

No health without mental health

A cross-government mental health outcomes
strategy for people of all ages

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FOREWORD

The Prime Minister, David Cameron, and the Deputy Prime Minister, Nick Clegg, have made it clear that the Coalition Government's success will be measured by the nation's wellbeing, not just by the state of the economy. The public health White Paper *Healthy Lives, Healthy People*¹ is the first public health strategy to give equal weight to both mental and physical health. This Government recognises that our mental health is central to our quality of life, central to our economic success and interdependent with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime.

The title of this strategy, *No Health Without Mental Health*, perfectly captures our ambitious aim to mainstream mental health in England. We are clear that we expect parity of esteem between mental and physical health services. The previous Government had expressed its intention to improve existing services for people with mental health problems and tackle the wider underlying causes of mental ill health. But it did not spell out how this would be delivered locally to give people better outcomes. Our approach aims to improve outcomes for all.

The challenges are enormous but the rewards of meeting them are great. At least one in four of us will experience a mental health problem at some point in our life, and around half of people with lifetime mental health problems experience their first symptoms by the age

of 14. By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does. So this strategy takes a life course approach, recognising that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much we can do to protect and promote wellbeing and resilience through our early years, into adulthood and then on into a healthy old age. Only a sustained approach across the life course will equip us to meet the social, economic and environmental challenges we face and deliver the short- and long-term benefits we need.

The costs of mental health problems to the economy in England have recently been estimated at a massive £105 billion, and treatment costs are expected to double in the next 20 years. We simply cannot continue to allow costs to spiral upwards without ensuring that every pound of public money is being used efficiently.

But this is not just a question of statistics and money. Social inequality of all kinds contributes to mental ill health, and, in turn, mental ill health can result in further inequality – for example worse outcomes in employment and housing for people with mental health problems. When mental health services don't work, they can fail black and minority ethnic communities, young people who don't have stable family backgrounds and many others.

But when they work well, and work well with local public, private and voluntary and community sector agencies, they help people to overcome disadvantage and fulfil their true potential. That is why this mental health strategy is both a public mental health strategy and a strategy for social justice.

There are two powerful themes to our new approach. First, the Government must demonstrate its commitment and do the things that only the Government can do – but it cannot, on its own, deliver the ambitions in this strategy. We are drawing on commitments across Whitehall departments, employers, schools, local authorities and the voluntary and community sector. We all have a part to play to meet the social and economic challenge posed by mental ill health, and to improve the wellbeing of the population.

Second, power is moving away from the centre. The concept of the Big Society captures this shift, whereby citizens take more control over their lives and build more capable communities. It is particularly relevant to mental health. We want more decisions about mental health taken locally, with more flexibility for local people to make decisions based on local needs.

Our approach is based on the principles that the Government has laid down for its health reforms:

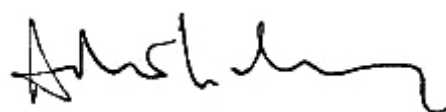
- putting people who use services at the heart of everything we do – ‘No decision about me without me’ is the governing principle. Care should be personalised to reflect people’s needs, not those of the professional or the system. People should have access to the

information and support they need to exercise choice of provider and treatment;

- focusing on measurable outcomes and the NICE Quality Standards that deliver them rather than top-down process targets; and
- empowering local organisations and practitioners to have the freedom to innovate and to drive improvements in services that deliver support of the highest quality for people of all ages, and all backgrounds and cultures.

The Government is investing around £400 million over the next four years to make a choice of psychological therapies available for those who need them in all parts of England, and is expanding provision for children and young people, older people, people with long-term physical health problems and those with severe mental illness.

We know the conditions that foster wellbeing. We know many of the factors that help people to recover from mental health problems and live the lives they want to lead. We know the interconnections between mental health, housing, employment and safe communities. This strategy builds on that knowledge, sets out the ambitions the Government shares with its partners and against which it will be judged, and invites others to join us in making better mental health for all a reality.



Rt Hon Andrew Lansley CBE MP

Secretary of State for Health



Paul Burstow MP

Minister of State for Care Services

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Supporting documents (published separately)

- No Health Without Mental Health: Delivering better mental health outcomes for people of all ages
- No Health Without Mental Health: Impact Assessment
- No Health Without Mental Health: Analysis of the Impact on Equality
- No Health Without Mental Health: Analysis of the Impact on Equality (Evidence Base)
- No Health Without Mental Health: The economic case for improving efficiency and quality in mental health
- Talking Therapies: A four-year plan of action
- Talking Therapies: Impact Assessment
- Talking Therapies: Analysis of the Impact on Equality

1: INTRODUCTION AND EXECUTIVE SUMMARY

1.1 Mental health is everyone’s business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential. The Prime Minister and the Deputy Prime Minister have made it clear that success for the Coalition Government will be assessed not just on bringing about a healthy economy but also on the wellbeing of the whole population. Moreover, good mental health and wellbeing also bring wider social and economic benefits. But to realise these benefits, we all need to take action and be supported by the Government to do so. We all need to take responsibility for caring for our own mental health and that of others, and to challenge the blight of stigma and discrimination. Our objectives for employment, for education, for training, for safety and crime reduction, for reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health.

1.2 This mental health outcomes strategy looks to communities, as well as the state, to promote independence and choice, reflecting the recent vision for adult social care. It sets out how the Government, working with all sectors of the community and taking a life course approach, will:

- 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.

1.3 This is a strategy for people of all ages, and throughout this document we will use the word ‘people’ to encompass infants, children, young people, working-age adults and older people.

1.4 While this strategy is specific to England, the challenges are common across the four countries of the United Kingdom. We will work closely with the Devolved Administrations in Northern Ireland, Scotland and Wales, recognising their particular and varying responsibilities. Each will consider the most appropriate arrangements to address the issues in ways that meet their own circumstances and needs.

Mental health is everyone’s business – a call to action

1.5 A wide range of partner organisations, including user and carer representatives, providers, local government and government departments, have worked with the Department of Health to agree

a set of shared objectives to improve mental health outcomes for individuals and the population as a whole. 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.

