

No health without mental health

Delivering better mental health outcomes
for people of all ages

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INTRODUCTION

- 1 This document is being published alongside *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*, which outlines the Coalition Government's overall approach to improving mental health outcomes. It describes the Government's key pledges and how its public sector reforms and commitment to a Big Society will transform public mental health and mental health services.
- 2 The Government's overall aims are to:
 - improve the mental health and wellbeing of the population and keep people well; and
 - improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.
- 3 The Government has worked with a wide range of partner organisations, including user and carer groups, service providers and local government, to agree six shared objectives to improve mental health outcomes.
- 4 This document explains in detail each shared objective, how it will improve mental health outcomes, effective interventions that we know work, and the underpinning evidence base for these.
- 5 The six shared objectives are as follows:
 - (i) **More people* will have good mental health**
More people of all ages and backgrounds will have better wellbeing and good mental health.
Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.
 - (ii) **More people with mental health problems will recover**
More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates, and a suitable and stable place to live.
 - (iii) **More people with mental health problems will have good physical health**
Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

* Throughout this document we will use the word people to mean individuals of all ages: infants, children, young people, working-age adults and older people.

(iv) More people will have a positive experience of care and support

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

(v) Fewer people will suffer avoidable harm

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

(vi) Fewer people will experience stigma and discrimination

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

effect on mental health outcomes. These are based on a well-established consensus on priorities for change within the mental health sector;

- outlines effective evidence-based interventions,* with examples of good practice, to assist local commissioners in meeting the needs of the local population;
- describes what the Government will do to support local action;
- explains the links between the high-level mental health objectives and indicators in the three outcomes frameworks – the NHS Outcomes Framework¹ and the proposed Public Health² and Adult Social Care Outcomes Frameworks;³
- identifies a number of more detailed indicators** that the NHS Commissioning Board may wish to consider using to assess progress and hold local commissioners to account; a number of indicators for consideration by local commissioners; and areas where outcome indicators may need to be developed to replace process indicators currently in use;*** and
- discusses the Quality Standards in development.

6 For each of these high-level objectives, this document:

- identifies the high impact areas – the areas for improvement that will have most

* These are selected on the basis that they tackle the key risk factors for poor mental health, including major inequalities, or they identify key ways of improving wellbeing and mental health, and that they are based on good evidence of effectiveness and designed to support efficiency savings and value for money.

** Some of the proposed indicators will provide information on national progress but not at local level, because the data are sourced from national surveys, which do not readily provide detail by localities, or because the numbers involved are small at local level and only reveal trends when aggregated nationally. Additionally, the Department of Health is working with colleagues in European Union member states to examine outcome indicators that could be used for international comparison.

*** We will continue to seek more and better indicators to measure outcomes and priorities for improvement. The availability of indicators is dependent on the continuing development of information and data architecture.

- 7 A suite of National Institute for Health and Clinical Excellence (NICE) **Quality Standards** will support the delivery of the outcomes set out in the NHS, Public Health and Adult Social Care Outcomes Frameworks. Quality Standards provide an authoritative definition of what high-quality care looks like for a particular care pathway or service. They are developed by NICE, in partnership with clinicians, leading experts, social care professionals and healthcare specialists in that particular field and draw on the best available evidence and practice.
- 8 The Department of Health currently commissions NICE to produce these standards. This commissioning function will transfer to the NHS Commissioning Board once it is established, and GP consortia will refer to these standards when commissioning services locally.
- 9 Within the next five years, NICE will produce a library of 150 Quality Standards that cover the majority of NHS activity, to support the NHS in delivering the outcomes in the NHS Outcomes Framework.

OBJECTIVE (i): MORE PEOPLE WILL HAVE GOOD MENTAL HEALTH

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

1.1 We need to do two things:

- improve the mental wellbeing and healthy life expectancy of individuals and the population; and
- ensure that fewer people of all ages and backgrounds will develop mental health problems.

1.2 Mental wellbeing is related to, but not the same as, the absence of mental ill health. It has been defined as the ability to cope with life's problems and make the most of life's opportunities. It is about feeling good and functioning well, both as individuals and collectively. It is independent of mental health status: people with mental health problems can enjoy good wellbeing, while some people without a diagnosed mental health problem may find it difficult to cope with life's problems. However, fewer people are likely to develop mental health problems in populations with high levels of mental wellbeing.

1.3 Resilience is the capacity of individuals and communities to deal with stress and adversity. Wellbeing, resilience and the prevention of mental health problems are thus distinct but linked, and many of the successful interventions affect all three.

1.4 Poor mental health is strongly associated with a number of social determinants – examples include socio-economic deprivation and social isolation. These determinants can both contribute to the development of mental health problems and result from them. They are also associated with poorer physical health. This relationship deepens health inequalities and adds to trans-generational patterns of poor health. The public health White Paper *Healthy Lives, Healthy People*⁴ gives an overview of the determinants of ill health and reduced wellbeing, and outlines key approaches across the life course to address these. It commits Public Health England to support local authorities to make public mental health part of public health.

1.5 The public health White Paper describes an approach of 'proportionate universalism', which was advocated in the Marmot Review⁵ to tackle health inequalities. This section outlines key

approaches to improving population wellbeing and ensuring that fewer people develop mental health problems. It should be read alongside Chapter 3 of *Healthy Lives, Healthy People*. We will also publish this year a series of public mental health reviews on the evidence for preventing mental illness and promoting mental health.

1.6 The key areas to achieve this high-level objective are the same as those in *Healthy Lives, Healthy People*. They are:

- starting well
- developing well
- living well
- working well
- ageing well.

Starting well – ensuring that everyone has the best start in life

1.7 A good start in life and positive parenting are fundamental to good mental health and wellbeing, and to lifelong resilience to adversity. This is particularly important because half of lifetime mental health problems have already developed by the age of 14.^{6,7}

1.8 The social and biological influences on a child's health and brain development start even before conception and continue through pregnancy and the early years of life. A mother's mental health during pregnancy is an important factor in determining the child's mental

health. Better maternal mental health is associated with better outcomes for the child, including better relationships, improved learning and academic achievement, and improved physical health.⁸

1.9 Maternal mental health problems during pregnancy increase the risk of adverse pregnancy outcomes as well as neuro-developmental problems for the child both before and after birth. Maternal depression is associated with increased rates of birth complications, stillbirths and low birth-weight babies.⁹

1.10 Anxiety and postnatal depression affect 13% of mothers shortly after birth and 22% of mothers one year after the birth.¹⁰ Being depressed can reduce a mother's ability to look after herself as well as her baby.¹¹ It is associated with a five-fold increased risk of later mental health problems for the child and can affect the child's cognitive and emotional development.^{12,13} Income, occupational position, marital status and number of children are significant predictors of postnatal depression,¹⁴ with more than half of low-income urban mothers experiencing postnatal depression in the three months following birth.¹⁵ Teenage mothers are particularly at risk, with a three times higher risk of postnatal depression and poor mental health for three years after the birth. This not only affects the wellbeing of the young mother but can also affect her ability to be an attentive and nurturing parent,

which can lead to an increased risk of accidents and behavioural difficulties for her child.¹⁶

1.11 A mother's physical health is just as important as her mental health. Smoking, and alcohol and drug use during pregnancy also negatively influence pregnancy outcomes and subsequent child mental health. For example, smoking during pregnancy is associated with a doubled risk of conduct disorder in boys,¹⁷ and increased antisocial behaviour and attention deficit hyperactivity disorder symptoms in children.¹⁸

1.12 The mental health of both parents is an important factor for the healthy development and safeguarding of children. Children whose mothers have poor mental health have a four- to five-fold increased risk of developing mental health problems;^{19,20} children of depressed parents have a two- to three-fold increased risk of developing depression.²¹

The importance of effective parenting

1.13 A child's early experiences lay the foundations for their future life chances. Although everyone is born with their own genetic make-up, these genes interact with the family and the environment to determine a child's future health and resilience. Infants do better if they are cared for in a safe, warm and responsive way. This supports their healthy development and enables them to acquire the basic skills of emotional

regulation and social communication. It also helps them to learn more easily and to assess risks. Effective parenting brings multiple benefits to children and is, therefore, fundamental to giving every child the best start in life.²²

1.14 Children who experience negative parenting, poor-quality relationships and other adversity in early life are at particular risk of a number of poor outcomes later on, including mental health problems. Good parent–child or carer–child relationships promote emotional, social and cognitive development, emotional resilience and healthy lifestyles. They are also associated with increased resilience against a range of difficulties, including mental illness.²³ A good relationship between the child's parents is also important: children of these parents tend to have high levels of wellbeing. In general, whether parents remain together or not, the quality and content of fathers' involvement matters more for children's outcomes than how much time they spend with their children.²⁴ Positive father involvement is associated with a range of positive outcomes for children and young people.²⁵

Examples of effective local interventions

1.15 *Healthy Lives, Healthy People* describes universal public health and early-years education programmes, at both neighbourhood and local government level, which have a particular focus on disadvantaged families.

1.16 The National Institute for Health and Clinical Excellence (NICE) clinical management and service guidance on antenatal and postnatal mental health (2007)²⁶ recommends the establishment of clinical networks for perinatal mental health services in all parts of the country, to co-ordinate input from across the relevant maternity, mental health, primary care and social care sectors.

1.17 There are a number of effective interventions that have been shown to reduce maternal depression, for example home visiting,²⁷ parenting programmes²⁸ and peer support.²⁹ More details will be published in the forthcoming series of public mental health reviews.

1.18 Additional support to parents can be delivered by:

- refocused Sure Start children's centres for those who need them most; and
- parent support advisers working with school staff and local services to help families to overcome the problems they face. These advisers can signpost parents who need specialist help to mental health services or to other family support workers, such as health visitors or early years outreach workers.

1.19 Targeted approaches include the Family Nurse Partnership Programme, which works intensively with the most disadvantaged young families with complex, interlinked problems.

This programme aims to bring about behaviour change and interrupt the trans-generational cycle of poor health. In the USA the programme has been shown to achieve significant benefits for child(ren) and parent(s), including better parenting, improved home safety, improved child behaviour and educational attainment, and better parental mental and physical health.³⁰ There have been similar findings in the UK.³¹

Government actions to support local approaches

1.20 The Coalition Government has pledged to increase the health visitor workforce by a further 4,200 posts. Health visitors will work to a new model of practice, which includes a stronger focus on maternal and infant mental health. They will work with Sure Start children's centres and GPs, and will lead and deliver the Healthy Child and Family Nurse Partnership Programmes.

1.21 The Department for Education has established a new cross-government programme to support families facing multiple, complex problems. It is introducing a new area-based Early Intervention Grant that will bring together funding for a number of early intervention and preventative services, including Sure Start children's centres. Schools and local areas report significant benefits from the Targeted Mental Health in Schools (TaMHS) programme.

Developing well

1.22 As children grow and become young adults, they continue to need a stable and nurturing environment that supports them to develop independence. However, it is important to target children and young people at particular risk of developing mental health problems. These include:

- those who experience negative parenting and poor-quality relationships;³²
- those who have suffered child abuse, including sexual, physical and emotional abuse and neglect;³³
- those in contact with the youth and adult criminal justice systems – 80% of crime is committed by adults who had a conduct problem as children;
- those underachieving in school;
- looked after children and early school leavers;³⁴
- young lesbian, gay and bisexual people;³⁵
- young homeless people;³⁶ and
- in particular, those who have suffered four or more adverse childhood experiences.³⁷

1.23 Adolescence is a particularly important transition point. It is a distinct developmental stage in its own right, and a time of major physical, emotional and neurological change. As the young person grows up, the major influences

on their lifestyle and health choices shift away from their parents and towards their environment and peers.^{38,39}

1.24 Increased health risk behaviours are associated with increased levels of mental ill health and lower levels of wellbeing. Smoking and alcohol and substance misuse are all much more common in adolescents with mental health problems and low levels of wellbeing. Improved mental health and lower levels of mental illness are associated with reduced health risk behaviours, including reduced smoking and alcohol and substance misuse.⁴⁰

Examples of effective local interventions

1.25 *Healthy Lives, Healthy People* outlines how local partnerships, including education and health services, can support young people to take control of their lives within clear boundaries, and help them to make healthier, positive choices, for example about using drugs and alcohol. Early identification and stepped care approaches can prevent and reduce alcohol and substance misuse among children and young people.^{41,42,43}

1.26 Systematic reviews of interventions to prevent conduct disorder, anxiety and depression before adulthood have shown that programmes targeting at-risk children that use parent training or child social skills training are the most effective.⁴⁴

- 1.27 The Healthy Child Programme, led by health visitors, will place greater emphasis on health promotion, prevention and early intervention. The number of families with violence, substance misuse and/or mental health problems is growing. Health visitors and their teams will identify children at high risk and ensure that they receive the appropriate support, including referral to specialist services where needed.
- 1.28 School-based programmes that target particular risk behaviours are less effective than whole-school mental health promotion intervention. School-based mental health promotion programmes result in a broad range of improved outcomes, including reduced health risk behaviours, improved wellbeing, reduced depression, conduct disorder and anxiety, and improved social outcomes.⁴⁵
- 1.29 The non-statutory personal, social and health education (PSHE) guidelines for schools provide a framework for age-appropriate teaching on relationships and sex, substance misuse and mental health issues.
- 1.30 Reviews of school-based interventions aimed at preventing violence and abuse have shown that they can lead to reductions in aggressive behaviour, conduct problems and attention problems, and improved social skills and social relationships, school performance and school attendance rates, and knowledge about and attitudes towards violence, bullying and sexual abuse.^{46,47}
- 1.31 Local services can develop systems for the early identification of children and young people with mental health problems in different settings, including schools. Stepped care approaches to treatment, as outlined in NICE guidance, can be delivered in age- and developmentally appropriate settings. The *You're Welcome* quality criteria self-assessment toolkit⁴⁸ devised by the Department of Health can be used to ensure that services and settings are acceptable and accessible to young people.
- 1.32 Whole-family approaches for families with multiple problems and needs, such as intensive Multisystemic Therapy (MST) and targeted parenting work, have been shown to improve the wellbeing and mental health of young people and their families. Whole-family approaches in which adult and children's services work more closely together have also been effective in supporting young carers – a particularly at-risk group.^{49,50}

Help for looked after children

Some 64,400 children – 0.5% of all under-18-year-olds – are looked after in England⁵¹ and 72% of these live in foster placements. These children and young people have a five-fold increased risk of mental disorders, a six- to seven-fold increased risk of conduct disorder and a four- to five-fold increased risk of attempting suicide in adulthood. The Department of Health has published statutory guidance on promoting the health and wellbeing of looked after children.⁵²

Care leavers continue to share many of the same health risks and problems as looked after children.

Improved identification and assessment: Some 45% of looked after children have a mental health disorder, rising to 72% for those in residential care.⁵³ Timely and effective health assessments are crucial to the speedy identification of problems and referral to support services. The use of screening tools such as the Strengths and Difficulties Questionnaire⁵⁴ can help to prioritise referrals to child and adolescent mental health services (CAMHS).

More effective commissioning ensures that the needs of looked after children, including those living outside their local authority area and care leavers, are reflected in joint strategic planning. Children and young people with the highest levels of need may require a complete package of care that addresses their mental health needs – for example through the Multidimensional Treatment Foster Care programme, which is evidence-based treatment for children with chronic antisocial behaviour, emotional and/or conduct disorders and unstable foster placements. The programme in England, piloted by the Department for Education, is in its seventh year. It has demonstrated improved outcomes for children and young people.⁵⁵

Government actions to support local approaches

1.33 The new Health Premium will ensure that national government funding is designed to encourage local authorities to promote equality and narrow the gaps in health between those living in deprived and affluent areas. From April 2011, schools will have further funding to support children from low-income families via the Pupil Premium.

1.34 The Department of Health is expanding access for children and young people

to a range of talking therapies.*

The supporting document, *Talking Therapies: A four-year plan of action*, gives more details.

