.3.3 A costing statement was produced for NICE guideline CG90 in 2009 as this recommendation was not considered to have a significant resource impact. However a [commissioning and benchmarking tool](#) for common mental health disorders has since been developed.

3.3.4 Costs associated with the delivery of psychological therapy for women during pregnancy and the first year after giving birth can be calculated using this commissioning and benchmarking tool.

3.4 *Benefits and savings*

3.4.1 Perinatal mental health networks ensure the availability of expertise for the delivery of appropriate care to woman with mental health problems during pregnancy and the first year after giving birth and their families. Managing mental health problems in the perinatal stage can prevent adverse effects on children. The average cost to society of 1 case of perinatal depression is about £74,000, of which £23,000 relates to the mother and £51,000 relates to the child ([Costs of perinatal mental health problems](#) Centre for Mental Health 2014).

3.4.2 Early interventions could result in savings in additional interventions. According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' statement on [Perinatal anxiety and depression](#) (2012), between 50% and 70% of women with untreated antenatal or postnatal depression will still have depression 6 months later; 25% will develop a chronic illness and 25% will develop recurrent depression.

3.4.3 Perinatal mental health networks will identify clear care pathways and a threshold for referrals to support healthcare professionals. The networks should also lead to more equitable and cost-effective use of inpatient services, by better evaluating the purpose of admission to a mother and baby unit and the likely risks and benefits of admission for women.

3.4.4 It is thought that about half of all cases of perinatal depression and anxiety go undetected. Perinatal mental health networks could play a key role in training, education and raising awareness of perinatal mental health and might help reduce stigma.

- 3.4.5 Early detection, assessment and management could prevent the development of postnatal mental health problems and improve the mother's quality of life during pregnancy ([NICE guideline CG192](#)). The costs of perinatal mental health problems indicate the potential benefits of intervention, an improvement in services should provide value for money.
- 3.4.6 There are also social costs that can be avoided through effective management of perinatal mental health problems, for example, costs relating to children being taken into care, or lifetime costs for children with conduct disorders. These costs can be calculated using the costing template for NICE guideline CG158 [antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management](#). Examples of other costs that could be avoided are costs relating to time out of work for the mother, and costs relating to marriage breakdown.

4 Sensitivity analysis

4.1 Methodology

- 4.1.1 There are assumptions in the model for which no empirical evidence exists; these are therefore subject to a degree of uncertainty.
- 4.1.2 Appropriate minimum and maximum values of variables were used in the sensitivity analysis to assess which variables have the biggest impact on the net cost or saving. This enables users to identify the significant cost drivers.
- 4.1.3 It is not possible to arrive at an overall range for total cost because the minimum or maximum of individual lines are unlikely to occur simultaneously. We undertook one-way simple sensitivity analysis, altering each variable independently to identify those that have greatest impact on the calculated total cost.

4.1.4 Appendix B contains a table detailing all variables modified, and the key conclusions drawn are discussed below.

4.2 *Impact of sensitivity analysis on costs*

Variation in the number of inpatient beds

4.2.1 The number of inpatient beds needed is uncertain. The baseline assumption of 70 beds leads to a cost impact of £10.8 million. Varying the number of beds needed from 60 to 80 leads to cost impacts of £8.3 million and £13.3 million.

Variation in the number of perinatal mental health networks

4.2.2 We determined the number of perinatal mental health networks to be established at between 13 and 26. The midpoint number of networks used in the costing template is 20.

4.2.3 The baseline assumption of 20 perinatal mental health networks leads to a cost impact of £10.8 million for the total number of births in England. Varying the number (of networks) from 13 to 26 leads to cost impacts of £10 million and £11.5 million.

5 Impact of guidance for commissioners

5.1.1 The way the NHS is funded has undergone reform. Clinical reference groups have been established to cover the range of specialised services defined within NHS England's mandate.

5.1.2 The commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England. Clinical reference group [C06. Perinatal Mental Health](#) covers specialised perinatal mental health services.

5.1.3 Other services that provide care for women in the perinatal stage will be commissioned by clinical commissioning groups.

5.1.4 Antenatal and postnatal mental health problems are categorised as an intermediate case mix level under the [Payment by Results](#)

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maternity pathway system. Therefore an increased tariff will be reimbursed.

5.1.5 Establishing perinatal networks needs to be agreed and commissioned by NHS England. The guideline states that networks should provide specialist inpatient services for a population of between 25,000 and 50,000 live births.

5.1.6 The guideline also states that each specialist perinatal service should normally provide 6 to 12 inpatient beds. The services should provide facilities designed for mothers and babies.

6 Conclusion

6.1 *Total national cost for England*

6.1.1 Using the significant resource-impact recommendations in table 1 and assumptions specified in section 3, we have estimated the annual impact of implementing these recommendations in England to be a cost of £10.8 million. Table 3 shows the cost of the significant resource-impact recommendations.