(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.

Why do we need a new outcomes strategy for mental health?

1.6 If we are to build a healthier, more productive and fairer society in which we recognise difference, we have to build resilience, promote mental health and wellbeing, and challenge health inequalities. We need to prevent

mental ill health, intervene early when it occurs, and improve the quality of life of people with mental health problems and their families.

1.7 Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. These issues will be further explored in a suite of public mental health evidence reviews to be published shortly by the Department of Health.

1.8 Some mental health problems* are long lasting and can significantly affect the quality of people's lives, especially if they are not treated. Some people only experience a single episode of mental ill health. Others, who may have longer-standing problems, can enjoy a high quality of life and fulfilling careers. However, the personal, social and economic costs of mental ill health can be considerable.

No other health area combines frequency of occurrence with persistence and breadth of impact to the same extent.² The stigma attached to mental ill health and the social barriers that surround it amplify its direct effects and damage the life chances of people with mental health problems.

1.9 There are indications that some problems are becoming more prevalent: for example, more young people have behavioural and emotional problems. The incidence of mental health problems – including in young people³ – can increase in times of economic and employment uncertainty, as can the rate of suicide. The number of older people in our population is growing, with a corresponding increase in the number of those at risk of dementia and depression.⁴

*** Note on terms used in this strategy**

The phrase 'mental health problem' is used in this strategy as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common, may be acute or longer lasting and may vary in severity. They manifest themselves in different ways at different ages and may (for example in children and young people) present as behavioural problems. Some people object to the use of terms such as 'mental health problems' on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative. A glossary including other frequently used terms can be found at Annex C.

Mental health problems – the statistics

At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.⁵

One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.⁶

Half of those with lifetime mental health problems first experience symptoms by the age of 14,⁷ and three-quarters before their mid-20s.⁸

Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).⁹

Almost half of all adults will experience at least one episode of depression during their lifetime.¹⁰

One in ten new mothers experiences postnatal depression.¹¹

About one in 100 people has a severe mental health problem.

Some 60% of adults living in hostels have a personality disorder.¹²

Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

recognised. Two examples are the development of Early Intervention in Psychosis teams and the improved access to psychological therapies. The development of community-based services and the widespread integration of health and social care has meant that fewer people need inpatient care and the number of inpatients taking their own life has reduced.

1.11 However, much still needs to change, and the pace of that change has to be faster. In recent years there has been considerable top-down direction, with more emphasis on structures and processes rather than on outcomes. Little has been done to promote mental health and wellbeing. The development of functional teams has delivered very good care in some areas, but in others has led to the fragmentation of care and inefficiencies across services. Only recently has attention been paid to the importance of employment and housing in the recovery process. Progress has been uneven between different areas and across different conditions. Critically, not all groups have benefited equally from improvements – for example, many people from black and minority ethnic communities. Access to services is uneven and some people get no help at all. This contributes to health inequalities within and between groups with ‘protected characteristics’.*

1.10 The quality of mental health care has improved significantly in recent years. Skilled and committed front-line staff have developed services that are internationally

1.12 High-quality services depend on high-quality commissioning. Too often, commissioning of mental health services has not received the attention at senior

* The ‘protected characteristics’ are set out in the Equality Act 2010 (see glossary at Annex C).

level that it requires. The focus has been on specifying what mental health providers should do, rather than on improving the quality of mental health commissioning – so, for example, new approaches to commissioning, such as Payment by Results, were not initially applied to mental health services.

They are more likely to have poor physical health. This is due in part to higher rates of health risk behaviours, such as smoking, and alcohol and substance misuse.²² Some people with mental health problems have poor diets, may not be physically active and may be overweight, though the reasons for this are complex.

The personal cost of mental health problems

1.13 Many mental health problems start early in life. Half of those with lifetime mental health problems first experience symptoms by the age of 14,¹³ and three-quarters by their mid-20s.¹⁴ Our most deprived communities have the poorest mental and physical health and wellbeing.¹⁵ People with severe mental illnesses die on average 20 years earlier than the general population.¹⁶ Improving the mental health and wellbeing of our population requires action across all sectors, locally and nationally. That is why this is a cross-government strategy.

1.14 Having mental health problems can be distressing to individuals, their families, friends and carers, and affects their local communities. It may also impact on all areas of people's lives. People with mental health problems often have fewer qualifications,¹⁷ find it harder to both obtain and stay in work,¹⁸ have lower incomes,¹⁹ are more likely to be homeless²⁰ or insecurely housed, and are more likely to live in areas of high social deprivation.²¹

1.15 Mental health problems can also contribute to perpetuating cycles of inequality through generations.* However, early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.** Such interventions not only benefit the individual during their childhood and into adulthood, but also improve their capacity to parent, so their children in turn have a reduced risk of mental health problems and their consequences.

1.16 Adults of all ages can also benefit from age-appropriate practice and provision that promotes mental health and wellbeing and prevents mental illness. The Foresight Report on mental capital and wellbeing²³ set out a range of interventions, including simple actions that individuals can take to maintain their mental wellbeing. The Health and Safety Executive Management Standards for work-related stress²⁴ set out what employers can do to limit work-related stress and create a culture in which the risks of stress are reduced.

* See the forthcoming public mental health evidence reviews for further information.

** See the forthcoming public mental health evidence reviews for further information.

The economic context

1.17 Mental ill health represents up to 23% of the total burden of ill health in the UK – the largest single cause of disability.²⁵ Nearly 11% of England’s annual secondary care health budget is spent on mental health.²⁶ Estimates have suggested that the cost of treating mental health problems could double over the next 20 years.²⁷ More than £2 billion is spent annually on social care for people with mental health problems.²⁸

1.18 Detailed estimates in 2003 put the costs of mental health problems in England at £77 billion, including costs of lost productivity and the wider impacts on wellbeing.²⁹ More recent estimates suggest that the costs may now be closer to £105 billion, of which around £30 billion is work related.³⁰ Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity.³¹ Mental health problems add considerably to the costs of the education and criminal justice systems and homelessness services. They are also the most common reason for incapacity benefits claims – around 43% of the 2.6 million people on long-term health-related benefits have a mental or behavioural disorder as their primary condition.³²

1.19 There are also the further, incalculable costs to the individual, their family and their community of lost potential and unrealised hopes and goals. The majority of mental health problems affect people early,

interrupting their education and limiting their life chances.