1.35 The forthcoming Department for Education Green Paper will set out plans to support children and young people with special educational needs and disabilities and their parents. The Green Paper will be based on responses to a call for views issued in 2010, and on the experience and expertise of families and those supporting them.

* 'Talking therapies' is a common term used to describe a wide range of psychological therapies. It is also the title of the four-year plan of action. In this document we use psychological therapies to describe a broad range, which sometimes includes play and non-verbal activities.

- 1.36 Family learning programmes, funded by the Department for Business, Innovation and Skills (BIS), offer a wide choice of locally designed and locally run learning programmes to the most deprived and disadvantaged families. These programmes encourage parental and carer involvement in their children's education and development, and can also build parental confidence and self-esteem, and foster community participation and engagement.
- 1.37 The National Citizen Service programme is supporting the Government's vision for building community capacity by helping young people to develop the skills and attitudes they need to get involved in their communities and become active and responsible citizens.
- 1.38 The Healthy Schools Programme, and programmes to promote wellbeing in further education institutions and universities, will continue to be developed by their respective sectors. The Department of Health will work with business and voluntary organisations to provide ongoing support.
- 1.39 The Department of Health will be reviewing the model of service and practice for school nursing, to ensure that school nurses are properly equipped to undertake their role in public mental health.
- 1.40 The Department for Education is leading a national campaign to support families with multiple problems.⁵⁶ Around 2% of all families in England (117,000) have at least five or more problems, which include mental health problems. The new approach will:
- remove the barriers that prevent practitioners from working together to deliver solutions that address the complex problems these families face;
 - increase local investment in the kind of support that we know works and can really help these families;
 - build partnerships with the private and voluntary and community sectors; and
 - disseminate information about what works to support further local innovation.
- 1.41 Evidence suggests that a single key worker supported by local agencies, including the police, schools, the health service and Jobcentres, can be effective in providing one-to-one support to all family members. Currently, up to 20 different services and agencies may be involved with each family, each with their own funding streams, thresholds and protocols. One well co-ordinated and integrated intervention costs on average £14,000 per family per year, compared with spending of £250,000–£330,000 per family when input is duplicated by several services operating in isolation from each other.

1.42 There are three key strands to the programme:

- **Investing to test and share.**

A small number of **exemplar areas** will test out new approaches, to make a local difference and attract national interest. The first of these will focus on helping adult members of families with multiple problems get into or back to work.

- **Learning from success.** 'Mentor areas', with a track record of successfully intervening with families with multiple problems, will receive government support to act as dissemination hubs and help others to develop evidence-based approaches locally.

- **Breaking down barriers.** From 1 April 2011, local agencies in the first 16 areas (in 28 local authorities) will be able to establish a Community

Budget to fund innovative and cost-effective family services. Local authorities will also be able to attract funds from outside sources. The new Early Intervention Grant will provide a further source of funds that local authorities can choose to use for these families, depending on local needs. The aim is for all local authorities to have Community Budgets by the end of the Spending Review period.

1.43 Helping families to overcome their multiple and complex problems brings:

- benefits for the families in terms of more fulfilled lives;
- benefits for society in terms of reduced antisocial behaviour; and
- benefits for the taxpayer in terms of financial savings that can be used for more preventative work.

Body image and eating disorders

Children and young people learn about what is considered normal behaviour and what society values from the people close to them, their surroundings and the media messages to which they are exposed. In the same way, young people's ideas about body image and what looks good are strongly influenced by fashion and friends, and body image is linked to self-esteem. Young peoples' diet and appetite can be affected by stress, worry or tiredness. Worries about weight, shape and eating are common, especially among young girls. Nearly 1% of women in the UK between the ages of 15 and 30 suffer from anorexia nervosa, and between 1% and 2% have bulimia nervosa.⁵⁷

Eating disorders start most commonly in adolescence and are associated with high levels of mortality, physical health problems and psychological distress, as well as impaired quality of life.

Concern has been voiced about media images being digitally enhanced to make models look thinner. *Safer Children in a Digital World: The Report of the Byron Review*,⁵⁸ published in March 2008, also raised concerns about websites that encourage anorexia and bulimia and which can have harmful effects on young people.

Access to high-quality mental health care, based on the best available evidence and delivered by staff with an appropriate range of skills and competencies, is critical to meeting the specific needs of this group of young people.

The Government is bringing together a group of experts to identify non-legislative ways of tackling low levels of body confidence.

NICE guidance on eating disorders was published in 2004 and is due for review in 2011.

Living well

1.44 A number of approaches to living well have been outlined in *Healthy Lives, Healthy People*. Individuals can improve their own mental health. The community and environment in which we live can also strongly influence both population and individual mental health and wellbeing.

1.45 We can help ourselves by drinking alcohol within safe limits, taking regular exercise and participating in meaningful activities such as arts, sports or volunteering.

1.46 The Foresight report⁵⁹ recommended 'five ways to mental wellbeing'. They are:

- **connect** – with the people around you, family, friends, colleagues and neighbours;
- **be active** – go for a walk or a run, garden, play a game;
- **take notice** – be curious and aware of the world around you;
- **keep learning** – try a new recipe, learn a new language, set yourself a challenge; and

- **give** – do something nice for somebody, volunteer, join a community group.

- 1.47 Interventions that encourage increased physical activity can achieve improvements in mild and moderate depression, enhance schoolchildren's ability to learn, and benefit mental health and wellbeing generally. They are just as effective with deprived communities and older people. There is evidence that leisure activities, including learning arts and creative activities, can increase mental health and wellbeing.^{60,61} Our environment is also important.^{62,63} Cleaner and safer environments, with access to green spaces, good housing and transport, can help people to take more exercise and get more involved in local activities and so be less isolated, all of which improve mental health and wellbeing.^{64,65,66}
- 1.48 Sustainable, connected and capable communities, as envisaged in the Government's Big Society approach, have lower rates of crime and better health across all age groups, as well as higher educational attainment and better mental health.⁶⁷
- 1.49 Conversely, financial insecurity, being homeless, drug and alcohol misuse and experiencing violence, including domestic violence and abuse, are all strongly associated with poor mental health.

Examples of effective local interventions

- 1.50 *Healthy Lives, Healthy People* recognises the importance of ensuring that public health approaches address physical as well as mental health problems. It also recognises the importance of public health interventions reaching people with mental health problems. An example of this is the provision of smoking cessation in-reach programmes to psychiatric hospitals and mental health units.
- 1.51 Volunteering increases wellbeing. Both the volunteer and the recipient of help can benefit. It can help to build self-esteem and promote a sense of purpose and self-worth in children and young people, working-age adults and retired people.^{68,69} It contributes to forming social networks and to community cohesion. For older people, volunteering has been shown to be associated not only with improved wellbeing but also with five-year survival rates.⁷⁰
- 1.52 Debt is known to be strongly associated with higher rates of mental health problems.⁷¹ Locally available services include Citizens Advice Bureaux and the Moneymadeclear service, run by the Consumer Financial Education Body (CFEB). This service is accessible to most people with mental health problems; people with more severe problems may need help to use it.

1.53 Social networks and social support can promote a sense of belonging and wellbeing and prevent a range of mental health problems.⁷² Participating in leisure, arts and other community activities can promote improved wellbeing and community connectedness.^{73,74}

Government actions to support local approaches

1.54 *A Vision for Adult Social Care: Capable communities and active citizens*⁷⁵ sets out the Government's commitment to strengthening local communities. Published in parallel, *Practical Approaches to Improving the Lives of Disabled and Older People Through Building Stronger Communities*⁷⁶ explains why building strong and resilient communities is a key component of social care transformation. It outlines approaches currently being developed by local authorities with their public sector and community partners, and directs readers to useful materials.

1.55 Informal adult and community learning programmes funded by BIS offer person-centred, flexible opportunities designed to overcome the real and perceived barriers that stop the most deprived and excluded sections of society accessing training and education. They are designed especially to engage people who may be intimidated by formal institutions, including homeless people and/or those who have multiple disadvantages.

1.56 The Government has published *Drug Strategy 2010 – Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life*. This tackles drug dependence and promotes a recovery-led approach to helping people to rebuild their lives.⁷⁷

1.57 The Department of Health is setting up a National Inclusion Board to champion the needs of the most vulnerable across health and social care and drive improvements in their health outcomes. The board will provide expertise to help local agencies to prioritise action to address health inequalities among the most disadvantaged people.

1.58 The Government is committed to overhauling the Licensing Act 2003 to give local authorities and the police much stronger powers. A consultation on rebalancing the Licensing Act ran from July to September 2010. The Home Secretary has set out measures in the new Police Reform and Social Responsibility Bill that give local authorities new powers to deal with premises causing problems, and doubling the maximum fines that can be levied for persistent under-age alcohol sales.

1.59 The Department for the Environment, Food and Rural Affairs is committed to ensuring that the interests of people in rural areas are fully and fairly recognised in all government policies, and that rural communities are freed up to address their own needs through locally driven initiatives.

- 1.60 CFEB is an independent organisation established in April 2010 by the Financial Services Act. It helps people to understand financial matters and manage their finances better by providing impartial information, education and advice through a national financial advice service. This includes free advice online and over the phone as well as face-to-face appointments in a number of priority areas across the UK (from Spring 2011 these will be available nationwide).
- 1.61 CFEB's service is universal, reaching everyone in the UK, including those who, due to their health or circumstances, may be vulnerable to the consequences of making poor financial decisions (including those with a mental health problem). The service is delivered in local settings, in partnership with a range of commercial and voluntary sector organisations and employers. CFEB is working in partnership with the Department of Health, the National Mental Health Development Unit and the NHS Confederation to raise awareness of the benefits that financial management skills have on building resilience and improving mental health and wellbeing.
- 1.62 A cross-government strategy, *Call to End Violence Against Women and Girls*,⁷⁸ was published in November 2010. The Government has committed £28 million in Home Office funding over four years to improve specialist local services and support for victims of rape, sexual assault and violence.

Emergency planning and recovery

We know from recent experience that civil emergencies (flooding, terrorist activities, explosions, rail accidents) have significant mental health implications.

Until now, mental health organisations have not been involved consistently in local resilience forums, and local emergency preparedness plans have therefore not benefited from expertise on the psychological impact of these events.

The current review of the Civil Contingencies Act 2004 provides an opportunity to reconsider structural arrangements and ensure that mental health organisations play an appropriate part in preparation, planning, and recovery from emergencies.

The Department of Health publication *NHS Emergency Planning Guidance: Planning for the psychosocial and mental health care of people affected by major incidents and disasters* (2010)⁷⁹ provides a framework for ensuring that input and emphasises the need to build on community resilience, to avoid over medicalising natural responses, and to provide evidence-based interventions where appropriate.

Commissioners and providers may wish to consider how mental health services will organise themselves to respond to incidents that, because of their size or severity, require the involvement of a number of organisations.

Working well

- 1.63 Being in work has important psychological and economic benefits. People who become unemployed are at increased risk of developing mental health problems. The longer a person is out of work, the harder it is for them to return to the job market. Early intervention can help to prevent deterioration of mental health and support job-seeking.⁸⁰
- 1.64 The Health and Safety Executive stress Management Standards⁸¹ set out what employers can do to limit work-related stress and create a culture in which the risks of stress are reduced.
- 1.65 Some employers find it hard to understand the difficulties faced by people experiencing mental health problems. They may need advice in order to support employees to remain in or return to work. By creating healthy workplaces and raising awareness of mental health issues, employers can reduce both sickness absence due to mental health problems and the costs associated with low productivity.⁸²

Examples of effective local interventions

- 1.66 NICE guidance (2009)⁸³ describes a number of effective interventions. Early detection and treatment of mental illnesses such as depression have been shown to lead to better outcomes for both individuals and organisations, with five-fold savings from reduced absence and increased productivity.⁸⁴

Targeted employment support for those recovering from mental illness results in three-fold increased rates of employment⁸⁵ and savings of £6,000 per client due to reduced inpatient costs over an 18-month period.⁸⁶ There is also evidence that work-based health promotion programmes not only benefit employees, but also lead to considerable improved productivity and reduced absenteeism for the employer (see the supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health*).

Government actions to support local approaches

- 1.67 Under the provisions of the Equality Act 2010, it is illegal for employers to ask job applicants health or health-related questions before making a conditional offer of employment.
- 1.68 The Department of Health will also renew its approach to cross-government action to improve the health of working-age people. This will build on the work outlined above and other successful work done in response to Dame Carol Black's review, *Working for a Healthier Tomorrow*,⁸⁷ which highlighted that working-age ill health costs the country £100 billion a year. Key challenges for a 21st-century approach include early intervention and prevention, health-promoting workplaces, better mental health and employment outcomes, building young people's resilience and lengthening healthy working lives. Effectively addressing health, work and

wellbeing provides the potential to reduce inequalities through increased economic prosperity, and greater stability and viability of local communities.

1.69 The Government has established a new integrated Work Programme to provide help for people to move into work and stay there. Work Programme providers and mental health services will work together to help people into work and remain in work when mental health problems arise. Better employment rates for people with mental health conditions are a key success factor.⁸⁸

1.70 Work Choice will help disabled people with complex barriers to find employment and stay in work (including self-employment). Access To Work provides financial support for individuals and employers to make adjustments so that people with health conditions can remain in work.

1.71 A range of advice and guidance is available to support individuals with mental health problems in and into work, and to help employers to meet their own business needs and statutory requirements for healthy workplaces. For example, Next Step, the integrated adult careers service, is designed to be sensitive to health issues, including the needs of people with mental health problems. A Department of Health Working for Mental Health website (www.workingformentalhealth/dh.gov.uk) is being set up to provide an easy one-stop access point for this information.

Ageing well

1.72 As life expectancy increases, healthy life expectancy also needs to increase. By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million in 2008 to 8.7 million. For those aged 85 and over, the projected increase is from 1.3 million in 2008 to 3.3 million in 2033.⁸⁹

1.73 Depression is the most common mental health problem in older people and is associated with social isolation, long-term physical health problems or caring roles, and living in residential care. There is more information about this in the section on objective (iv). Dementia affects 5% of people aged over 65 and 20% of those aged over 80,⁹⁰ and some have both depression and dementia. Delirium is also a significant mental health condition in older people.

1.74 Some 20% of people live in rural communities; these communities are scattered across 86% of the country. Although most people living in rural areas experience a high quality of life, the poorest and most disadvantaged have much poorer physical and mental health. Much of this deprivation is hidden and so more difficult to address. Older people may be particularly disadvantaged, and rural communities tend to have an older age profile: the median age in rural communities is six years older than in urban areas.

Examples of effective local interventions

- 1.75 *Healthy Lives, Healthy People* sets out a range of local approaches to improve physical and mental health in older people. Approaches of particular importance include:
- reducing isolation, support during times of difficulty,⁹¹ and increasing social networks and opportunities for community engagement;⁹²
 - providing easy access to continued learning;
 - improving support for informal carers;⁹³
 - warm homes initiatives;⁹⁴ and
 - promotion of physical activity and physical health.⁹⁵

Government actions to support local approaches

- 1.76 *A Vision for Social Care: Capable communities and active citizens* sets out the Government's commitment to improving local support for older people.
- 1.77 Measures to promote mental health outlined in *Healthy Lives, Healthy People* include the continuation of the Warm Front home-heating scheme until 2012/13 and the introduction of Active at 60 Community Agents – peer workers who can help people to stay active and engaged in later life.

- 1.78 The Local Government Improvement and Development programmes on ageing well and healthy communities will help local authorities to develop their public health and ageing strategies and services.
- 1.79 The recently published Carers Strategy⁹⁶ sets out how carers will be supported and their contribution recognised. It outlines how carers will be involved in the delivery of care, and the support they will receive for their own mental and physical health so that they can enjoy work, family and community life. The Government is providing £400 million over the Spending Review period for local areas to fund carers' breaks.
- 1.80 Improving the quality of care for people with dementia and their carers is a major priority for the Government. We are committed to more rapid improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them. This approach is set out in *Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy*,⁹⁷ the revised, outcomes-focused implementation plan for the National Dementia Strategy.