Table 3 Resource impact of implementing guidance

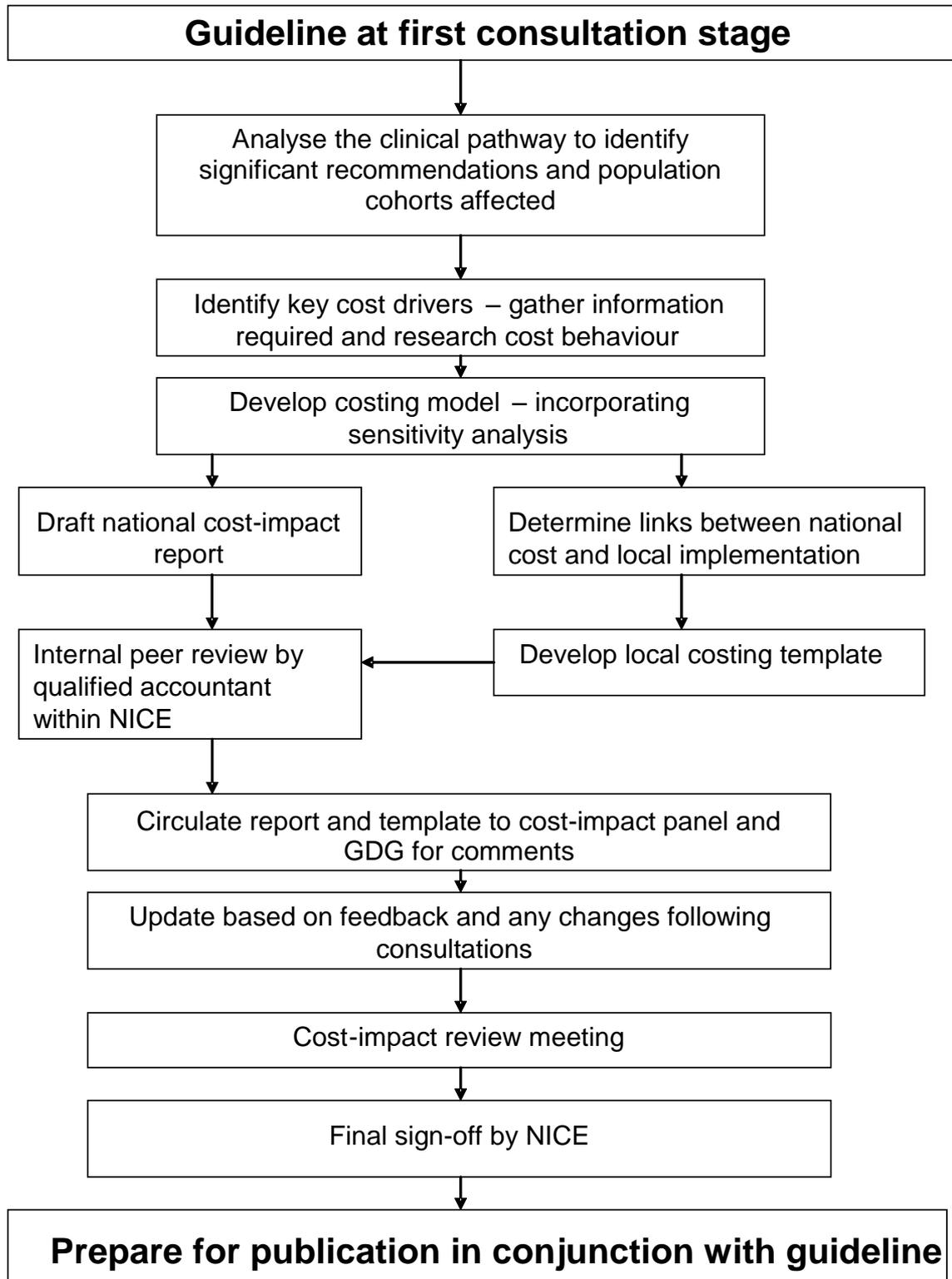
Resource impact area	Annual cost impact £(million)
Core staff to manage perinatal mental health network	2.2
Cost of additional mother and baby unit beds	8.6
Total cost impact (£ million)	10.8

6.1.2 The costs presented are estimates and should not be taken as the full cost of implementing the guideline. Commissioners, providers and health and wellbeing boards will need to work together to ensure all benefits are realised.

6.2 ***Next steps***

- 6.2.1 The local costing template produced to support this guideline enables organisations such as NHS England area teams, health boards in Wales or health and social care trusts in Northern Ireland to estimate the impact locally and replace variables with ones that depict the current local position. A sample calculation using this template showed a minimum additional cost of £1.7 million could be incurred for every 100,000 maternities. Use this template to calculate the cost of implementing this guidance in your area.

Appendix A. Approach to costing guidelines



Appendix B. Results of sensitivity analysis

The table below shows the sensitivity of the total cost of implementation to changes in each variable individually. If there are 2 or more variables that make up 100% between them, they have been varied together to ensure the model remains realistic.

The sensitivity ratio allows comparison of the variables by analysing the percentage changes in the variables and associated cost. The closer the ratio is to 1, the more sensitive the overall cost is to fluctuations in the variable.

Individual variable sensitivity	Recurrent costs						
	Baseline value	Minimum value	Maximum value	Baseline costs (£000s)	Minimum costs (£000s)	Maximum costs (£000s)	Change (£000s)
Number of perinatal mental health networks	20	13	26	10,823	10,035	11,484	1,449
Number of consultant psychiatrist sessions	96	72	120	10,823	10,629	11,018	389
Number of inpatient beds	70	60	80	10,823	8,349	13,298	4,949

Appendix C. References

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