1.20 We spend a great deal of public money on dealing with the consequences of mental health problems. Much of this money could be spent more efficiently, and many of the personal, social and economic costs could be prevented, by addressing the causes of these problems and identifying and treating them if, and as soon as, they arise. This strategy sets out what everyone needs to do to work towards this, and how it can be achieved.

A new approach

1.21 The Government has a new approach. We are committed to achieving change by putting more power into people’s hands at a local level. We recognise that we can only achieve a stronger, more cohesive society and better mental health outcomes for everyone if people and communities are able to take more responsibility for their own wellbeing. We also know that taking the right action through early intervention can make a long-lasting difference to people’s lives.

1.22 This mental health outcomes strategy will demonstrate how the Government’s localised approach,³³ together with the reforms to health and other public services and action across all government departments, will deliver improvements by:

- lifting the burden of bureaucracy;
- empowering communities to do things their way;

- personalising the production and delivery of services and support;
- increasing local control of public finance;
- diversifying the supply of public services;
- opening up the Government to public scrutiny;
- promoting social action, social inclusion and human rights; and
- strengthening accountability to local people.

for public health in England. *A Vision for Adult Social Care: Capable communities and active citizens*³⁹ describes the direction for adult social care, focusing on personalised services and outcomes. Three outcomes frameworks have been developed alongside these strategies. Together they provide a coherent and comprehensive approach to tracking national progress against an agreed range of critical outcomes. Improving mental health outcomes is central to achieving the outcomes in all these three frameworks.

1.23 The Government has already published strategy documents and introduced legislation that will improve mental health outcomes. These include the Drug Strategy,³⁴ the cross-government strategy to tackle violence against women and girls,³⁵ responses to the call for views about the Department for Education's Green Paper on special educational needs and disability (the Green Paper will be published shortly),³⁶ and the Ministry of Justice's Green Paper.³⁷ It has also set out its ambition to turn around the lives of families with multiple and complex needs. Further details of other key government policies and strategies are described in Chapter 5 and summarised at Annex B.

1.24 The Department of Health has published a number of key policy documents setting out its proposals for reforms in the NHS, public health and adult social care. The NHS White Paper *Equity and Excellence: Liberating the NHS*³⁸ sets out the long-term vision for the NHS. *Healthy Lives, Healthy People* describes the strategy

Outcomes strategies

1.25 This new approach to government means a different approach to direction setting – developing strategies to achieve outcomes. Outcomes strategies reject the top-down approach of the past. Instead, they focus on how people can best be empowered to lead the lives they want to lead and to keep themselves and their families healthy, to learn and be able to work in safe and resilient communities, and on how practitioners on the front line can best be supported to deliver what matters to service users within an ethos that maintains dignity and respect.

1.26 Such cross-cutting strategies recognise that the Government can achieve more in partnership with others than it can alone, and that services can achieve more through integrated, pathway working than they can from working in isolation from one another. This new approach builds on existing joint working across central

government departments – and between the Government, local organisations, employers, service users and professional groups – by unlocking the creativity and innovation suppressed by a top-down approach.

1.27 In particular, outcomes strategies set out:

- the Government's work with the private and voluntary sectors to help shape policies, approaches and services that meet the needs of the population as a whole;
- the work across government nationally and locally that will help to deliver the broad range of public services and approaches that will meet the needs of the population and service users;
- the support that the Government will provide to these services to meet the outcomes for which they are accountable;
- the ways in which these services will be held to account for the outcomes they deliver – for example, through the public health, social care and NHS outcomes frameworks;
- our ambitions for the quality of services we want to make available to the population and service users, and to their families and carers, without exception; and
- the support, information and choices that will be offered to the public, service users, families and carers to enable them

to make best use of these high-quality services.

1.28 This mental health outcomes strategy sets out how actions across government will help to deliver better mental health outcomes. It is more than a service improvement plan; it seeks to promote a transformation in public attitudes towards mental health.

1.29 It also sets out how care and support services (public health, adult social care, NHS healthcare and children's services) will contribute to the ambitions for progress, including improved mental health, that will be set by the Secretary of State for Health in each of the outcomes frameworks. The domains in all three outcomes frameworks already include proposed indicators that are relevant to mental health. These frameworks will evolve as further research is commissioned and better data on mental health outcomes become available. Being clear about our shared mental health objectives will help us to identify gaps in our information. This in turn will also inform the development of future indicators for the outcomes frameworks.

1.30 This mental health outcomes strategy is being published at a time of transition in local government, and health and social care. The Health and Social Care Bill proposes a shift of power away from the Department of Health towards people, communities and front-line staff, to give people greater control over the way in

which services are designed and delivered to meet local needs. Where this document refers to the new structures, these are the Government's current intentions for those bodies, subject to Parliamentary approval.

1.31 A companion document, *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*, describes in greater detail how we will improve mental health outcomes using this new health infrastructure, what 'good' looks like in terms of outcomes, and the underpinning evidence base for interventions.

What will the strategy deliver?

1.32 As well as improving the mental health and wellbeing of the population, and services for people with mental health problems, this strategy will also help to deliver the best value for our society from the resources committed to mental health. By defining high-level objectives and providing evidence of effective practice, we will support local decision-making. Local services can then be designed to best meet the needs of local people. We will support high-quality local commissioning by the use of tools such as Payment by Results.