Objective (i): outcome indicators

1.81 Mental health is an intrinsic aspect of health and wellbeing. Many of the effective interventions mentioned in this section are also outlined in *Healthy Lives, Healthy People*. The Public Health Outcomes Framework consultation document proposes a number of national level indicators to help local health and wellbeing boards and local communities to track progress. Many

of these are therefore directly relevant to improving the mental health of both individuals and the population as a whole. While the domains will remain unchanged over the next few years, the indicators within each domain will develop over time. Consideration will need to be given to more robust and systematic data collection across all outcomes and indicators in relation to protected characteristics.*

1.82 The indicators with particular relevance to mental health are as follows:

Vision: To improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest

Proposed indicators

- increasing healthy life expectancy
- reducing the differences in life expectancy and healthy life expectancy between communities and groups, e.g. people with mental health problems.

Domain 1: Health protection and resilience: protecting the population's health from major emergencies and remaining resilient to harm

Proposed indicator

- comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard.

* The 'protected characteristics' or groups are characteristics against which the Equality Act 2010 prohibits discrimination; they are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Domain 2: Tackling the wider determinants of ill health: tackling factors that affect health and wellbeing

Proposed indicators

- children in poverty
- truancy rate
- school readiness: foundation stage profile attainment for children starting Key Stage 1
- first-time entrants to the youth justice system
- proportion of people with mental illness and/or disability in employment* **
- proportion of people with mental illness and/or disability in settled accommodation**
- incidents of domestic abuse**
- statutory homeless households
- housing overcrowding rates
- fuel poverty
- access and utilisation of green space
- older people's perception of community safety**
- rates of violent crime, including sexual violence
- reduction in proven reoffending
- social connectedness
- the percentage of the population affected by environmental, neighbour and neighbourhood noise.

* Shared responsibility with the NHS.

** Shared responsibility with Adult Social Care.

Domain 3: Health improvement: helping people to live healthy lifestyles and make healthy choices

Proposed indicators

- smoking prevalence in adults (over 18)
- rate of hospital admissions per 100,000 for alcohol-related harm
- number leaving drug treatment free of drug(s) of dependence
- percentage of adults meeting the recommended guidelines on physical activity (5 x 30 minutes per week)
- hospital admissions caused by unintentional and deliberate injuries to 5–18-year-olds
- under-18 conception rate
- self-reported wellbeing.

Domain 4: Prevention of ill health: reducing the number of people living with preventable ill health

Proposed indicators

- hospital admissions caused by unintentional and deliberate injuries to under-5-year-olds
- work sickness absence rate
- rate of hospital admissions as a result of self-harm
- maternal smoking prevalence (including during pregnancy)
- incidence of low birth weight of term babies
- child development at 2–2.5 years
- smoking rate of people with serious mental illness
- emergency readmissions to hospitals within 28 days of discharge* **
- health-related quality of life for older people.**

* Shared responsibility with the NHS.

** Shared responsibility with Adult Social Care.

Domain 5: Healthy life expectancy and preventable mortality: preventing people from dying prematurely

Proposed indicators

- suicide rate
- mortality rate of people with mental illness.*

* Shared responsibility with the NHS.

1.83 An equivalent to ‘work’ for children is being developed. This will fill the gap in both the NHS and Public Health Outcomes Frameworks. Attendance at school is an insufficient measure of mental health on its own; participation and achievement are also important factors.

1.84 The consultation document *Transparency in Outcomes: A framework for adult social care*,⁹⁸ published in parallel with *A Vision for Social Care*, sets out a new strategic approach to improving quality and outcomes in adult social care and

includes a number of outcomes with relevance to mental health. These are grouped within four areas, all directly relevant to the mental health objectives:

- promoting personalisation and enhancing quality of life for people with care and support needs;
- preventing deterioration, delaying dependency and supporting recovery;
- ensuring a positive experience of care and support; and
- protecting from avoidable harm and caring in a safe environment.

Examples of indicators of mental health outcomes for consideration by local commissioners

- 1.85 A number of indicators can be used to measure progress against local strategic needs assessments:
- One well-evidenced example for measuring adult mental wellbeing is the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), which is used, for example, in the North West of England.⁹⁹ The Health Survey for England now contains a WEMWBS, so data will also be available nationally.
 - The Office for National Statistics (ONS) is consulting on national measures of wellbeing. Disaggregation of the data to local area detail will be useful for local planning.
 - The Psychiatric Morbidity Surveys for adults and children can be used to estimate the rates of mental health problems such as anxiety and depression and conduct disorder, and also to monitor changes over time.
 - The General Health Questionnaire (GHQ-12) is also collected by the Health Survey for England.¹⁰⁰
 - The Labour Force Survey¹⁰¹ collects data on the sickness absence that is attributable to mental ill health.

Areas where fewer indicators are currently available

- 1.86 The main information gap is the need for more frequent and timely information on prevalence, such as that available from the Psychiatric Morbidity Surveys.

Quality Standards in development

- 1.87 Relevant standards already in development are:
- long-term conditions/people with co-morbidities/complex needs
 - drug use disorders in those aged over 16
 - alcohol dependence.

Useful information

The Role of Local Government in Promoting Wellbeing (November 2010), produced by Local Government Improvement and Development and the Department of Health, and researched and written by nef (the new economics foundation), examines how local government can support a better life for its citizens, to help build wellbeing and resilient communities, both now and in the long term. The work provides a useful resource for local health and wellbeing boards and for supporting local government's future lead role in public health and health improvement.

www.idea.gov.uk/idk/core/page.do?pagelId=23692693

The Mental Wellbeing Impact Assessment (MWIA) Toolkit is designed to facilitate the assessment and improvement of a policy, programme, service or project to ensure that it has a maximum and equitable impact on people's mental wellbeing. It can also be used to measure the impacts and outcomes of an intervention. The toolkit has been developed over the last seven years by a partnership of specialists and organisations. Like the Health Impact Assessment, the Mental Wellbeing Impact Assessment focuses on population groups that may experience health inequalities and social injustice, and has a particular emphasis on those most at risk of poorer wellbeing. It also focuses on enhancing control, resilience, assets, participation and inclusion. These dimensions of wellbeing are essential to achieving a wide range of social and economic outcomes. The toolkit has been used in over 450 programme projects and services, ranging from Liverpool, the European Capital of Culture in 2008, to TimeBanks and parenting programmes. The MWIA can help to:

- refocus efforts to create better existing and new services to improve mental wellbeing;
- develop a shared, coherent understanding of mental wellbeing with a range of stakeholders;
- ensure that policies, services, programmes or projects have a positive impact on mental wellbeing;
- actively engage all partners in service development and fostering co production of mental wellbeing; and
- support community needs assessment and the development of relevant and meaningful local indicators of mental wellbeing.

www.hiagateway.org.uk

Commissioning Mental Wellbeing for All (December 2010) was commissioned by the Department of Health and developed and published by the University of Central Lancashire. It is aimed at NHS, GP and local government commissioners and the voluntary sector to help improve local planning, delivery and commissioning of services to support improved mental health and wellbeing in the general population. www.nmhdu.org.uk/news/commissioning-wellbeing-for-all-a-toolkit-for-commissioners/

OBJECTIVE (ii): MORE PEOPLE WITH MENTAL HEALTH PROBLEMS WILL RECOVER

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

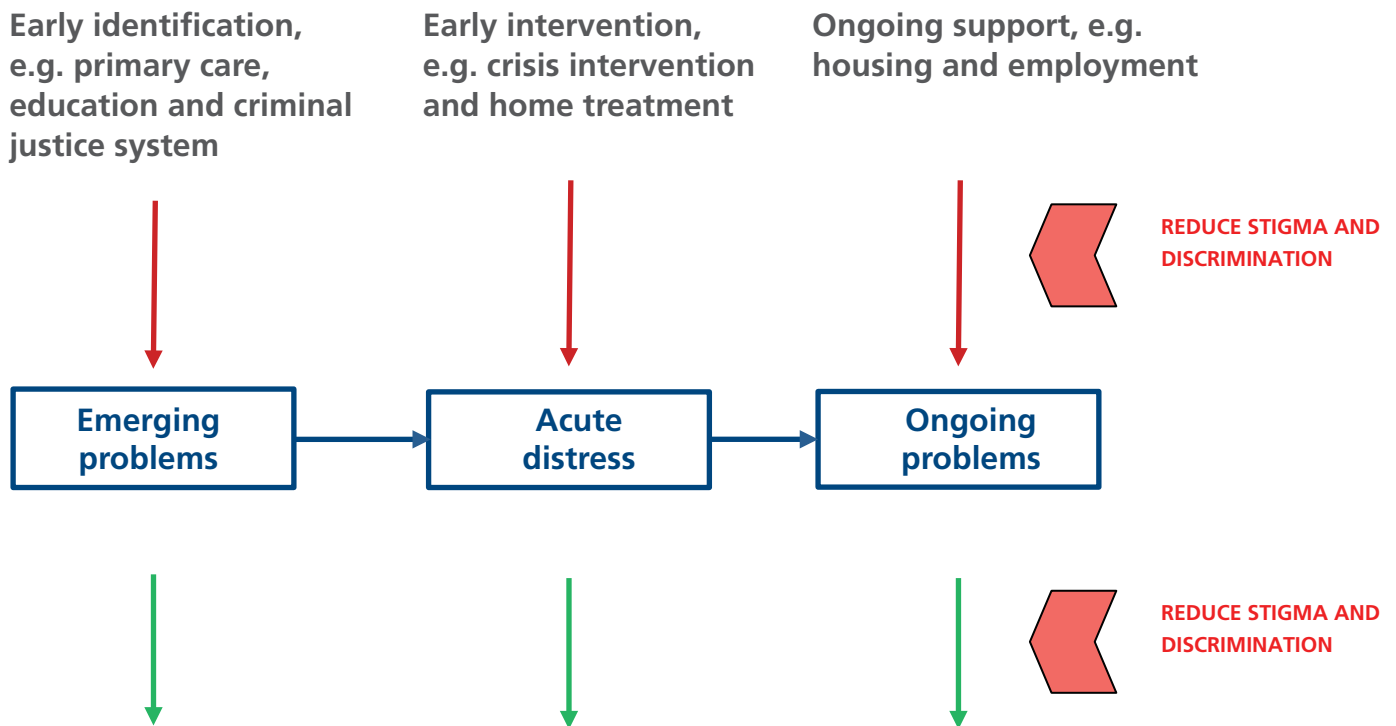
2.1 Mental health problems are common and vary in their nature and severity. Some people experience long-term and severely disabling effects; many people recover fully, including from severe mental health problems. There are many social and other determinants and consequences of mental health problems so we need approaches covering a broad range of outcomes – whether ‘psychological’, such as reduced distress, or ‘social’, such as employment and improved relationships and physical health.

2.2 The diagram on the next page shows, in a simplified way, some of the key stages someone with a mental health problem may experience as they progress along their care pathway to recovery.

2.3 Different approaches are required for children, young people and adults, although some interventions are effective in reducing distress and improving functioning across all age groups. Stigma and discrimination create barriers for people with mental health problems of all ages and their families and carers. The principles of the recovery approach, which emphasises the equal importance of good relationships, education, employment and purpose alongside reduction in clinical symptoms, apply equally to children and young people.

2.4 There are a growing number of effective approaches and National Institute for Health and Clinical Excellence (NICE) guidelines have outlined evidence-based interventions that cover the majority of mental health conditions and problems that people may experience over their lives. These include guidelines on schizophrenia (2009),¹⁰² borderline personality disorder (2008)¹⁰³ and many more.

INTERVENTIONS



Outcomes: reduced distress, improved social functioning, good relationships, education, skills, employment, purpose, good physical health, reduced risk of relapse

Emerging problems – this is in the very early phase, when someone may be feeling some distress either for the first time or as a recurrence of previous problems. Early intervention may prevent things becoming worse.

Acute distress – this is when the mental health problems have become more severe and distressing and may interfere with a person's

ability to function normally. Timely and effective interventions may rapidly reduce distress and enable people to resume their lives.

Ongoing problems – these occur if mental health problems persist for longer. If this happens people may require longer-term care and support to enable them to improve the quality of their lives.

Principles of high-quality care

These apply at all stages of care and support and there is an established consensus about what these are:

- putting the person at the centre and sharing decision-making – ‘No decision about me without me’ should be a governing principle in service design and delivery;
- early recognition of and intervention in problems in early year settings, schools, workplaces, primary care, acute health and social care settings and the criminal justice system;
- where appropriate, adopting a whole-family approach;
- equal and timely access to appropriate services and evidence-based interventions;
- proactive, assertive engagement, particularly with young people at higher risk (e.g. young people at risk of offending/offenders);
- single assessments that underpin continuity of care – using the principle of ‘ask once’;
- co-ordinated interventions planned around outcomes agreed by the user of the service, tailored to their individual needs, choices and preferences, with a recovery-based focus on building individual strengths and improving quality of life, including improvements in employment, accommodation and social relationships;
- co-ordination of care and support – using tools such as the Care Programme Approach;
- care in the least restrictive setting;
- sometimes treatment has to be delivered under the Mental Health Act without a person’s consent. Where that happens, it is important that the guiding principles in the Act’s Code of Practice be applied. That includes the least restriction principle: people taking action without a person’s consent must attempt to keep to a minimum the restrictions they impose on the person’s liberty;
- age and developmentally appropriate settings and approaches for children and young people, and adults of all ages;
- culturally appropriate integrated approaches that recognise mental health problems may often be complex and may co-exist with alcohol and illicit drug use;
- early intervention and other evidence-based interventions, including diversion delivered by high-quality services along a stepped pathway of care from primary to secondary services;
- involvement of family, friends and other carers; and
- good, clear information to inform people’s choices and decision-making.

Useful information

NHS Evidence, launched in 2009, is an online portal that allows everyone to access a wide range of information to help them deliver high-quality care.

www.evidence.nhs.uk

NICE guidelines on schizophrenia, depression and anxiety, eating disorders and other mental health conditions are all available at: www.nice.org.uk

Tackling emerging problems

2.5 We want to:

- improve recognition of mental health problems and access to evidence-based interventions in primary care and community services;
- improve early recognition and intervention for mental health problems in children and young people, including those in or at risk of moving into the youth justice system;
- intervene early in psychosis;
- improve identification of mental health problems or risk factors that result in poor outcomes in all criminal justice settings; and
- improve approaches to people with emerging and established personality disorder.

Improve recognition of mental health problems and access to evidence-based interventions in primary care and community services

2.6 About 90% of people with mental health problems are managed entirely in primary care. Ensuring that all people have access to effective primary health care is fundamental to improving the recognition and management of mental health problems. NICE evidence-based guidelines describe a co-ordinated, stepped-care approach for the management of mental health problems in primary, secondary and specialist

care.¹⁰⁴ Primary care is best placed to ensure that these guidelines are implemented effectively, both through the improved access to and provision of services at a primary care level and through effective commissioning of specialist mental health services.

Examples of effective local interventions

2.7 Improving access is an important first step in improving mental health care for everybody, but particularly for those at higher risk, including some black and minority ethnic groups, homeless people, people with low skills, asylum seekers and those in the criminal justice system. Improving access is about finding innovative ways of meeting the needs of those who may find the standard general practice systems difficult to use. Simple steps for improving access include offering variable lengths of appointment times or an outreach approach, such as holding sessions in community centres or hostels.

2.8 Improving the skills of primary care staff to enable them to recognise mental health problems early, deliver appropriate treatments in a primary care setting and refer on appropriately is fundamental. Healthcare professionals working in primary care are well placed to understand the relationship between physical health problems and mental health. Mental illness, such as depression, is associated with a 50% increased mortality and doubles the risk of coronary heart disease; furthermore,

having two or more long-term physical conditions increases the risk of depression seven-fold.¹⁰⁵

2.9 Improving the skills of primary care staff to enable them to recognise and manage both the physical condition and the mental health condition is recommended by NICE guidelines. These highlight the importance of a comprehensive approach to care, close to the patient's home. It is also important that primary care staff are alert to any mental health problems in the family – for example, a parent may be struggling in their role because of mental health difficulties, which has implications for their children. In such cases, staff should refer to local multi-agency family support services.