1.33 Specifically, we will:

- ensure that mental health is high on the Government's agenda by asking the Cabinet sub-Committee on Public Health to oversee the implementation of this strategy at national level,

while the Cabinet Committee on Social Justice will tackle many of the underlying issues;

- make mental health a key priority for Public Health England, the new national public health service, and set out in this strategy why, at a local level, the new health and wellbeing boards and directors of public health will want to treat mental health as a priority;
- agree and use a new national measure of wellbeing;
- prioritise early intervention across all ages;
- take a life course approach, with objectives to improve outcomes for people of all ages;
- tackle health inequalities, and ensure equality across all protected characteristics, including race and age, in mental health services;
- challenge stigma by supporting and working actively with the Time to Change programme and others;
- invest around £400 million over four years to make a choice of psychological therapies available for those who need them in all parts of England, and expand provision for children and young people, older people and their carers, people with long-term physical health problems and those with severe mental illness;
- ensure that by 2014 people in contact with the criminal justice system will have improved access to mental health

services, as outlined in the Ministry of Justice Green Paper *Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*;

- commit funding from the Department of Health to ensure the best treatment possible for Service and ex-Service personnel;
- bring together a group of experts to identify non-legislative solutions to tackle low levels of body confidence;
- launch a set of 'recovery' pilots to test the key features of organisational practice to support the recovery of those using mental health services;
- publish, by April 2011, a series of reviews of evidence on improving public mental health;
- review the models of service and practice for both health visiting and school nursing;
- work with the Royal College of General Practitioners and the Royal College of Psychiatrists to agree advice and support for GP consortia to commission effective mental health services that are accessible to all, including the most disadvantaged and excluded;
- ensure that close working between the Department of Health and the Department for Work and Pensions supports mental health service providers to help people to enter into and return to work; and

- publish a new cross-government suicide prevention strategy this year.

1.34 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, 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 sets out the Government's commitment to promoting equality and reducing inequalities in mental health. This commitment is embedded throughout the strategy and will be underpinned by an action plan covering the analysis of the impact on equality to support implementation, delivery and monitoring.

Central support for delivering the strategy

1.35 As set out in this strategy, the Government's reforms will provide the levers for delivering the services and outcomes that people with mental health problems want. Local action by health and social care professionals, freed to innovate and respond to the needs of service users, will be critical to achieving our outcomes.

1.36 At national level, the Cabinet sub-Committee on Public Health will oversee the implementation of the strategy and the Cabinet Committee on Social Justice will tackle many of the underlying issues.

We will also establish a Mental Health Strategy Ministerial Advisory Group of key stakeholders, including people with mental health problems and carers, to work in partnership to realise this strategy's aim to improve mental health outcomes for people of all ages.

1.37 During 2011 and 2012, while the NHS Commissioning Board and Public Health England are being established, this group will identify actions in the transitional year to deliver the mental health strategy. We will review the function of the Advisory Group from 2012 onwards once the NHS Commissioning Board and Public Health England have been established. However, we anticipate that it will become a focus for stakeholders to discuss how implementation of the strategy will take place and to review progress. It may advise on improved indicators for tracking progress against the mental health objectives that could be used locally, by the NHS Commissioning Board and potentially in future versions of outcomes frameworks.

1.38 Our approach in this strategy is to:

- set out clear, shared objectives for mental health;
- state what government departments will do to contribute to these objectives;
- set out how the three Department of Health outcomes frameworks – for public health, adult social care and the NHS – will require improvements in mental health outcomes;

- articulate how the improvements envisaged in those three frameworks will only be delivered through improvements in mental health;
- explain how these objectives can be achieved at both national and local levels and across agencies at a time of financial challenge; and
- show that positive change in people's lives is achievable.

2: GUIDING VALUES AND PRINCIPLES

2.1 This strategy is underpinned by the Coalition Government's three main guiding principles of:

- freedom;
- fairness; and
- responsibility.

Freedom – reaching our potential; personalisation and control

2.2 Wellbeing and good mental health are essential for each of us to reach our full potential. Mental health problems often start early in life and can have long-term and wide-ranging consequences – especially if they are not addressed. Prevention and early intervention can reduce and prevent these long-term adverse effects.

2.3 Having control over your life is associated with better physical and mental health. This also means ensuring that people with mental health problems are able to plan their own route to recovery,* supported by professional staff who:

- **help them identify and achieve the outcomes that matter to them**, including a suitable and stable place to live, educational opportunities, jobs and social contact; and

- **put them, and their families and carers, at the centre of their care** by listening to what they want, giving them information, involving them in planning and decision-making, treating them with dignity and respect, and enabling them to have choice and control over their lives and the services they receive.

Fairness – equality, justice and human rights

2.4 Any mental health outcomes strategy is a strategy for equality and human rights. This is because reducing inequality and promoting individuals' human rights reduces the risk of mental illness and promotes wellbeing. Moreover, there is clear evidence that mental health services do not always meet the needs of certain groups, particularly black and minority ethnic communities and older people. Many homeless people do not receive the support they need to overcome their mental health and substance misuse problems. The public sector duty in the Equality Act 2010 means that public bodies will need to be particularly mindful of how the inclusion and equitable treatment of all protected groups is incorporated, as public agencies produce, monitor and report on how they have met their equality objectives.

* The term 'recovery' has developed a specific meaning in mental health. It has been defined as: 'A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life' (Anthony, 1993)⁴⁰ (see Glossary at Annex C). Although the term is not used in relation to children and young people, the underlying principles of the recovery approach are equally applicable.

2.5 The Government is committed to delivering equity of access to treatment, prevention and promotion interventions, as well as equality of experience and outcomes across all protected groups. This strategy also takes account of the impact of socio-economic status. It upholds the aims of the Equality Act 2010, protects and promotes human rights in accordance with UN and European Conventions, and supports compliance with the UN Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child.

Responsibility – everyone playing their part and valuing relationships

2.6 Participation in meaningful activity is associated with improved self-esteem, wellbeing and mental health.⁴¹ Good social relationships are associated with a range of positive outcomes, including better physical and mental health. Reducing isolation and building supportive social networks and relationships promotes good mental health and recovery as well as preventing mental health problems. Real improvement, however, will require acknowledging and addressing the differentials – both social and economic – that exist within and between protected groups.