2.10 The World Health Organization recently published evidence-based guidelines that support the development of competence in diagnosis and management of mental health problems in non-mental health specialists. These guidelines are presented as flow charts in order to simplify the process of providing care in the primary healthcare setting.¹⁰⁶

2.11 As well as benefiting from training, primary care staff benefit from continuing support from mental health professionals. NICE guidelines¹⁰⁷ recommend a model called 'Collaborative Care' as being particularly effective for people with common mental health and long-term physical health conditions. An alternative model of care for those with predominantly

severe and enduring mental health problems involves regular liaison meetings between primary care and secondary mental health care staff. In both examples, it is the close working relationship with secondary care teams that provides improved confidence and skills to primary care staff, which enables them to deliver effective mental health care.

2.12 Improving the confidence of specialist mental health staff is also important. Closer working between primary and secondary care staff can also improve the confidence of specialist mental health staff in both preventing and intervening early with physical health problems. People with severe and enduring mental health problems are more likely to suffer significant physical health problems, and these are often complex. Having the support of primary care staff in the management of these people will ensure a comprehensive approach and improve outcomes.

2.13 A number of interventions can be delivered more speedily and closer to the person's home. Such interventions include smoking cessation services, guided self-help, exercise on prescription, support for remaining in or returning to work and a flexible range of psychological therapies (including those delivered via the talking therapies services). Accessible and timely services are more likely to be acceptable to people and, therefore, are more likely to be effective. Ensuring that a range

of services is available, within a planned system of care, is an important step in improving mental health services.

– for example, through behavioural difficulties.

Government actions to support local approaches

- 2.14 The delivery of psychological therapies has focused on the Improving Access to Psychological Therapies (IAPT) programme. This aims to offer those with depression and anxiety disorders evidence-based, NICE-approved therapies.
- 2.15 The Coalition Government is investing around £400 million over four years to make a choice of psychological therapies available for those who need them in all parts of England. This will expand provision to children and young people, older people, people with long-term physical health problems and those with serious mental illness. Details are in the supporting document, *Talking Therapies: A four-year plan of action*.

Improve early recognition and intervention for mental health problems in children and young people, including those in or at risk of moving into the youth justice system

- 2.16 Early identification and intervention for children and young people who are developing problems is critical – half of all lifetime mental health problems arise by the age of 14 and three-quarters by the mid-20s.^{108,109} Mental health problems may manifest themselves differently in children and young people

- 2.17 There is growing evidence that intervening early in conditions such as conduct disorder and psychosis can make a big difference to individuals, their families and society, across a wide range of outcomes.^{110,111} Some estimates suggest that a quarter to a half of mental health problems in adults could be averted with timely and effective interventions in childhood and adolescence.¹¹²
- 2.18 The supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health* outlines the economic case for effective intervention for conduct disorder. These approaches not only benefit the individual throughout their childhood and adulthood but also improve their capacity to parent, breaking the trans-generational inequality that can run through families.
- 2.19 Similar considerations apply to other evidence-based interventions for children and young people – for example, approaches to young people with depression, eating disorders and attention deficit hyperactivity disorder^{113,114,115} and for the effective detection and intervention for developmental disorders such as Asperger and Tourette syndromes.
- 2.20 There is growing evidence that a large proportion of crime is associated with conduct problems and disorder in

childhood and adolescence. Estimates suggest that as much as 80% of criminal activity can be attributed to people who had conduct problems when younger, at a cost of some £60 billion every year in England and Wales.¹¹⁶ A number of effective interventions for tackling conduct problems have been outlined under objective (i).

Examples of effective local interventions

2.21 A number of targeted interventions for supporting families and children who experience multiple and complex problems have been described under objective (i). In the youth justice system, liaison and diversion schemes have been piloted that seek to divert those who need it into appropriate treatment.

2.22 Early intervention for conduct disorder through individual parenting programmes can improve child behaviour, family relationships and educational outcomes, and reduce antisocial behaviour and crime.¹¹⁷ It also results in reduced mental illness and personality disorder in adulthood.

2.23 School-based prevention and intervention programmes for children with sub-threshold disorder can improve mental health, behaviour at school and at home, and social and academic skills.¹¹⁸

2.24 The Targeted Mental Health in Schools (TaMHS) programme, which has been rolled out to school clusters in all local

authorities in England, provides school-based early intervention and targeted mental health support for vulnerable children (aged 5 to 13) and their families. This can involve one-to-one work, group work or work with parents and carers. Schools and local areas report significant benefits from the TaMHS programme. Through the Early Intervention Grant (2011–14), local authorities will be able to support targeted mental health provision for vulnerable children and young people, and to sustain any services previously delivered through TaMHS.

2.25 Looked after children have a five-fold increased risk of mental health problems. See the box on p. 15 for further information.

Government actions to support local approaches

2.26 The talking therapies programme is being extended to children and young people. Up to 80% of adults with depression and anxiety disorders first experienced them before the age of 18.¹¹⁹ Developing the psychological resilience of children and young people was a core recommendation of the child and adolescent mental health services (CAMHS) review.¹²⁰ Competency frameworks and training plans, based on IAPT key principles and learning, are being drawn up to develop the psychological therapy skills of the CAMHS workforce and other partners.

Early intervention in psychosis

2.27 The last 10 years have seen the establishment of a specialised service model that provides evidence-based interventions for treating psychosis in the early phase and at a relatively young age (14–35 years old). There is an increasing body of evidence that supports this approach as more effective than the traditional generic community mental health team approach.^{121,122} This includes evidence that early intervention for psychosis results in a better course of illness, fewer symptoms at eight years old and a halving of the suicide rate. Early intervention also results in higher employment rates and a reduced risk of homicide. This approach has been developed further to include treatment at the earliest stage of psychotic illness (at-risk mental state). This approach has been shown to reduce rates of transition to full psychotic illness from 35% to 15%.¹²³ The supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health* has full details.

Improve recognition of mental health problems in criminal justice settings

2.28 Whether in custody or under community supervision, offenders experience many health inequalities. They typically have high health and social care needs combined with difficulty in accessing appropriate services. Being in the criminal justice system can provide an opportunity to engage with an otherwise vulnerable and socially excluded group.

2.29 Mental health is a particular issue for this group. Prisoners have been shown to have significantly higher rates of mental health problems than the general public. For example, 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems. Some may have complex problems, including personality disorder combined with another mental health problem, complicated further by alcohol and/or drug misuse.¹²⁴ Learning disability among offenders in the UK is thought to range from 1% to 10%.¹²⁵

2.30 A large proportion of crime is associated with conduct problems and disorder in childhood and adolescence. As noted in paragraph 2.20, estimates suggest that as much as 80% of criminal activity can be attributed to people who had conduct disorder when younger. Conduct disorder, before the age of 10, is associated with a 70-fold increased risk of imprisonment by the age of 25. Interventions such as parenting support are effective in improving outcomes and make good economic sense (see the supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health*).

2.31 While the long-term aim must be to meet the complex needs of offenders through mainstream services, there is a need to provide targeted interventions in the short term so as to address the specific needs of those with particularly

poor health outcomes. The focus of these interventions needs to be on ensuring that people are assessed and their health needs identified and addressed as early as possible in the offender pathway, including through prevention and early intervention. This can then inform subsequent decisions about where an individual is best placed to receive treatment. This will lead to improved health, and help to reduce the risk of reoffending, taking into account public safety, safety of the individual and the punishment of an offence.

Examples of effective local interventions

2.32 Improved diversion services. Effective diversion services in police custody suites and courts can help to identify people with mental health needs at an early stage, and support the diversion of offenders with mental health problems and learning disability from custody into community treatment. The Department of Health is identifying best practice for these services and supporting their expansion to every police custody suite and court. Similar diversion schemes have been piloted for children and young people. Offenders with personality disorder can also be identified at an early stage and diverted from prison to community management within a criminal justice pathway.

2.33 Timely transfer of prisoners. For those offenders who are already in prison and meet the criteria for detention under the Mental Health Act, it is vital

to secure timely transfer to inpatient care. It is equally important to ensure that the prisoner's remission pathway (or discharge, depending on individual circumstances), when treatment is no longer required, is timely and effective.

2.34 Improved commissioning. Primary care services for those in contact with the criminal justice system must be easily accessible, deliver continuity of care back into the community, offer choice and be responsive. They are best placed to identify and effectively meet the primary healthcare needs of offenders and their families, with the aim of improving health outcomes and reducing health inequalities and mortality associated with suicide and health-related offending. The Department of Health is scoping a possible transfer to the NHS of health services that are currently provided in police custody suites in support of this aim. More widely, it is also working to ensure that the needs of those in touch with both the adult and youth justice systems are fully reflected in emerging commissioning arrangements for the NHS by:

- raising awareness. The training of criminal justice staff in mental health and learning disability awareness contributes to the improved identification of offenders with mental health and learning disability issues at any point in the criminal justice system. Along with improved assessment processes, this will support health needs being picked up at

an early stage. Taking part in joint training can build links between the health and criminal justice sectors and promote understanding of the issues facing those with mental health problems;

- revising the offender mental health care pathway to clarify the range of services and interventions that should be available to people at each stage of their journey through the criminal justice system; and
- improving the use of the Care Programme Approach for individuals in custodial settings in order to ensure ongoing support and clear Care Plans across the criminal justice system and health and social care systems.

Government action to support local approaches

2.35 **The Ministry of Justice Green Paper** has confirmed the approach outlined in Lord Bradley's report.¹²⁶ The Department of Health, the Ministry of Justice and the Home Office are working with the NHS, which has funding and commissioning responsibility. We will identify a number of pilot projects that will help to shape best practice, quantify the benefits and develop appropriate Quality Standards. The areas targeted by these pilot projects will include young people. We will aim to complete this work by 2012 and, subject to an assessment of the success of the projects, roll out a national implementation programme.

Improve approaches to people with emerging and established personality disorder

2.36 **Personality disorders** are common conditions. People with complex problems may make frequent and chaotic use of primary care, A&E, mental health and social care services. This can generate huge costs and frustration, and the underlying problems can remain untreated. Some of the people in question are offenders and a small number are violent or dangerous.

2.37 Lack of access to early, community-based treatment and support can mean that young people with personality disorder graduate into institutional and secure care, and offenders continue to reoffend, with frequent spells in prison.¹²⁷

Examples of effective local interventions

2.38 **Improved identification and intervention for children and young people at risk of developing mental health and personality problems in adulthood.** CAMHS can establish robust methods of identifying children at risk of developing conduct disorders and adolescents who may have emerging personality disorder. This is critical given that, although there is good evidence for effective programmes, the last Office for National Statistics (ONS) survey results showed that only 25% of children and adolescents with conduct and emotional disorder are seen by CAMHS.¹²⁸ Multi-modal interventions, including cognitive

behavioural elements, can be effective for children of eight years and older where parent training programmes alone are not enough.

2.39 **Improving access to mental health services for people with personality disorder.** NICE guidelines¹²⁹ recommend the following:

- effective engagement and intervention for people with borderline personality disorder or emerging personality disorder by appropriate **secondary care** mental health services; and
- effective multi-disciplinary **specialist services** for people with personality disorder.

2.40 **Improving outcomes and reducing risk to others from offenders with personality disorder.** The NHS and the National Offender Management Service (NOMS) share responsibility for managing offenders with personality disorder. Effective services will be supported by:

- improved staff understanding and awareness of personality disorder across criminal justice settings; and
- effective inter-agency partnerships for delivering joint management of offenders with personality disorder.

Government actions to support local approaches

2.41 A new Offender Personality Disorder strategy has been agreed by the Ministry of Justice and the Department of Health. It focuses on men and women over the age of 18 who present a high risk of harm to others. It envisions joint lifelong management of this population group by NOMS through an integrated pathway, early identification and effective management in secure services, prison settings and in the community.

2.42 The Government is piloting Multisystemic Therapy (MST) for young people with severe conduct disorder. Some young people show signs of emerging difficulties at an early age, although it is not good practice to diagnose personality disorder before the age of 18. Some young people with severe conduct disorder may go on to develop antisocial personality disorder. NICE recommends MST for young people aged 12–17 years with severe conduct problems and a history of offending who are at risk of out-of-home placement in care or custody.¹³⁰ A randomised controlled trial is examining whether MST can effectively reduce these risks and improve family relationships.

2.43 The Government is rolling out educational and training programmes for staff groups across health, social care and criminal justice services. These will work directly or indirectly with people with personality disorder.

Tackling acute distress

2.44 However effective prevention and early intervention are, some people will still experience periods of acute mental distress. Four high-impact areas have been identified for improving outcomes for people in acute distress:

- delivering high-quality acute care;
- improving access to acute care for all homeless and other at-risk people;
- improving access to mental health services for homeless and other at-risk people; and
- improving mental health services for armed forces personnel.

Delivering high-quality acute care

2.45 Although acute care has improved considerably over the past decade, too many people still do not receive care where and when they need it. Episodes of acute distress sometimes require a period of inpatient care. People with severe mental health problems require high-quality care in the least restrictive environment. Commissioners must ensure that inpatient services are able to meet the particular needs of older people, who may have physical co-morbidities, and ensure that such services are not based on the assumption that 'one size fits all'.

Examples of effective local interventions

2.46 High-quality acute care services that promote recovery and inclusion are critical. The principles of high-quality acute care are widely accepted and are applicable across the age range (see also the Children's National Service Framework Standard 9, CAMHS).¹³¹

2.47 The Acute Care Declaration¹³² affirms that a number of key organisations will work together to achieve good-quality inpatient and community mental health services through:

- encouraging commissioning and provision of high-quality care;
- promoting recovery and inclusion;
- supporting a specialist acute care workforce; and
- championing positive perceptions of acute care services.

2.48 Work aimed at improving the quality of care and efficiency in acute care is being undertaken by a number of commissioner and provider organisations. The King's Fund and the Centre for Mental Health have recently published a joint report entitled *Mental Health and the Productivity Challenge*,¹³³ which looks at ways of delivering mental health services in a different and more cost-effective way.

Government actions to support local approaches

- 2.49 Guidance on supporting carers of people with acute and severe mental health problems has been published by the Princess Royal Trust for Carers and the National Mental Health Development Unit. *Triangle of Care – Carers included*¹³⁴ describes best practice in ensuring that carers are appropriately involved in the care planning process.
- 2.50 The Department of Health will review the models of service and practice for both health visiting and school nursing to ensure that these staff are properly equipped to manage their roles in identifying and supporting parents, infants, children and young people in need of support for their emotional or mental health. The Department will also work with key partners, including Health Education England, provider-based education networks and the Royal College of Nursing, to examine the skills and competencies required of CAMHS nurses.
- 2.51 As part of the work on Quality, Innovation, Productivity and Prevention (QIPP), the Department of Health has been working with a number of partner organisations to improve quality and efficiency in adult, and child and adolescent acute mental health care (see the supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health* for more details).

Improving access to mental health services for homeless people and other vulnerable groups

- 2.52 The causes of homelessness are complex. For some people homelessness may result from relationship breakdown, from leaving institutional care or because of financial difficulties. For some, mental health problems, which often go undiagnosed, can play a significant part. People who are homeless have 40 to 50 times higher rates of mental health problems than the general population.¹³⁵ Homeless girls and women have twice the rate of post-traumatic stress disorder (PTSD). Children in homeless families miss, on average, 55 school days a year – roughly a quarter. Housing is a key issue for prisoners and ex-offenders. A third of prisoners are homeless on entering prison, while a further third lose their accommodation because of their imprisonment. However, settled housing is associated with reduced reoffending.
- 2.53 Research by the Social Exclusion Task Force and the Department of Health has found that homeless people are 40 times less likely than the general population to be registered with a GP and five times more likely to use A&E.¹³⁶ Other vulnerable people in society who have high rates of mental health problems include:
- women in prostitution – 68% meet the criteria for PTSD, comparable with rates among victims of torture;

- sex workers – 45% report having experienced sexual abuse and 85% physical abuse within their families; and
- gypsies and travellers – their risk of anxiety is nearly three times higher than average and they are twice as likely to be depressed. Women in these communities are twice as likely as men to experience mental health problems.

Examples of effective local interventions

- 2.54 Improving access to primary care services is critical. Innovative approaches such as running primary care services in hostels and offering flexible appointment times may be helpful, as will other outreach approaches. Joint working between mental health services and alcohol and drug misuse workers ensures co-ordinated and timely responses to complex problems and the removal of barriers to accessing appropriate care. There is good practice to learn from, for example, practice followed by the New Directions Team in Merton.¹³⁷ Ready availability of practical support such as housing support, with appropriate ongoing support, is an essential aspect of all approaches.¹³⁸
- 2.55 Acute mental health services also have an important role to play in preventing homelessness, by ensuring that people are not discharged from hospital with nowhere to go. Being homeless can prevent people from recovering quickly

from their period of ill health, meaning they require further treatment and potential re-admission.

- 2.56 The Joint Strategic Needs Assessment (JSNA) and new health and wellbeing boards are key to ensuring that commissioning of primary healthcare services responds to the needs of local people, with a new requirement to tackle health inequalities. This will ensure that health services are designed to address the health needs of groups often previously excluded from primary healthcare services. The JSNA will bring together assessments of need, including on wider outcomes such as housing, to promote joint commissioning activity.

Government actions to support local approaches

- 2.57 Homeless people require good-quality housing to facilitate recovery and independent living. The Government is continuing its investment in the Places of Change programme in order to help to improve the quality of hostel accommodation, and help providers to deliver more appropriate services to rough sleepers, with the aim of helping them to make the transition into a settled home, training or employment.
- 2.58 **The Inter-Ministerial Working Group on Preventing and Tackling Homelessness** brings together relevant government departments to share information, resolve issues and avoid unintended policy consequences. Such

a co-ordinated, multi-agency approach is the best way to tackle the multifaceted issues that contribute to homelessness.

- 2.59 The Department of Health is working to improve the outcomes of vulnerable groups through the Inclusion Health Programme. A national Inclusion Health Board is being established, whose key role is to champion the needs of the most vulnerable and to address health inequalities among the most disadvantaged. Information on gypsy, Roma and traveller communities can be found at:
www.webarchive.nationalarchives.gov.uk/20090617170011/pcc.nhs.uk/204.php

Improving mental health services for ex-service personnel

- 2.60 The Government is committed to the health and welfare of people serving in the armed forces, both during and after their time in service. This is part of rebuilding the **Military Covenant**, which is the basis for government policy aimed at improving the support available for the armed forces community. Mental health services have a key role to play in fulfilling this Covenant.
- 2.61 The great majority of the five million ex-service personnel and the 180,000 personnel serving in the UK armed forces do not experience mental health problems, either when they are serving or afterwards. However, some do

experience mental health problems and require timely and effective interventions.

- 2.62 For serving personnel, the Ministry of Defence (MoD) provides a comprehensive mental health service with support from a consortium of NHS mental health trusts for those who require inpatient care. The MoD is also devising strategies for stigma reduction and managing alcohol consumption for serving personnel. Stress management programmes exist to support troops before, during and after operational deployment.
- 2.63 The MoD also provides a Medical Assessment Programme for those recently discharged and a Reserves Mental Health Programme for those who combine military and civilian careers.
- 2.64 When individuals leave the armed forces, their healthcare needs become the responsibility of the NHS. For the great majority, that works well. However, for some veterans extra provision is needed because of their reluctance to seek help or because of difficulties navigating civilian health systems.
- 2.65 Models of how to provide this additional help were initially investigated through six mental health pilots put in place by the MoD/NHS. A number of different models were piloted. An initial evaluation suggested that either appointing a dedicated veterans therapist in every trust, or training

front-line staff in military culture, improved veterans' access to services and achieved comparable outcomes to those achieved with the civilian population.

2.66 These community-based mental health services continue to operate beyond the trial period and the findings will allow all other mental health services to fulfil the expectation of the NHS Operating Framework, which is that they will make special provisions for veterans during 2011/12.

2.67 To facilitate this, the Government has committed further resources in order to work with our strategic partners in ensuring the best treatment possible for veterans with mental health problems. The focus is on the following areas:

- creating more posts for veterans therapists in NHS trusts;
- exploring the use of online counselling services;
- extending the hours of the Combat Stress helpline so that it functions 24 hours a day, seven days a week;
- providing training to GPs and other NHS staff who may come into contact with veterans with mental health needs; and

- raising awareness among veterans themselves about services available to those with mental health problems.

2.68 The veterans therapists will:

- provide direct clinical services within their capabilities;
- refer people to specialist services within the trust and elsewhere;
- create and maintain links with service charities and MoD mental health services; and
- provide advice to the trust on military issues and culture.

2.69 The Department of Health has also provided grant funding to Combat Stress to enable it to work directly with mental health trusts and ensure that the services they provide are accessible to and appropriate for veterans. This involves making clinical appointments, with postholders having clinical accountability to the NHS and managerial accountability to Combat Stress.

2.70 In addition, a number of sites involved in the IAPT programme have taken a special interest in veterans and are tailoring their services to take veterans' needs into account.

2.71 There is a perception that veterans are over-represented in the prison population. However, recent data¹³⁹ have not borne out this assumption. Nevertheless, the development of a network of prison officers with an interest in the welfare of veterans is welcome and mental health trusts providing services into prisons will make special provision for veterans where this is appropriate.

Tackling ongoing problems

2.72 Some mental health problems leave a longer shadow after the acute phase is over. Outcomes for people with longer-term mental health problems can be improved through:

- sound principles of high-quality care;
- better quality specialist services;
- improved personal outcomes, including improved relationships, education, confidence, employment and purpose; and
- stable and appropriate housing.

Sound principles of high-quality care

2.73 The principles of high-quality, recovery-focused care are:

- **hope** – increasing sense of optimism and hope for the future;
- **agency** – increasing the control that people with mental health problems have over their symptoms, personal goals and lives; and
- **opportunity** – increasing opportunities for people with mental health problems to lead meaningful and independent lives, to be included and participate fully in the wider community, and to gain employment.¹⁴⁰

Examples of effective local interventions

2.74 A number of approaches can help people to receive care that is self-directed as far as is possible so that they can achieve their preferred goals and outcomes.

Recovery-focused principles

The three principles of high-quality care listed above have been converted into a set of 10 service level indicators ('organisational challenges') that describe the key features of organisational practice that are necessary for supporting the recovery of people using these services. A project is currently being delivered as a partnership between the Centre for Mental Health and the NHS Confederation to test the effectiveness of this framework in assisting services to undertake self-assessments against these indicators and then plan changes and evaluate progress. Initial results will be available within the next 12 months.

Peer professionals

One way for people with mental health problems to participate effectively in paid employment is as direct care staff in mental health services. Although controlled trial evaluations are not yet available in the UK, there is potential for improved quality of care and resource savings – in terms of both service outcomes (reduced bed days) and overall costs – from using the expertise of people with lived experience of mental health problems in the workforce. This is a radical development of the recovery approach that has been shown to be feasible¹⁴¹ and is widely used in the USA. One such study¹⁴² reported that weekly one-to-one peer support sessions reduced readmissions for a group with co-morbid mental illness and substance misuse in a matched control study. In Australia, peer support services have been found to significantly reduce bed days and readmission rates.¹⁴³

Better quality specialist services

2.75 A number of specialist services have been developed in mental health care and several are supported by NICE clinical guidelines – for example, services for eating disorders and perinatal mental health disorders.¹⁴⁴

Secure services

2.76 Mental health secure services provide treatment for people whose mental health disorders mean that they are at significant risk of harming themselves or others. Many of these patients will be detained under the Mental Health Act. Many, but not all, will be convicted offenders.

2.77 In 2009/10, approximately £1.2 billion was spent on secure mental health care. This corresponds to 18.9% of all public expenditure on adult mental healthcare¹⁴⁵ and is an increase of 141% in real terms since 2002/03. This rapid expansion of spending needs to be stabilised and efficiency improved. This means considering how to better balance public protection, the need to spend taxpayers' money wisely and the rights and needs of individual patients. For further information, see the supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health*.

2.78 The most effective way to reduce need for secure care is through early intervention when disorders first appear, and by effective interventions so that the numbers of people who progress to needing secure services are reduced. But once people need secure care, good-quality care can be delivered by:

- clearly agreed outcomes and accountabilities for services as part of a national approach;
- daily decisions about individuals' treatment taken by their clinicians, within clear guiding principles on quality of care and security;
- improved joint decisions and arrangements within and across NHS and criminal justice system pathways;
- working with communities in order to improve public perception and understanding of risk and positive outcomes for patients;
- ensuring that information, intelligence and risk assessment are high quality, up to date and shared with others who need to know; and
- ensuring that services focus on supporting people to move on to the right care at the right time by having effective care management arrangements across services.

2.79 In addition, as part of QIPP, commissioners are focusing on improving quality and efficiency in medium secure mental health services.

Improved personal outcomes, including improved relationships, education, confidence, employment and purpose

2.80 People with mental health problems want effective interventions and approaches. They also want the same things as all of us in their lives: healthy, positive relationships; access to education, employment and meaningful activities; secure, decent housing; and financial security.

Relationships

2.81 The talking therapies programme will improve access to treatment for people with co-morbid depression and severe and enduring mental illness under the care of community mental health teams or inpatient settings. Psychological approaches can help individuals to understand themselves and their relationships better.

Education and employment

- 2.82 Having a purpose in life and being employed can protect people's mental health and wellbeing. Employment is an important part of many people's recovery from mental health problems. People with mental health problems have the lowest employment rate of any disability group, yet the overwhelming majority want to work, and, with the right support, many can. Only 30% of specialist mental health service users are in paid work or full-time education.¹⁴⁶ For some people the onset of mental health problems in childhood or early adulthood may have adversely affected their chances of gaining qualifications and skills that help to establish a career path.
- 2.83 Stigma and discrimination may be another barrier to employment, as can the low expectations held by health, social care and other staff, and indeed the person with mental health problems themselves.
- Examples of effective local interventions*
- 2.84 More can be done to embed employment and education in people's care pathways. Proven effective vocational support and skills development services exist, including talking therapies in primary care and Individual Placement and Support in secondary care services. Informal adult learning programmes offer an introduction to learning in a friendly, non-threatening environment that can enable people with mental health problems to progress, in time, to more structured opportunities and sustainable employment.
- 2.85 Employers in all sectors, including the public sector, can play an important role in supporting the health and wellbeing of their staff by providing healthy workplaces which support their employees' mental health and wellbeing.¹⁴⁷
- 2.86 Employment can also be an important part of many people's recovery from mental health problems. People with mental health problems can and do work – and supporting them to do so can save employers significant costs of staff turnover, under-performance and untapped potential. There is a significant amount of guidance available on what employers can do to help people with mental health problems to stay in, return to and perform well at work – often these are simple, low-cost and common-sense interventions.¹⁴⁸
- 2.87 High-quality employment support will be geared towards meeting individuals' employment needs. Some individuals will be able to obtain or retain employment with 'light touch' support. A fundamental principle is that

individuals are supported so that they can take action themselves where they can. This support may be provided by organisations such as Jobcentre Plus or other employment providers. The quality of their support will be helped by effective relationships with health service providers. Other individuals will need long-term rehabilitation in order to progress to employment. Progress is the key, and should be a benchmark of provision. High-quality employment support will also be based on an appropriate understanding of psychology and work, including the importance of:

- confidence in returning to and retaining work;¹⁴⁹
- employers' and individuals' beliefs that the individual can perform the job and that their condition is manageable in the workplace;
- the relationship between appropriate work and wellbeing; and
- the need for employers to make appropriate recruitment decisions and manage workplace health.

Government action to support local approaches

2.88 A new **Responsibility Deal** with industry, and non-governmental and other organisations will look at ways of improving the health and wellbeing of the working-age population in order to enable people to remain in employment and return to work after a period of illness.

2.89 As one of the world's largest employers, the NHS is leading the way through, for example, implementing Dr Steven Boorman's recommendations¹⁵⁰ for improving staff health and wellbeing.

2.90 The Department for Work and Pensions is developing a reformed Welfare to Work programme, ensuring that work always pays, by replacing existing means-tested working-age benefits with a single Universal Credit. Existing support will be consolidated into a new integrated Work Programme to provide help for people to move into work. The new Work Programme will operate a differential funding model which will provide additional support for people who have traditionally been harder to help – including mandatory Employment and Support Allowance claimants, and claimants who were recently in receipt of Incapacity Benefit.

2.91 Programmes to help people include Work Choice; this will help disabled people with complex barriers to employment to find and stay in work (including self-employment). Access to Work also provides financial support for individuals and employers, allowing them to make adjustments so that people with health conditions can remain in work. Reforms launched in December 2010 have allowed people to receive an indicative decision on their eligibility for the scheme before applying for a job. The Government has asked Liz Sayce, chief executive of the Royal Association

for Disability Rights (RADAR), to conduct an independent review of specialist disability employment programmes. The review, due to report in summer 2011, will evaluate current specialist disability employment programmes, and make recommendations for future strategy.

- 2.92 Cross-government action is also helping people to stay in work. Our innovative Fit for Work Service pilots are multi-disciplinary projects delivered by local providers, focusing on early intervention and designed to get workers who are off sick back to work faster and to keep them in work. The programme is being evaluated and the results will enable us to determine what works and in what circumstances.
- 2.93 The Government is committed to delivering a coherent learning, skills and employment offer that meets the needs of individuals and promotes economic growth. This includes the vital role of careers guidance in increasing confidence, motivation and the desire to succeed, and the need for mental health service providers to work collaboratively with local learning providers.
- 2.94 The Government will also shortly be consulting with business on extending to all employees the right to request flexible working, which will help carers of people with mental health problems to manage their caring role alongside work.

Stable and appropriate housing

- 2.95 Housing is important to people who use mental health services,¹⁵¹ and to carers.¹⁵² Secure housing facilitates recovery and independence, and underpins a high quality of life. But too often people become stuck in costly and inappropriate residential care or out-of-area placements, or their discharge from psychiatric hospital is delayed because of lack of appropriate housing.¹⁵³

Examples of effective local interventions

- 2.96 The JSNA is a key mechanism for joint action at local level in order to identify housing needs and ensure that housing provision is available to meet the range of needs. Local housing data can be drawn from the Supporting People programme, the Housing Health and Safety Rating System, the Mental Health Minimum Dataset, homelessness data, and housing and support providers.

Government action to support local approaches

- 2.97 Government action to prevent homelessness is described earlier in this section.

Objective (ii): outcome indicators

- 2.98 Recovery in mental health is different from, although related to, clinical recovery. Recovery is unique to each individual and defined by them. It includes reduction in distress, improved mental and physical health and wellbeing, and improvement in functioning. It may include improved relationships, returning to education or gaining employment. Recovery applies to the whole spectrum of mental health problems, from one-off episodes of anxiety and depression to longer-term difficulties. As recovery includes improvement in many dimensions, there is no ideal single instrument to measure it. It can be difficult to compare the progress of different individuals, as recovery means different things to different people.
- 2.99 However, it is important to try to capture all the elements of recovery and measure progress at individual, team and service levels. *The Outcomes Compendium: Helping you select the right tools for best mental health care practice in your field* summarises many of the measures currently available for use in different mental health settings.¹⁵⁴
- 2.100 The Recovery Star¹⁵⁵ is an example of a tool that can measure individual progress towards recovery, as defined by the user. It comprises 10 domains, or outcome areas, including living skills, relationships, work, and identity and self-esteem. Service users set their personal goals within each domain and measure over time how far they are progressing towards these goals. This can help them to identify their goals and what support they need to reach them. The Recovery Star can also be used to demonstrate to commissioners that service users are getting the right outcomes from the services they fund.
- 2.101 The Health of the Nation Outcome Scales (HoNOS) are also a useful, easily applied outcome measure that is being used in the Payment by Results pilots. It is therefore increasingly used across most mental health services. Its use is mainly restricted to those with severe and enduring mental illness.
- 2.102 Although recovery is unique to each individual, employment and education, secure accommodation, physical health and living independently are generally seen as important aspects of recovery for most adults. Indicators for measuring improvements in these areas have been selected to measure progress at a local and national level in the NHS, Public Health and Adult Social Care Outcomes Frameworks.