2.7 Strong and cohesive communities provide an environment that fosters improved wellbeing and resilience. The Government has a critical role, but will only improve the wellbeing and mental health of individuals and the population if everyone plays

their part. Professionals can provide tools for individuals to achieve better outcomes; families, friends, teachers, carers, employers and the wider community can motivate and support people to use them. Practitioners also have a key role in working with other services to identify and respond to wider individual and family needs.

Good practice example: the Brandon Centre for Counselling and Psychotherapy for Young People

The Brandon Centre in London is a charitable organisation that has existed for over 42 years. It offers confidential help and advice for 12–21-year-olds and its services include:

- contraception and sexual health;
- counselling and psychotherapy, including cognitive behavioural approaches;
- parenting work; and
- **Multisystemic Therapy (MST)**. The Centre ran the first randomised controlled trial of MST in the UK in partnership with Camden and Haringey Youth Offending Services, funded by the Tudor Trust, Atlantic Philanthropies and the Department of Health.

The Brandon Centre has strong links with the local community, statutory services and academic institutions, and has a good track record in terms of engaging with young people whom other services find hard to reach.

3: IMPROVING OUTCOMES IN MENTAL HEALTH: OUR SHARED OBJECTIVES

3.1 We have worked with partner organisations and across government to develop **six shared high-level mental health objectives**. Together they describe a shared vision for mental health. We have also agreed a number of key areas for action under each objective. *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*, the companion document to this strategy, describes them in more detail.

3.2 This is the first time we have had a comprehensive set of shared objectives and priorities for mental health that cover better mental wellbeing in the population, better mental health care and support and better physical health for those with mental health problems, across the life course.

3.3 The Coalition Government is committed to a clear focus on, and a transparent approach to, outcomes across government, both nationally and locally. The shared mental health objectives and key areas for action will be delivered through the Government's approach to devolving power, co-ordinated cross-government action and the reformed health, adult social care and public health systems.

Outcome indicators

3.4 Some of these shared objectives relate directly to outcomes for which the Secretary of State for Health will hold the NHS Commissioning Board to account, and that are well supported by existing indicators in the NHS Outcomes Framework. Others are covered by proposed outcomes and indicators in the Public Health Outcomes Framework, on which the Government is consulting.⁴² Nearly all these objectives are encapsulated in the proposed outcome descriptions in the consultation paper on the Adult Social Care Outcomes Framework.⁴³ The outcomes frameworks are discussed further in Chapter 5.

3.5 In some cases we will need to develop the indicators in these frameworks – to ensure that they are sufficiently sensitive and specific to demonstrate progress in mental health. The NHS Commissioning Board will set out more detailed measures as part of its Commissioning Outcomes Framework, which will incentivise GP consortia to secure improvements in outcomes. This strategy sets out examples of possible indicators and data sources that the NHS Commissioning Board could use in developing commissioning guidance for GP consortia.

3.6 The following paragraphs briefly describe the high-level objectives agreed with our partners, their relationship with the outcomes frameworks, and possible additional indicators that may be used to assess progress. More detailed analysis of available indicators for each objective (and any gaps) is discussed in the companion document *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

The six mental health objectives

3.7 The **first agreed objective** is:

(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.

3.8 To achieve this, we need to:

- improve the mental wellbeing of individuals, families and the population in general;
- ensure that fewer people of all ages and backgrounds develop mental health problems; and
- continue to work to reduce the national suicide rate.

3.9 This objective links directly to the Prime Minister's announcement on measuring the wellbeing of the nation.

3.10 A good start in life and positive parenting promote good mental health, wellbeing and resilience to adversity throughout life. Many mental health problems start early and are associated with a number of known risk factors, including inequality. We know that employment is generally good for people's mental health and that being out of work carries an increased risk of mental health problems. Poor mental health and wellbeing are associated with a broad range of adverse outcomes, including high levels of health risk behaviours such as smoking, and alcohol and drug misuse, and experience of violence and abuse. Conversely, access to green spaces is associated with better mental health.⁴⁴

3.11 Risk behaviours may become ways of dealing with emotional and other problems. As young people move through their teenage years and make the transition into adulthood, our aim is to strengthen their ability to take control of their lives and relationships, and to help to increase their self-esteem and emotional resilience.

3.12 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. Eating disorders have a peak age of onset in adolescence. For more information see *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

3.13 Problems may be many and interrelated – for example, a third of families with multiple problems have at least one family member who has a mental health problem. A whole-family approach that addresses mental health together with other issues, such as domestic violence or alcohol misuse, has been shown to reduce the risks associated with mental health problems. As life expectancy increases, it is critical that healthy life expectancy also increases. We know more about which interventions and factors work to improve mental wellbeing and prevent problems developing. By focusing on the prevention of mental health problems and the promotion of mental wellbeing, we can significantly improve outcomes for individuals and increase the resilience of the population, while reducing costs. This is explained in more detail in *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* and in the forthcoming public mental health evidence reviews.

3.14 The agreed key areas for action are:

- ensuring a good start in life; and
- reducing the social and other determinants of mental ill health across all ages, and the inequalities that can both cause and be the result of mental health problems including, for example, social isolation, particularly among older people.

How will we know if we are making progress on the key areas for action?

3.15 A great deal of work has been done on developing measures for mental health and wellbeing to show whether or not we are making tangible improvements in mental health outcomes and tackling the determinants of mental ill health. There is still more to do to establish a definitive set of measures, but a range of potential indicators is set out below:

- The Office for National Statistics (ONS) is consulting on national measures of wellbeing.
- A well-evidenced example for measuring adult mental wellbeing is the Warwick-Edinburgh Mental Wellbeing Scale, which has been included in the Health Survey for England.
- The Psychiatric Morbidity Surveys can be used to estimate the rates of mental health problems in adults and children and changes over time.
- All 21 of the proposed indicators on tackling the wider determinants of ill health in the Public Health Outcomes Framework will have a positive effect on mental health, and there is also a range of appropriate indicators in other domains, including self-reported wellbeing.

3.16 The **second agreed objective** is:

(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.