2.103 In the NHS Outcomes Framework, the term ‘recovery’ is used principally to mean clinical recovery. However, the framework does recognise that employment and good physical health are important outcomes for people with mental health problems.

2.104 The NHS Outcomes Framework describes a number of national-level outcome goals that the Secretary of State for Health will use to hold the NHS Commissioning Board to account, and that are relevant to recovery. These include:

Domain 2: Enhancing quality of life for people with long-term conditions

Improvement areas

Enhancing quality of life for people with mental illness

Indicator is:

- employment of people with mental illness.

Enhancing quality of life for carers

Indicator is:

- health-related quality of life for carers (EQ-5D).*

* EQ-5D is a trademark of the EuroQol Group. Further details can be found at www.euroqol.org

Domain 3: Helping people to recover from episodes of ill health or following injury

Overarching indicator

- emergency readmissions within 28 days of discharge from hospital.

The Adult Social Care Outcomes Framework

2.105 *Transparency in Outcomes: A framework for adult social care*, published in parallel with *A Vision for Adult Social Care*, sets out a new strategic approach to quality and outcomes in adult social care, including new use of evidence-based Quality Standards in social care, a greater emphasis on transparency in local services, and work to reform the shared datasets which demonstrate the outcomes achieved. Proposals are subject to consultation, and include a set of

outcome measures which could be used initially from April 2011.

2.106 The initial Adult Social Care Outcomes Framework sets out a number of available measures, many of which have relevance to mental health. As with the NHS and public health partners, the outcomes are grouped into four proposed domains, all directly relevant to the mental health objectives:

- promoting personalisation and enhancing quality of life for people with care and support needs;

- preventing deterioration, delaying dependency and supporting recovery;
- ensuring a positive experience of care and support; and
- protecting from avoidable harm and caring in a safe environment.

2.107 Of the specific outcome measures highlighted, many would be relevant to mental health. As well as confirming which of these have sufficient support

to be used nationally, the consultation process is also expected to identify gaps in current data collections, so that further work can improve the Outcomes Framework over future iterations.

2.108 The framework deals directly with recovery under Domain 2, where a number of outcome measures are shared with the NHS Outcomes Framework to promote shared approaches to common areas:

Domain 2: Preventing deterioration, delaying dependency and supporting recovery

Overarching measures

- emergency readmissions within 28 days of discharge from hospital*
- admissions to residential care homes, per 1,000 population.

Outcome measures

Helping older people to recover their independence

- the proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into reablement/rehabilitation services.

Preventing deterioration and emergency admissions

- emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over-75s.*

(This indicator is relevant to recovery because of the close links between physical and mental health in older people.)

Supporting recovery in the most appropriate place

- delayed transfers of care.*

Delivering efficient services which prevent dependency

- the proportion of council spend on residential care.

* Measures drawn from NHS or other non-council data sources.

2.109 It is recognised that looking at employment does not capture information about older people with mental illness, nor does it include children and young people. For older people with mental illness, there are currently no suitable indicators for measuring outcomes, and the Department of Health will be looking to develop these over time, particularly focusing on how well the NHS is supporting those with dementia.

2.110 To ensure that outcomes for children and young people with mental illness are fully reflected within the NHS Outcomes Framework, we will look at developing an indicator for measuring outcomes for this group. We are also examining the feasibility of using the EQ-5D-Y,* as a measure of health status for young people with long-term conditions in general.

2.111 The Public Health Outcomes Framework includes a number of indicators that are relevant to the recovery of functioning in people with mental health problems:

Domain 2: Tackling the wider determinants of ill health: tackling factors that affect health and wellbeing

Proposed indicators

- first-time entrants to the youth justice system
- proportion of people with mental illness and/or disability in employment* **
- proportion of people with mental illness and/or disability in settled accommodation**
- reduction in proven reoffending.

* Shared responsibility with the NHS.

** Shared responsibility with Adult Social Care.

Domain 3: Health improvement: helping people to live healthy lifestyles and make healthy choices

Proposed indicators

- rate of hospital admissions per 100,000 for alcohol-related harm
- number leaving drug treatment free of drug(s) of dependence
- hospital admissions caused by unintentional and deliberate injuries to 5–18-year-olds.

* EQ-5D-Y is a version of the EQ-5D tool developed specifically for children over seven years of age. More information is available at: www.euroqol.org

Domain 4: Prevention of ill health: reducing the number of people living with preventable ill health

Proposed indicators

- hospital admissions caused by unintentional and deliberate injuries to under-5-year-olds
- work sickness absence rate
- rate of hospital admissions as a result of self-harm
- emergency readmissions to hospitals within 28 days of discharge* **
- health-related quality of life for older people.**

* Shared responsibility with the NHS.

** Shared responsibility with Adult Social Care.

More detailed indicators that the NHS Commissioning Board may wish to consider for holding local commissioners to account in meeting the NHS Outcomes Framework and for assessing progress

2.112 Talking therapies services already regularly measure outcomes of interventions and access to services by different groups. Older people may not be referred for such interventions. Potential indicators, therefore, include:

- the proportion of those receiving talking therapies who are assessed as moving to recovery by the end of their treatment;
- the proportion of those receiving talking therapies who are over 65;
- the proportion of older people receiving talking therapies who are assessed as moving to recovery by the end of their treatment;
- the proportion of those with a severe mental health problem who are in settled accommodation;
- the proportion of those with severe mental illness who have started a new spell of care and who are assessed by HoNOS as improved after six months or improved on discharge if care ends earlier;
- aligning the General Practice Serious Mental Illness Quality and Outcome Framework (QOF) registers and Care Programme Approach registers in mental health providers (currently this is low in some areas); and
- the percentage of people identified with long-term serious mental illness (SMI) or dementia on QOF SMI registers in comparison with expected/calculated local prevalence.

Examples of indicators of mental health outcomes for consideration by local commissioners

2.113 Local commissioners will also want to ensure that they have indicators that can demonstrate better outcomes across the full range of mental health problems and all the dimensions of recovery. They will also wish to know that outcomes are improving across all ages and groups of people in their communities.

2.114 Examples of indicators include:

- the number of inpatient stays by main diagnostic categories which last longer than a national benchmark level;
- the proportion of those receiving specialist care for depression who show improvements on the measure PHQ 9 (Personal Health Questionnaire Depression scale, or for children and young people the Moods and Feelings Questionnaire) after six months' care (or less);
- the proportion of those with first onset psychosis who are taken on by early intervention services as a proportion of locally assessed incidence; and
- the average duration of untreated psychosis.

Areas where there are fewer indicators currently available

2.115 Consideration will need to be given to more robust and systematic data collection across all outcomes and indicators in relation to protected characteristics.

2.116 The NHS Outcomes Framework will be developed over time to include indicators that cover the full spectrum of mental health problems and recovery in primary, secondary and specialist care.

2.117 Focusing entirely on burden of disease or mortality excludes children and young people. The Government is committed to ensuring that outcomes for children and young people are fully reflected in the NHS Outcomes Framework as it develops to reflect advances in practice and data collection.

2.118 Other areas that may be considered include:

- measures of high-quality transition between services;
- improvement of function in older people that is not reliant on employment, for example non-paid employment or learning; and
- proportion of families with a child who has conduct disorder receiving evidence-based intervention.

Quality Standards in development

2.119 There are several Quality Standards in development:

- schizophrenia
- alcohol dependence
- depression in adults
- long-term conditions/people with co-morbidities/complex needs
- bipolar disorder in adults
- bipolar disorder in children and adolescents
- drug use disorders (over-16s)
- postnatal care.

OBJECTIVE (iii): MORE PEOPLE WITH MENTAL HEALTH PROBLEMS WILL HAVE GOOD PHYSICAL HEALTH

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

3.1 Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50%¹⁵⁶ and doubles the risk of coronary heart disease in adults.^{157,158} People with schizophrenia and bipolar disorder die on average 16 to 25 years sooner than the general population.^{159,160} They have higher rates of respiratory, cardiovascular and infectious disease and have higher rates of obesity, abnormal lipid levels and diabetes.¹⁶¹ They are also less likely to benefit from mainstream screening and public health programmes.

3.2 Children with early conduct disorder have been shown to have poorer physical health and reduced life expectancy.¹⁶² Obesity is associated with reduced wellbeing and disproportionately affects people with mental illness and learning disability.

3.3 *Healthy Lives, Healthy People* highlights the links between smoking and raised morbidity and mortality rates in the general population and confirms that smoking is the largest cause of

preventable death in the UK. It is responsible on average for a 10-year reduction in life expectancy. People with mental health and substance misuse problems are more likely to smoke and to smoke more heavily and, as a consequence, experience even greater smoking-related harm. Smoking is, therefore, responsible for the largest proportion of health inequality in people with mental health problems.

3.4 Some 70% of psychiatric inpatients smoke compared with 21% of the general population.¹⁶³ Furthermore, those with mental disorder consume 42% of all tobacco consumed in England.¹⁶⁴

3.5 Adolescents with conduct disorder are six times more likely to smoke, and those with emotional disorder are four times more likely to smoke than their peers. Together they account for 43% of all smokers under the age of 17.¹⁶⁵

3.6 Smoking is also associated with increased risk of developing mental disorder.¹⁶⁶

3.7 Stopping smoking results in improved mental health, reduced depressive symptoms, lower required doses of some

psychiatric medications and reduced financial stress.¹⁶⁷ Stopping smoking also reduces the risks of developing physical illness, increases life expectancy and may play a role in preventing mental illness. Although smokers with mental illness are just as motivated to stop as the general population,¹⁶⁸ they are less likely to be offered cessation support. Effective interventions for those with mental health problems are fundamentally similar to those for the general population but with additional monitoring.

3.8 Mental health problems are also much more common in people with physical illness. People with diabetes, hypertension and coronary artery disease have double the rate of depression compared with the general population. They are also at risk of developing vascular dementia. Those with chronic obstructive pulmonary disease, cerebrovascular disease and other chronic conditions have triple the rate of depression. People with two or more chronic physical conditions are seven times more likely to have mental health problems. Having both physical and mental health problems delays recovery from both conditions.¹⁶⁹

3.9 Delirium is a life-threatening mental health condition particularly affecting older people. People with dementia are at high risk of developing delirium.

3.10 Children with a long-term physical illness are twice as likely to suffer from emotional problems or disturbed behaviour.¹⁷⁰

Examples of effective local interventions

3.11 Primary care services are central to effective integration of care across physical and mental health services. Collaborative Care approaches can improve the management of both the mental health problem and the physical health condition.¹⁷¹

3.12 Many of the indicators for increased risk of physical illness such as obesity and smoking are present early in life. This allows opportunities to intervene early to promote healthy lifestyles and reduce health risk behaviours, in order to prevent future ill health.

3.13 Smoking cessation programmes can improve mental health, reduce depression and anxiety and reduce levels of medication needed by people with severe mental illness. Ensuring that people with mental health problems who smoke are identified and supported to stop smoking through, for example, improved access to smoking cessation programmes is critical. Targeting people with mental health problems to reduce smoking could significantly reduce health inequalities. Awareness raising and training of both primary and secondary healthcare staff (including mental

health workers) in smoking cessation approaches could contribute significantly to this reduction. Smoking usually starts before adulthood, so programmes aimed at stopping young people taking up the habit are also needed. Models have been developed for managing the mental health needs of people with physical conditions in primary and secondary care. Specialist programmes can help people recovering from mental illness to lose weight. Physical activity improves not only sub-threshold depression but also mild and moderate depression and improves wellbeing.¹⁷²

- 3.14 Health professionals working with children with physical health needs may benefit from training in the assessment of emotional and mental health needs and referral to appropriate treatment. The Royal College of Psychiatrists' curriculum for child mental health states that fully trained paediatricians should: '... understand the impact of illness on mental functioning, for both children, young people and their parents and the effect of each upon behaviour and functioning of the other', '... be able to manage and know how to obtain support for the consequences of chronic illness for a child, young person and their family' and '... understand the responsibility of paediatricians to consider all aspects of a child's wellbeing including biological, psychological and social factors'.

- 3.15 Psychological therapies have been shown to improve outcomes for people of all ages with long-term physical conditions and mental health problems and for those with medically unexplained symptoms. Integrating talking therapies into the care pathways for people with these conditions will improve outcomes and has the potential to reduce costly use of NHS resources. The supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health* has further details.

- 3.16 Sexual health risk behaviour is associated with mental ill health and lower levels of wellbeing. Sexual health education programmes are as effective in those with mental health problems as the general population.¹⁷³

Useful information

The Mental Health in Primary Care forum has developed guidance on medically unexplained symptoms. This has been endorsed by the Royal College of General Practitioners and the Royal College of Psychiatrists.
www.rcgp.org.uk/mental_health/resources.aspx

Government actions to support local approaches

- 3.17 The Department of Health is supporting an integrated approach to people of all ages with long-term conditions and medically unexplained symptoms in all settings. They are integrating initiatives

between mental health, long-term conditions, children and families, and across disease-specific areas. Evidence of cost-effective approaches and good practice models will be disseminated. The talking therapies programme is being expanded to include access to appropriate treatments for people with long-term conditions and medically unexplained symptoms.

with serious mental illness is an important area in both.

3.19 The NHS Outcomes Framework Domain 1 includes as an indicator the under-75 mortality rates in people with serious mental illness.

3.20 The Public Health Outcomes Framework proposes a number of national level indicators. The indicators with particular relevance to mental health are:

Objective (iii): outcome indicators available nationally and locally

3.18 The NHS and Public Health Outcomes Frameworks both have indicators that link directly to this high-level objective. Reducing premature death in people

Vision: To improve and protect the nation's health and wellbeing and to improve the health of the poorest fastest

Proposed indicators

- increasing healthy life expectancy
- reducing the differences in life expectancy and healthy life expectancy between communities and groups, for example people with mental health problems.

Domain 1: Health protection and resilience: protecting the population's health from major emergencies and remaining resilient to harm

Proposed indicator

- comprehensive, agreed, inter-agency plans for a proportionate response to public health incidents are in place and assured to an agreed standard.

Domain 2: Tackling the wider determinants of ill health: tackling factors which affect health and wellbeing

Proposed indicators

- children in poverty
- truancy rate
- school readiness: foundation stage profile attainment for children starting Key Stage 1

- first-time entrants to the youth justice system
- proportion of people with mental illness and/or disability in employment* **
- proportion of people with mental illness and/or disability in settled accommodation**
- incidents of domestic abuse**
- statutory homeless households
- housing overcrowding rates
- fuel poverty
- access and utilisation of green space
- older people's perception of community safety**
- rates of violent crime, including sexual violence
- reduction in proven reoffending
- social connectedness
- the percentage of the population affected by environmental, neighbour and neighbourhood noise.

* Shared responsibility with the NHS.

** Shared responsibility with Adult Social Care.

Domain 3: Health improvement: helping people to live healthy lifestyles and make healthy choices

Proposed indicators

- smoking prevalence in adults (over 18)
- rate of hospital admissions per 100,000 for alcohol-related harm.

Domain 4: Prevention of ill health: reducing the number of people living with preventable ill health

Proposed indicators

- maternal smoking prevalence (including during pregnancy)
- smoking rate of people with serious mental illness
- screening uptake of national screening programmes
- uptake of the NHS Health Check programme by those eligible.

Domain 5: Healthy life expectancy and preventable mortality: preventing people from dying prematurely

Proposed indicator

- mortality rate of people with mental illness.*

* Shared responsibility with the NHS.

More detailed indicators that the NHS Commissioning Board may wish to consider

3.21 These include indicators that are already available in the Quality and Outcomes Framework:

- the proportion of people with serious mental illness who have a physical health review annually; and
- the proportion of people with diabetes who are screened for depression.