3.17 Mental health problems are common, and vary in their nature and severity and in their impact on an individual over time. They can be long lasting and can have a serious impact on quality of life for individuals and their families and carers. Again, we know a great deal about what works to improve outcomes; for example, we know that by intervening early we can prevent problems becoming more serious and long lasting. Different approaches are required for children, young people, adults of working age, adults with complex multiple needs and older people, but some approaches are effective in reducing distress and improving functioning across all protected groups. For instance, the principles of the recovery approach, which emphasises the importance of good relationships, education, employment and purpose alongside reductions in clinical symptoms, can apply to all age groups. Mental health services also need to recognise that it might be necessary to respond differently to some groups, particularly those with

protected characteristics, in order to achieve similar outcomes.

3.18 The principles of high-quality care are widely accepted and described in the companion document.

3.19 The key areas for action, agreed with partner organisations, are:

- to identify mental health problems and intervene early across all age groups;
- to ensure equity of access for all groups, including the most disadvantaged and excluded (for example people who are sleeping rough) to high-quality, appropriate, comprehensive services;
- to build care and support around outcomes that matter to individuals to enable them to live the lives they want to live, including good relationships, purpose, education, housing and employment;
- to offer people age- and developmentally-appropriate information, and a choice of high-quality evidence and/or good practice-based interventions, including psychological therapies;
- to ensure that all people with severe mental health problems receive high-quality care and treatment in the least restrictive environment, in all settings; and
- to work with the whole family, using whole-family assessment and support plans where appropriate.

3.20 In partnership with the Centre for Mental Health and the NHS Confederation, the Department of Health will launch a set of 'recovery' pilots to test the key features of organisational practice to support the recovery of those using mental health services. Initial results will be published within the next 12 months.

How will we know if we are making progress on the key areas for action?

3.21 The proposed Adult Social Care Outcomes Framework describes key aspects of recovery. In particular, it recognises that:

- earlier diagnosis and intervention mean that people are less dependent on intensive services; and
- when people become ill, recovery takes place in the most appropriate setting and enables people to regain their wellbeing and independence.

3.22 In the NHS Outcomes Framework, recovery is the focus of Domain 3: 'Helping people to recover from episodes of ill health or following injury'. This domain reflects the importance of helping people to recover as quickly and as fully as possible from ill health or injury. In this context, the term is used principally to mean clinical recovery.

3.23 Recovery is also captured within Domain 2: 'Enhancing quality of life for people with long-term conditions', through the two improvement areas: 'Enhancing quality of life for people with mental illness –

employment of people with mental illness' and 'Enhancing the quality of life for carers'.

3.24 However, these indicators do not cover the full spectrum of positive mental health outcomes. The problem is not that outcome measures have not been defined – in fact, many outcome measures are in use by different provider organisations – but few are standardised and routinely collected across mental health services. We will work with partner organisations to agree and develop an appropriate number of key outcome measures and ways to collect them. This will provide the information that individuals need to make real choices between services and approaches, and will allow commissioners and providers to benchmark their services against one another. We will need to give consideration to the collection of more robust and systematic data in relation to all groups.

3.25 In the meantime, the Mental Health Minimum Dataset allows the collection of a number of mainly proxy indicators that are relevant to this outcome. It also includes the Health of the Nation Outcome Scales (HoNOS) for people with severe mental illness. Improving Access to Psychological Therapies (IAPT) services record individual service user outcomes, using standard assessment tools on each contact. The NHS Commissioning Board may wish to use indicators from these datasets in assessing whether or not progress is being made

on improving mental health outcomes. Examples include:

- the proportion of people discharged from inpatient care who are followed up within seven days. There is good evidence to suggest that this seven-day period is critical in helping to prevent suicide and self-harm following discharge;
- community survival time from inpatient discharge to readmission in mental health services; and
- employment and education status for people using IAPT services.

3.26 The **third agreed objective** is:

(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.

3.27 Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50%⁴⁵ and doubles the risk of coronary heart disease in adults.⁴⁶ People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population.⁴⁷ They have higher rates of respiratory, cardiovascular and infectious disease and of obesity, abnormal lipid levels and diabetes.⁴⁸ They are also less likely to

benefit from mainstream screening and public health programmes.

3.28 Increased smoking is responsible for most of the excess mortality of people with severe mental health problems. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England.⁴⁹ Many wish to stop smoking, and can do so with appropriate support. Over 40% of children who smoke have conduct and emotional disorders.⁵⁰ This is particularly important as most smoking starts before adulthood. People with mental health problems need good access to services aimed at improving health (for example, stop smoking services).

3.29 Mental health problems such as depression are also much more common in people with physical illness. Having both physical and mental health problems delays recovery from both.⁵¹ Children with a long-term physical illness are twice as likely to suffer from emotional or conduct disorder problems.⁵² People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression.⁵³ Adults with both physical and mental health problems are much less likely to be in employment.

3.30 The agreed key areas for action are:

- that fewer people with mental health problems should have poor physical health;

- that fewer people with mental health problems should die prematurely; and
- that fewer people with physical ill health, including those with long-term conditions and medically unexplained symptoms, should have mental health problems.

How will we know if we are making progress on the key areas for action?

3.31 The proposed Public Health Outcomes Framework suggests indicators on:

- the mortality rate of people with mental illness (Domain 5); in Domain 1 of the NHS Outcomes Framework a related indicator is 'Under 75 mortality rate in people with serious mental illness';
- the rate of hospital admissions for alcohol-related harm (Domain 3);
- the smoking rate of people with serious mental illness (Domain 4);
- the uptake of national screening programmes (Domain 4);
- the suicide rate (Domain 5);
- the infant mortality rate (Domain 5); and
- mortality rates from cardiovascular disease and chronic respiratory diseases (Domain 5), which will be influenced by improvements in the mental health of people with these conditions.

3.32 The **fourth agreed objective** is:

(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.

3.33 Putting individuals at the heart of services is a key driver of the Government's *Equity and Excellence: Liberating the NHS* reforms. This means that people can, as far as possible, control and manage their own support so that it matches their needs and aspirations. People feel they are respected as equal partners, and know what choices are available to them and who to contact when they need help.