3.22 Indicators that could be considered for further development include:

- rates of identification and treatment of mental health problems in people with acute ill health in acute settings;
- mortality rates by different physical health diagnoses for people with serious mental illness;
- the number of people with a long-term condition and anxiety and/or depression or with medically unexplained symptoms who are offered psychological therapy; and
- smoking rates among those with common mental disorder.

Examples of indicators of mental health outcomes for consideration by local commissioners

3.23 Locally, a number of possible indicators can be developed, such as:

- access to screening and smoking cessation programmes for people

with mental health problems and cessation rates for those completing programmes; and

- use of hospital beds and access to psychological therapies by people with medically unexplained symptoms.

Areas where there are fewer indicators currently available

3.24 Consideration will need to be given to more robust and systematic data collection across all outcomes and indicators in relation to protected characteristics.

3.25 Data on the mortality rate of people with mental health problems are potentially available at primary care trust level but these will not capture the impact of new approaches for some time so are not ideal for holding local services to account. A proxy/intermediate indicator would be helpful.

3.26 Relevant indicators are needed for different ages for measuring change in both the level of physical ill health in those with mental illness and the level of mental health problems in those with physical ill health.

Quality Standards in development

3.27 Relevant standards already in development are:

- alcohol dependence
- drug use disorders.

OBJECTIVE (iv): MORE PEOPLE WILL HAVE A POSITIVE EXPERIENCE OF CARE AND SUPPORT

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

4.1 The Government wants to achieve:

- greater choice, control and personalisation;
- improved experience for children and young people and improved transition from children's to adults' services; and
- improved mental health outcomes for all: promoting equality and reducing inequalities.

Greater choice, control and personalisation

4.2 'Choice listens to me, involves me, responds to me, values me, and supports me on my road to recovery. If we are serious about putting service users at the heart of modern mental health services, providing choice is essential.' Laurie Bryant, service user, *Choice in Mental Health*.¹⁷⁴

4.3 This is fully covered in Chapter 4 of *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*.

South West Yorkshire Partnership Foundation Trust, Kirklees Council and Kirklees PCT – integrating Payment by Results and a resource allocation system

Following its participation in the Care Pathways and Packages Project to develop a currency and tariff for mental health services, an area of Yorkshire and Humber has committed itself to developing an integrated resource allocation system.

Kirklees PCT, South West Yorkshire Partnership Foundation Trust and Kirklees Council are working together to fully integrate health and social care resources into one system. This will simplify the current arrangements so that service users can better understand how to access services and resources.

The use of one shared resource allocation system will combine the personalisation and funding agendas and help to promote recovery and the better use of resources.

Improving the experience for children and young people

- 4.4 Getting the experience of care right for children and young people and involving them in the design and review of services are important both for their current and future health and their willingness to use services if they need them later in life. Services need to be appropriate to the child's or young person's developmental stage. Of particular importance is ensuring effective transition from children's to adults' services.

Examples of effective local interventions

- 4.5 Services can improve transitions, including from children and adolescent mental health services (CAMHS) into adult mental health services or back to primary care by:
- planning for transition early, listening to young people and improving their self-efficacy;
 - providing appropriate and accessible information and advice so that young people can exercise choice effectively and participate in decisions about which services they receive; and
 - focusing on outcomes and improving joint commissioning, to promote flexible services based on developmental needs.

Government actions to support local approaches

- 4.6 The quality criteria self-assessment toolkit You're Welcome has been produced by the Department of Health to help providers and commissioners make services young people friendly and more appropriate to their needs.
- 4.7 The NHS Outcomes Framework will be underpinned by a comprehensive and authoritative set of Quality Standards developed by the National Institute for Health and Clinical Excellence (NICE). The Government is considering how Quality Standards developed for the life course might reflect some of the overarching quality and experience themes, including transitions that relate to children and young people's health services.
- 4.8 The Department of Health has funded a series of practical tools and learning resources (including evidence-based guides for practitioners, interactive e-learning tools and online self-assessment tools) for improving local CAMHS services.

Useful information

You're Welcome. Further information, including the detailed criteria, can be found at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

Young Minds (see Mental Health manifesto 2010)

www.youngminds.org.uk/young-people/YoungMinds%20Manifesto%20Oct09.pdf

Children and Young People in Mind: The final report of the National CAMHS Review (Department for Children, Schools and Families, 2008)

www.dcsf.gov.uk/CAMHSreview/downloads/CAMHSReview-Bookmark.pdf

Achieving Equity and Excellence for Children and Young People

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449

The Department of Health is funding a programme to improve the experience of young people who are moving from mental health services for adolescents to adult services. This programme is being run by the National Mental Health Development Unit (NMHDU), the National CAMHS Support Service (NCSS) and the Social Care Institute for Excellence (SCIE). It recognises the need for comprehensive and accessible age-appropriate services for young people who have significant emotional, behavioural or psychological problems and who are in need of, or already receiving, a mental health service in the community or in an inpatient setting.

The programme will run to November 2011 and will produce a series of practical tools and learning resources (including evidence-based guides for practitioners, interactive e-learning tools and online self-assessment tools) that will each be tailored to the needs of specific audiences such as young people, families, parents and carers, local commissioners, local providers and practitioners.

SCIE is producing a practice enquiry and a research briefing. The practice enquiry is capturing innovative and emerging practice using the SCIE Good Practice Framework. It is also mapping transitional pathways and processes in three areas in England to explore entry routes and pathways for different groups of young people making transitions in mental health services. The research briefing will be a concise summary of key research sources identified in searches, and will signpost routes to further information.

SCIE will also produce a multimedia web-based guide for practitioners and service providers, with an accompanying At A Glance summary. The guide will present key findings and examples of what is working well to inform practice in an engaging and accessible way. The focus will be on practice to improve the care pathways and process of transition for young people. The guide will include what young people and their families need at each stage of the transition process, who should provide it, how to ensure that this happens, and what support staff need to put this into practice.

Improved mental health outcomes for all: promoting equality and reducing inequality

4.9 Better mental health, mental wellbeing and better services must be better for all – whatever people's age, race, religion or belief, sex, sexual orientation, disability, marital or civil partnership status, pregnancy or maternity, or gender reassignment status. These areas constitute the 'protected characteristics' or groups as set out in the Equality Act 2010. Chapter 6 of *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages* sets out the Government's commitment to promoting equality and reducing inequalities in mental health in relation to the protected characteristics. This commitment is embedded throughout the strategy and will be underpinned by an equality impact assessment action plan to support implementation, delivery and monitoring.

Improving mental health outcomes for older people

4.10 The Government is fully committed to ending age discrimination in health and social care by 2012, with no exemptions to the Equality Act 2010 requirements.

4.11 *Achieving Age Equality in Health and Social Care*¹⁷⁵ sets out how the health and social care sectors can end age discrimination and promote age equality in light of the provisions in the Equality Act. An age equality resource pack¹⁷⁶ is being piloted in a number of mental health services. Results of these pilots will be available by March 2011.

Depression

4.12 Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention. Symptoms of depression are common and usually short-lived but some may develop into a clinical depression: 11% of older people will have minor depression and 2% a major depression.¹⁷⁷ Older people with physical ill health, those living in residential care and socially isolated older people are at higher risk.¹⁷⁸ Yet these problems often go unnoticed and untreated. Studies show that only one out of six older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment.¹⁷⁹

4.13 As well as the impact on quality of life, untreated depression in older people can increase the need for other services – including residential care. Older people can, however, respond very well to psychological and medical treatments. As we complete the nationwide roll-out of psychological therapy services for adults who have depression or anxiety disorders, we will pay particular attention to ensuring appropriate access for people over 65 years of age. People who remain healthy into older age are more likely to continue in employment if they wish and to participate actively in their communities. The supporting document, *Talking Therapies: A four-year plan of action* explains this in detail. We will continue to monitor older people's access to the new psychological therapy services.

4.14 The Department of Health, the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Psychiatrists and the British Psychological Society will continue to

co-operate and develop ways to improve the recognition of depression in older people in primary care. The NMH DU is producing an online learning package on mental health problems in older people which will be available in March 2011.

Dementia

4.15 We are committed to more rapid improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them. This approach is set out in *Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy*¹⁸⁰ – the revised, outcomes-focused implementation plan for the National Dementia Strategy.

4.16 Approaches to improving the wellbeing of older people and preventing mental health problems developing are covered under objective (i), Ageing well.

Useful information

Count Me In census of inpatients and patients on supervised community treatment and in learning disability services in England and Wales

www.countmeinonline.co.uk

Race Equality Dashboard

www.nmhdu.org.uk/our-work/mhep/delivering-race-equality/dre-dashboard

Achieving Age Equality in Health and Social Care sets out how the health and social care sectors can end age discrimination. *The NHS Operating Framework for 2010–11* highlights the need for the NHS to take account of this report. The Association of Directors of Adult Social Services has endorsed the report's recommendations and advised local authorities to use them in their work.

The NHS Operating Framework for 2010–11

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

Achieving Age Equality in Health and Social Care (2009)

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107278

A resource pack to help health and social care prepare for the implementation of the Equality Act was published in September 2010 and is available at: www.southwest.nhs.uk/age-equality.html

Objective (iv): outcome indicators

4.17 Critical to this outcome is understanding the experience of all individuals, their families and carers. A number of surveys and outcome indicators have been developed to better understand service user experience and outcomes. It is important that people from all ages and backgrounds and all protected characteristics are involved so that a comprehensive picture of services can be captured.

4.18 Local HealthWatch will be commissioned by local authorities to provide an independent voice for patients, service users and carers of all ages throughout

the commissioning cycle. It will be able to provide advocacy services on behalf of service users, including those who are seldom heard, such as offenders, gypsies and travellers. See *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages* for more information on the role of HealthWatch.

Links between the high-level mental health objectives and indicators in the three outcome frameworks

4.19 The NHS Outcomes Framework outlines a number of national level indicators relevant to this objective. The indicators with particular relevance to mental

health are under Domain 4: 'Ensuring that people have a positive experience of care – Improving experience of healthcare for people with mental illness – Patient experience of community mental health services'. There are several relevant questions in the Care Quality Commission's community mental health survey, including access and waiting times, safe, high-quality and co-ordinated care, better information and choice, and building closer relationships.

4.20 An Analysis of the Impact on Equality (AIE) of this strategy has been undertaken covering all 'protected characteristics'. The related action plan will be reviewed annually as part of the review process for the strategy itself.

4.21 The proposed Adult Social Care Outcomes Framework includes the following indicators:

Domain 3: Ensuring a positive experience of care and support

Overall satisfaction with local adult social care services

Improving access to information about care and support

- the proportion of people using social care and carers who express difficulty in finding information and advice about local services.

Treating carers as equal partners

- the proportion of carers who report they have been included or consulted in discussions about the person they care for.

More detailed indicators that the NHS Commissioning Board may wish to consider for holding local commissioners to account in meeting the NHS Outcomes Framework and for assessing progress

4.22 Possible indicators include:

- access to community mental health services and talking therapies services by people from black and minority ethnic groups and older people; and
- rates of detention under the Mental Health Act by ethnicity.

Examples of indicators of mental health outcomes for consideration by local commissioners

4.23 Possible indicators to be developed include:

- rates of identification and treatments of older people with depression; and
- talking therapies – experience of choice, i.e. location, time and therapist, and clinically appropriate treatment.

Areas where there are fewer indicators currently available

4.24 Locally there are several possible indicators that can be developed and used for monitoring improvements in service experience and access.

These include:

- patient or user experience surveys across different ages and services;
- the choice of 'any willing provider' offered to people receiving specialist mental health care; and
- access to and availability of specific mental health services, for example talking therapies, crisis and home treatment services for older people.

Quality Standards in development

4.25 Relevant standards already in development are:

- depression in adults
- dementia
- patient experience (generic)
- postnatal care
- patient experience in adult mental care.

OBJECTIVE (v): FEWER PEOPLE WILL SUFFER AVOIDABLE HARM

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

5.1 The Government wants to achieve the following:

- fewer people will suffer avoidable harm from the care and support services they receive;
- fewer people will suffer avoidable harm from themselves;
- fewer people will suffer harm from people with mental health problems; and
- improvement in safeguarding of adults, children and young people.

Fewer people will suffer avoidable harm from the care and support services they receive

5.2 People using mental health services should have confidence that the services they use are of high quality and as safe as any services in the world. People should understand the risks of their conditions, and the risks associated with treatments and approaches. They should expect to receive care when they need it, without risk of additional harm or injury.

5.3 A particular issue of concern has been safety and dignity in inpatient care, including in secure environments. There are a number of initiatives, such as the Acute Care Declaration,¹⁸¹ which will continue to improve the quality and safety of the inpatient environment.

5.4 Mental health services, particularly in the NHS, must be alert to safeguarding concerns and must ensure that policies and procedures of the local adult safeguarding board are followed as well as internal procedures for serious untoward incidents.

5.5 Three principles have been identified in the NHS Outcomes Framework that are applicable across all mental health services:

- protecting people from further harm;
- an honest and open culture that promotes the reporting of incidents; and
- learning from mistakes – making tangible changes to improve safety.

5.6 The NHS Outcomes Framework has proposed an overarching indicator and data source that can be used for mental health and other care services.

Consideration is also being given to whether further safety measures in these areas should be developed.

- 5.7 Local systems can do a great deal to ensure that identification of risks occurs effectively and quickly and that the local culture and systems support rapid learning and dissemination across all areas.

Fewer people will suffer avoidable harm from themselves

- 5.8 A number of factors may increase the likelihood of someone taking their own life. These include having a mental health, alcohol or drug misuse problem, social isolation and having a physically disabling or painful illness. A new cross-government suicide prevention strategy will be published shortly.
- 5.9 Young people may use self-harm as a form of coping with difficult feelings or thoughts, to relieve tension, or to punish themselves. An episode of self-harm is often triggered by an argument or another upset, but often also reflects more complex situations and can be associated with low mood, bullying, low self-esteem, and worries about sexual orientation. Depressive disorder or other problems may underlie the self-harm.
- 5.10 Suicidal acts in older people are likely to be planned in advance, rather than a spontaneous act, and are more likely to be successful than if committed by a younger person. All suicidal threats

or attempts by older people should be taken seriously.

- 5.11 Self-harm should be seen as a call for help – everyone who has taken an overdose, tried to kill themselves or is considered at high risk of suicide or serious self-harm needs an urgent assessment of risk and support needs by an appropriately trained professional, as soon as possible. Risk management is a dynamic process. The treatment of self-harm should be according to the National Institute for Health and Clinical Excellence (NICE) guidelines (2004)¹⁸² and the Department of Health guidance on risk management.¹⁸³

Fewer people will suffer harm from people with mental health problems

- 5.12 The vast majority of people with mental health problems pose no danger to themselves or anyone else. Those with severe mental illness are more likely to be the victims of violence than its perpetrators.¹⁸⁴ In a few cases, a person's mental disorder does raise the risk of them harming someone else. This raised risk is mainly due to people with serious antisocial personality disorder, substance dependence and/or hazardous drinking. However, there are 35–40 homicide convictions per year among people with schizophrenia. This is about 6% of all homicides. The risk in people with schizophrenia is partly due to related substance misuse.¹⁸⁵ In considering risks, mental health services need to consider risks to others as well as risks to self.

All types of risks should be assessed. These include the harm that a parent's or any family member's mental ill health might pose to the welfare of children or other members of the household, the danger that someone's paranoid delusions might pose to particular individuals, or, in very rare cases, the threat that someone's mental disorder may pose to the community at large.

- 5.13 This does not mean that mental health services are solely responsible for monitoring service users' behaviour. Nor does it mean that mental health services should be held accountable for anything and everything that people in their care do. Although cases of violence towards the community at large are extremely rare, we recognise the public's concerns about safety. Mental health services must play their part in managing and reducing risks of harm, through their own interventions where they are best placed to intervene, or by helping other agencies to do what they are best placed to do.