3.34 Those who provide support will respect the human rights of each individual. They will respect their privacy and dignity and ensure that support is sensitive to their particular needs.

3.35 A truly individually focused approach such as this necessarily results in non-discriminatory services for people of all backgrounds.

3.36 In the case of mental health, these principles are particularly important: being in control of your own life helps you to recover. They are equally important to families and carers. However, many mental health service users and their families and carers still report their frustration that mental health services fall a long way short of these principles.

3.37 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 are applied. These include the least restriction principle: 'People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed'.

3.38 Care and support should be appropriate for the age and developmental stage of children and young people, adults of all ages and all protected groups. Careful planning of the transfer of care between services will prevent arbitrary discontinuities in care as people reach key transition ages. Services can improve transitions, including from child 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 adult and other services they receive; and
- focusing on outcomes and improving joint commissioning, to promote flexible services based on developmental needs.

3.39 The Department of Health is funding a programme to support services to improve the experience of young people who are moving from CAMHS to adult services. The programme is being run in partnership by the National Mental Health Development Unit (NMHDU), the National CAMHS Support Service and the Social Care Institute for Excellence. The programme will produce a series of practical tools and learning resources and will run to November 2011.

3.40 It is particularly important to maintain a positive experience of care and support for people who 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 predicted. The 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.

3.41 The agreed key areas for action are:

- that services should be designed around the needs of individuals, ensuring appropriate, effective transition between services when necessary, without discriminatory, professional, organisation or location barriers getting in the way; and
- that, wherever possible, services should listen to and involve carers and others with a valid interest and provide them with information about a patient's care, to ensure that confidentiality does not become an obstacle to delivering safe services. Best practice on involving families and carers is included in Chapter 4.

How will we know if we are making progress on the key areas for action?

3.42 Historically, it has generally been difficult to measure the experience of people with mental illness, and that is why in the NHS Outcomes Framework we have selected an improvement area that will capture the experiences of this group. In Domain 4, 'Ensuring that people have a positive experience of care', the improvement area 'Improving experience of healthcare for people with mental illness' has been included, and will use the indicator 'Patient experience of community mental health services'. The mental health services indicator will draw on the new Community Mental Health Services Survey. We will also review the previously developed Mental Health Inpatient Survey to assess the extent to which it is possible to include it in future frameworks.

3.43 This is also an area where the NHS Commissioning Board is likely to need to identify more detailed progress indicators.

3.44 The Adult Social Care Outcomes Framework comprehensively covers this area. It proposes a range of indicators for service user experience of care and support, including the proportion of people who use 'self-directed support'. Some of these types of indicator may well be helpful to the NHS Commissioning Board, particularly once the pilots of personal health budgets are evaluated and the learning put into practice. One proposed measure also takes account of the proportion of carers who report that they have been included or consulted in discussions about the person they care for.

3.45 All outcome indicators will be disaggregated by protected characteristics to support monitoring and delivery of services. It will take time to do this, in order to comply with the law, but it is particularly important in terms of mental health services. The NHS Commissioning Board will have a particular responsibility for reducing inequalities in healthcare. The Board, and local health and wellbeing boards, will want to take account of more detailed indicators, such as the use of detention in some minority ethnic groups and the under-representation of Asian women receiving support from mental health services.

3.46 The **fifth agreed objective** is:

(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.

3.47 Improved services will result in:

- fewer people suffering avoidable harm from the care and support they receive;
- fewer people harming themselves;
- fewer people suffering harm from people with mental health problems; and
- further progress on safeguarding children, young people and vulnerable adults.

3.48 Particular issues of concern have been human rights, and safety and dignity in inpatient facilities, including secure environments. There are a number of initiatives, such as the Acute Care Declaration,⁵⁴ which will continue to improve the quality and safety of the inpatient environment.

3.49 Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed in their lifetime).⁵⁵ Only a fraction of cases are seen in hospital settings; therefore, all those in contact with young people should be aware of how, and when, to refer somebody on for further assessment and support.

3.50 A continuing focus on reducing suicide rates in people with mental health problems and the population in general will be critical. A new cross-government suicide prevention strategy will be published this year outlining shared objectives for action.

3.51 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. 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 hazardous drinking.

3.52 Although serious incidents involving a person with severe mental illness are extremely rare, we recognise the public's concerns about safety. However, we also recognise that such serious incidents can add significantly to the stigma surrounding mental health. Mental health services must play their part in reducing and managing 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. The companion document *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* has further details on the management of risk, appropriate sharing of information and learning lessons from serious incidents.

How will we know if we are making progress on the key areas for action?

3.53 The relevant proposed outcome statements for adult social care are as follows:

- everyone enjoys physical safety and feels secure;
- people are free from physical and emotional abuse, harassment, neglect and self-harm; and
- people are protected as far as possible from avoidable deaths, disease and injury.

3.54 There are relevant indicators within several of the NHS Outcomes Framework domains. For example, the overarching indicators of Domain 5 are:

- patient safety incident reporting;
- severity of harm; and
- number of similar incidents.

3.55 This is likely to be an area where the NHS Commissioning Board will wish to identify or commission more detailed indicators of progress – for example, the rate of suicide among people in contact with NHS-commissioned services. Collection of suicide rates by ethnicity is also important. The ONS collects annual statistics on suicides and undetermined deaths. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness will publish its latest analysis of the findings of independent investigations into patient homicides later this year.

3.56 The **sixth agreed objective** is:

(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.

3.57 Stigma and 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. 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 stigma and discrimination, driven by ignorance and fear, and some people's negative attitudes towards them. Stigma can also affect the attitudes and behaviours of clinicians, including mental health clinicians, and commissioners. It can:

- stop people from seeking help;
- keep people isolated, and therefore unable to engage in ordinary life, including activities that would improve their wellbeing;
- mean that support services have low expectations of people with mental health problems, for example their ability to hold down a challenging job; and

- stop people working, being educated, realising their potential and taking part in society.

working actively with Time to Change and other partners on reducing stigma for people of all ages and backgrounds.