Examples of effective local interventions

- 5.14 The principles of good risk management are fundamentally the same as those that underpin all good-quality mental health care. In particular they include:

- good record-keeping and access to information about history and risks;
- addressing the person's needs in the round – including co-morbid substance abuse problems, and awareness of any dependent children's needs;
- effective communication within and between agencies;
- appropriate sharing of information. It is critical that practitioners across all agencies are aware of when and how to share information so that the needs of safety and confidentiality are appropriately managed;*
- effective risk assessment and management, for example through use of a case formulation approach that incorporates assessment of risks posed to the self (including risky behaviours such as self-harm), risks posed to others, risks posed from others and safeguarding issues. This enables comprehensive care planning and provides a baseline against which to review subsequent case progress in treatment;
- consideration of risk and protective factors, including social, biological and psychological factors. This approach supports a richer understanding of an individual's problems and risks in a wider context;
- clarity about objectives and responsibilities; and
- effective use of the Mental Health Act.

* Information Sharing and Mental Health; Guidance to support information sharing by mental health services (2009). Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104949

- 5.15 It is particularly important to maintain a positive experience of care and support where people are treated under the Mental Health Act. In 2009/10 there was an increase in detentions under the Mental Health Act. The early use of community treatment orders was also much greater than the previous Government had predicted. The Coalition Government will ensure that the use of detention and community treatment orders is kept properly under review, so that action can be taken if necessary to change the law.
- 5.16 The Multi-Agency Risk Assessment Conferences (MARAC) take a multi-agency approach to risk assessment and to supporting and monitoring families where there are concerns about violence and abuse.
- 5.17 Multi-Agency Public Protection Arrangements (MAPPA) are in place in all areas for the management of offenders who pose a serious risk of harm to the public. Mental health and social services may be involved in managing the risk of some individuals with mental health problems.
- 5.18 It is also vital to learn lessons when things go wrong. It is rarely possible to predict homicides or specific incidents of serious violence committed by people with mental disorder. Mental health services cannot be expected to prevent all such incidents, even where they are in contact with the person concerned. But there are still too many cases where more could and should have been done to reduce the risk, and inquiries often highlight the same problems.
- 5.19 When it appears that a service user's mental health problem has played a part in them harming someone else, it is as much a patient safety incident as when service users themselves come to harm. There are well-established procedures for this. Services should investigate, report and learn from it. For providers of NHS services, this includes making an incident report to the National Reporting and Learning Service.
- 5.20 Similarly, where a current or recent service user commits a homicide – or in other cases where the seriousness demands it – there are also well-established procedures for investigation, to ensure that lessons can be learned both locally and nationally:
- a rapid initial management review must be followed by a thorough internal investigation;
 - the responsible strategic health authority should commission an independent investigation as soon as possible;
 - investigations should (where necessary) lead to action plans, which are implemented immediately; and
 - families of victims should be kept fully informed, to be able to contribute to the investigations, and should be told what is being done to implement any recommendations to help prevent similar tragedies occurring again.

Government actions to support local approaches

5.21 The Department of Health has issued updated guidance on assessment and management of risk: *Best Practice in Managing Risk: Principles and guidance for best practice in the assessment and management of risk to self and others in mental health services*.¹⁸⁶ This guidance makes it clear that risk assessment is an intrinsic aspect of all high-quality clinical assessment and not a separate activity.

Improvement in safeguarding of adults, children and young people

- 5.22 Two main risks in relation to mental health that affect safeguarding children and young people are:
- parents and/or carers who are ill or disturbed, who need support and may pose a risk; and
 - children and young people who are vulnerable as a consequence of their parent's ill or disturbed state and who present after a safeguarding issue, including concerns arising from siblings or other young people.
- 5.23 Approximately 30% of adults with mental health problems have dependent children. Appropriate treatment and support usually mean that mental health problems can be managed effectively and, as a result, the majority of parents are able to care successfully for their children. However, in rare cases a child may sustain severe injury, may suffer

profound neglect, or may even die. Very serious risks may arise if the parent's illness incorporates delusional beliefs about the child and/or incorporates the child in a suicide plan.

5.24 Information from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹⁸⁷ suggests that there are about 30 convictions a year where a parent or step-parent kills a child (this excludes those cases where the parent then goes on to commit suicide). In 37% of these cases, the parent was found to have mental health problems, including depressive illness or bipolar disorder, personality disorder, schizophrenia, and/or drug or alcohol dependence. In a 2009 review of Serious Case Review reports, almost two-thirds of the children were found to have lived in a household with a parent or carer with current or past mental illness.¹⁸⁸

Examples of effective local interventions

5.25 It is essential to assess the implications of parental mental ill health for each child in the family. This includes assessing how social difficulties, physical ill health or substance misuse of a parent with mental health problems may have an impact on other family members. After assessment, appropriate additional support should be provided, by effectively sharing information and working with local multi-agency services for children and families. The Department for Education and the

Department of Health will publish the findings of research into safeguarding. These findings should be incorporated into local practice.

5.26 When assessing and/or treating children or young people:

- age-appropriate environments are important, to protect children and young people from exposure to potential dangers or exploitation;

- careful case formulation and clear inter-agency communication enable assessment and organisation of responses to safeguarding issues; and
- getting the environment and service experience right for children and young people can strongly influence their current and future engagement with care. Getting this right can diminish any adverse impacts.

Useful information

Preventing Harm to Children from Parents with Mental Health Needs, a National Patient Safety Agency Rapid Response Report, provides advice to services on responding to the needs of families where there is parental mental ill health.

www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59898&p=2

Think child, think parent, think family Practice guidance produced by the Social Care Institute for Excellence (SCIE).

www.scie.org.uk/children/thinkchildthinkparentthinkfamily/index.asp

Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services (Department of Health, 2007)

www.webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf

Good Practice Guidance: Independent investigation of serious patient safety incidents in mental health services (National Patient Safety Agency, 2008)

www.nrls.npsa.nhs.uk/resources/?EntryId45=59836

Information Sharing and Mental Health: Guidance to support information sharing by mental health services Guidance for mental health services to support the sharing of information in a way that is safe for everyone, issued in August 2009.

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104949

No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health and the Home Office, 2000)

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

See, Think, Act: Your guide to relational security (Department of Health, 2010)

Effective relational security is an integral part of risk management; staff in secure services should understand and work within the guidance set out in *See, Think, Act*.

<http://its-services.org.uk/silo/files/see-think-act-your-guide-to-relational-security.pdf>

Useful information (continued)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (University of Manchester, 2010)

www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualreports/AnnualReportJuly2010.pdf

Getting the Medicines Right: Medicines management in adult and older adult acute mental health wards (National Mental Health Development Unit (NMH DU), 2009)

www.library.nhs.uk/commissioning/Viewresource.aspx?resID=322782

Getting the Medicines Right 2: Medicines management in mental health crisis resolution and home treatment teams (NMH DU, 2010)

www.nmhdu.org.uk/news/getting-the-medicines-right-2/

Initiative to reduce fire deaths

Around 50% of those who lose their life in a fire are known to local health and social care agencies. There are several local good practice examples of collaboration between the Fire Service and the NHS aimed at reducing the risk to individuals.

It is often difficult to find appropriate low-secure settings for people with a history of fire setting who are ready to move on from mental health services with a higher level of security. The Fire Service may have a role in managing these risks.

The Department of Health has begun work with the Chief Fire Officers Association to determine what advice can be provided to local services to facilitate the spread of these initiatives.

Objective (v): outcome indicators

5.27 In the NHS Outcomes Framework, Domain 5: 'Treating and caring for people in a safe environment and protecting them from avoidable harm', recognises that patient safety is of paramount importance in terms of quality of care and delivering better health outcomes.

5.28 The overarching indicators for this domain seek to measure the broader outcomes resulting from the development of a patient safety

culture across the NHS. The overarching indicators will be made up of three measures derived from the National Reporting and Learning Service, which are:

- patient safety incident reporting;
- severity of harm (measuring the number of incidents resulting in severe harm or death); and
- number of similar incidents.

Westminster Missing People pilot on information sharing, safeguarding and reconnecting

Data indicate that there is concern for the mental health and wellbeing of up to four in every five of the 250,000 adults reported missing.

Several thousand missing people are found every year when they are accessing services such as refuges, day services, clinics and hospitals, but service providers may not know that a vulnerable adult they are supporting has been reported missing.

With the support of the Department of Health, Missing People created an information-sharing protocol for the safe, confidential exchange of information about vulnerable missing adults between the charity, statutory and voluntary organisations. The protocol has been tested in the City of Westminster in a partnership between a range of statutory and voluntary agencies.

The same protocol also allows partner organisations to request information from Missing People about individuals in their care whose identity is uncertain. If the individual is known to the charity, Missing People will provide details of the investigating police force.

This partnership demonstrates what can be achieved by working together. Missing people are commonly perceived to be a police matter, yet there are important safeguarding issues that have an impact across many public agencies. Partners have spoken of their increased awareness of the problem of missing people, as well as improved information sharing and partnership working for the benefit of vulnerable clients.

Grampian Police have developed guidance on how to plan a response to a missing person report.¹⁸⁸

Missing People aims to extend the use of the protocol to improve partnership working across other areas of the country over the next three years.

Further information is available at: www.missingpeople.org.uk

- 5.29 The overarching indicators are relevant to all NHS providers, including mental health services, and are designed to measure how well the NHS is adopting a safety culture and delivering improvements in safety as a result. It is not about ensuring that services or organisations are safe to practise – that is the role of the Care Quality Commission.

- 5.30 The proposed Public Health Outcomes Framework includes the suicide rate. The proposed Adult Social Care Outcome Framework includes:

Domain 4: Protecting from avoidable harm and caring in a safe environment

Overarching measure

- the proportion of people using social care who feel safe and secure.

Outcome measures

Ensuring a safe environment for people with mental illness

- the proportion of adults in contact with secondary mental health services in settled accommodation.

Ensuring a safe environment for people with learning disabilities

- the proportion of adults with learning disabilities in settled accommodation.

Supporting quality measures

- support commissioning and analysis of productivity of services.

Providing effective safeguarding services

- the proportion of referrals to adult safeguarding services which are repeat referrals.

Could also be supported by relevant activity and finance data related to adult social care.

More detailed indicators that the NHS Commissioning Board may wish to consider for holding local commissioners to account in meeting the NHS Outcomes Framework and for assessing progress

5.31 The potential indicators include:

- the suicide rate for those in contact with specialist mental health services;
- rates of inpatient suicides;
- inpatient admissions and A&E

attendances with a diagnosis of self-harm;

- Care Programme Approach seven-day follow-up (or possibly follow-up within 48 hours); and
- homicides by people in contact with mental health services.

Examples of indicators of mental health outcomes for consideration by local commissioners

- 5.32 Local commissioners will wish to consider looking at serious untoward incidents reported locally to the National Patient Safety Agency, and the use of suicide audits by providers and commissioners.

Areas where there are fewer indicators currently available

- 5.33 Consideration will need to be given to more robust and systematic data collection across all outcomes and indicators in relation to protected characteristics.

Quality Standards in development

- 5.34 Relevant standards already in development are:
- safe prescribing
 - falls in a care setting
 - nutrition in hospital, including for young people.

OBJECTIVE (vi): FEWER PEOPLE WILL EXPERIENCE STIGMA AND DISCRIMINATION

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

6.1 Stigma and the experiences of discrimination continue to affect significant numbers of people with mental health problems. This discrimination is damaging, unlawful and costly – for individuals, their families and carers, organisations, communities and society as a whole.

6.2 A recent survey showed that more than one quarter of the UK population still thinks that people who have mental health problems should not have the same rights to a job as everyone else.¹⁹⁰ The Stigma Shout Survey 2008 found that people with mental health problems were most likely to be discriminated against by immediate family, employers, neighbours and friends. Even the staff of mental health services may themselves hold attitudes that negatively stereotype people with mental health needs.^{191,192}

6.3 People with mental health problems have worse life chances than other people. Part of this is the direct effect of the condition, but a very large part is

due to the stigma, ignorance, prejudice and fear surrounding mental health.¹⁹³

This can:

- affect the attitudes of clinicians and commissioners;
- stop people from seeking help;
- keep people isolated and therefore unable to engage in ordinary life, including activities that would improve their wellbeing; and
- stop people working, being educated, realising their potential and taking part in civil society.

6.4 Scotland's See Me anti-discrimination campaign found that more than half (57%) of people who had experienced a mental health problem had concealed the fact when applying for a job.¹⁹⁴

6.5 Tackling stigma and discrimination and promoting human rights are critical priorities for this strategy. The Government should play a role in this by leading by example. The Equality Act 2010 establishes the responsibilities of organisations and employers towards people with disabilities, including those with mental health problems.

- 6.6 But legislation is not enough. To shift public attitudes substantially requires a major and sustained social movement. Recognising this, YoungMinds has prioritised combating stigma in its *Children and Young People's Manifesto*, as children and young people can suffer greatly from the effects of mental health stigma. Comic Relief and the Big Lottery have funded a major anti-stigma campaign, Time to Change, led by Mind and Rethink and evaluated by the Institute of Psychiatry. The programme of 35 projects aims to inspire people to work together to end the discrimination surrounding mental health. The programme is backed by international evidence on what works, and has at its heart people with direct experience of mental health problems. Supporters include individuals, employers, sports organisations, NHS trusts and other organisations.
- 6.7 The Government knows, from discussions with voluntary and private sector organisations, that there is an appetite for an even more ambitious programme. We will give this 'social movement' our full support. We commit to supporting and working actively with Time to Change and other partners on reducing stigma for people of all ages and backgrounds.
- 6.8 Public Health England will have a role in taking forward initiatives that can help tackle stigma and discrimination. These can be combined with health promotion activities such as improving the physical health of individuals with mental health problems in a way that promotes mainstream social contact and engagement.
- 6.9 A study on the effectiveness of anti-stigma interventions, *The Power of Contact*,¹⁹⁵ has shown that a crucial element of anti-discrimination activity is group and personal contact. Social theory proposes that increased contact between social groups results in decreased conflict and better understanding between the groups.
- 6.10 A number of mental health trusts currently undertake local anti-stigma and discrimination activities with the active involvement of service users. This can have the added benefit of supporting their recovery. The National CAMHS Support Service has published *Tackling Stigma: A practical toolkit*.¹⁹⁶ This brings together guidance, best practice examples, case studies, resources and literature to help tackle the stigma associated with children's and young people's mental health.
- 6.11 While stigma can affect people of any age, the impact on children and young people at a time when their brains, identities and social skills are still developing can be considerable. Recognising this, YoungMinds has prioritised combating stigma in its *Children and Young People's Manifesto*. Educating children and young people about mental health is important if attitudes are to change.

Objective (vi): outcome indicators

- 6.12 Time to Change already uses a range of indicators to measure change in attitudes to mental health in the population at large, among employers and in the experience of people with mental health problems. The Government will work with Time to Change to agree the best ways to assess improvements over the lifetime of this strategy, including an annual attitudes survey.

Stigma and employment: Graham's story

'I work for Sheffield Health and Social Care Foundation Trust and I was diagnosed with psychotic depression 20 years ago. I hear voices.

'We've all had the experience of disclosing our mental health issues, and watching the other person take a step back. If you tell them you're a voice hearer, they think you attack people. Actually we don't.

'I was unemployed for 10 years and was told by the Benefits Agency that I was effectively unemployable. A job came up which basically supported people with mental health problems to keep a job or find a job. People often feel many job opportunities exclude them because of negative attitudes about people with mental health problems, so the user support and employment service in the trust provides advice, training and ongoing practical support to overcome this. I applied for it and managed to get it. It was good going back to work. I don't work full time; my hours are flexible and I work 21 hours a week. If I needed to start later I could, or finish earlier.

'I have to have music in the office because if I sit in an office that's quiet then I tend to start listening to the voices and lose concentration. You do have periods where you're not very well and you may be off work but, by and large, you can hold down a job and keep going. That's what I try and do.

'We want employers to realise that we're good workers, we work hard, we're conscientious and we don't like taking time off. They should employ us; we're better than most.'

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