3.58 Tackling stigma and discrimination and promoting human rights are at the heart of this strategy. A number of mental health trusts currently undertake local anti-stigma and discrimination activities, gaining additional benefit by encouraging service user involvement, thereby aiding their recovery.

3.61 The Government also plays a role in this by leading by example and providing the legislative framework. For example, the Equality Act 2010 sets out the responsibilities of organisations and employers towards disabled people, including people with mental health problems.

3.59 However, to shift public attitudes substantially requires a major and sustained social movement. Recognising that children and young people can suffer greatly from the effects of mental health stigma, YoungMinds has prioritised combating stigma in their Children and Young People's Manifesto. 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 and NHS trusts.

3.62 The agreed priority is that fewer people will suffer from stigma and discrimination as a result of negative attitudes and behaviours towards people with mental health problems – to be achieved by improving public attitudes and reducing the institutionalised discrimination inherent in many organisations, including support services.

How will we know if we are making progress on the key areas for action?

3.60 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

3.63 Time to Change already uses a range of indicators to measure change in attitudes to mental health in the general population, among employers and in the experience of people with mental health problems. We 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.

4: IMPROVING OUTCOMES IN MENTAL HEALTH: WHAT DOES THIS MEAN FOR INDIVIDUALS, FAMILIES AND COMMUNITIES?

4.1 The mental health and resilience of individuals, families and communities is fundamental to building a fair and free society which protects people's human and civil rights. This can only be achieved if we all work together in partnership. We know that, being in control of our own lives, good relationships, purposeful activities and participation in our communities improve our mental health.

4.2 The Coalition Government is committed to putting more power into people's hands at local level. It recognises that only when people and communities have more power and better information and can take more responsibility will we achieve a stronger society, better mental health, and fairness and opportunity for all. Local communities, local people and local services are best placed to solve the problems they face.

4.3 This does not mean that the Government has no responsibility. The Government as a whole must take a lead and will be held to account for improving mental health outcomes. But the Government alone cannot deliver the changes necessary to achieve our shared objectives.

4.4 Every one of us has something to contribute to improving individual and

population mental health. As individuals we can get involved in different ways:

- we can all challenge stigma and discrimination, and negative attitudes by trying to gain a better understanding of mental health problems;
- we can ensure that we look after our own mental health better; and
- we can get more directly involved in local decision-making, volunteering and local action, including in schools and colleges, at work and in our local communities.

4.5 Users of services will increasingly be able to take decisions about their own healthcare. They and their carers may wish to become involved in the planning and design of local services.

Information

4.6 To become involved and to take control in all these ways, people need the right information at the right time. Some people also need support and advocacy. This section of the chapter describes our proposals on information reform. In chapter five we set out the new framework for advocacy in the health and social care systems.

- 4.7 The Government will continue to work with partner organisations to explore different ways – in the media and elsewhere – of improving public understanding of mental health issues. This will include working with Time to Change (see paragraph 3.60), the national campaign to raise awareness of mental health issues and change attitudes and behaviours towards people with mental health problems.
- 4.8 The Government will ensure that the population as a whole knows what it can do to improve its wellbeing and stay healthy. There are many things individuals can do to improve their own mental health; for example, drinking within safe limits, taking regular exercise and participating in meaningful activities, such as arts and sports activities and experiencing the natural environment.*
- 4.9 A model that individuals can adopt to improve their personal wellbeing was recommended in the Foresight report on mental capital and wellbeing.⁵⁶ The 'Five ways to wellbeing' suggests that people:
- **connect** – with the people around them, family, friends and neighbours;
 - **be active** – go for a walk or a run, do the gardening, play a game;
 - **take notice** – be curious and aware of the world around them;
 - **keep learning** – learn a new recipe or a new language, set themselves a challenge; and
- **give** – do something nice for someone else, volunteer, join a community group.
- 4.10 Already, some local mental health trusts and some public health bodies, particularly in the north west, are publicising what people can do to improve their wellbeing in this way. This will be a clear responsibility for Public Health England, and local government, through health and wellbeing boards, will wish to develop this further. The Government has published advice to local commissioners on the evidence base for wellbeing.⁵⁷ The Department of Health is also working with the Department for Business, Innovation and Skills on a project to better understand some of the effective ways of communicating these key messages about mental wellbeing to the public.
- 4.11 *Equity and Excellence: Liberating the NHS* stated: 'Information, combined with the right support, is the key to better care, better outcomes and reduced costs.' It sets out a number of important changes that will ensure timely, high-quality information is available to patients, families, carers and the public so that they can make decisions about their own mental health care and support, and about mental health services.
- 4.12 Tailored, age- and developmentally-appropriate methods are needed to communicate with children and young people so that they can understand their mental health problems and the choices they have about their treatment and care.

* The natural environment is defined as the green open spaces in and around towns and cities as well as the wider countryside and coastline.

This will include evidence-based care and services – for example, communicating through play – especially for very young children. Better communication across all groups is key. These include people from minority ethnic groups; people for whom English is a second or third language and who may not read English; and people who use British Sign Language. Third parties will be encouraged to provide information on services. Web-based support groups and charities could have an important role to play in sharing information with families about services.

Greater choice, control and personalisation

- 4.13 Personalisation is about respecting a person’s human rights, dignity and autonomy, and their right to shape and determine the way they lead their life. Personalised support and services are designed for the purposes of independence, wellbeing and dignity. Every person who receives support should have choice and control, regardless of the care setting. This is of critical importance for people with mental health problems – we know that feeling in control leads to better mental health. Choice and control over their support services is just as important for ex-offenders, drug users and other socially excluded groups.
- 4.14 The NHS White Paper *Equity and Excellence: Liberating the NHS* sets out a range of proposals for giving people greater choice and control over their care and treatment. These were described in more detail in the consultation document *Liberating the NHS: Greater choice and control* published in October 2010. The proposals envisage that greater choice and control over care and treatment, choice of ‘any willing provider’ wherever relevant, and choice of treatment and healthcare provider will become the reality in the vast majority of NHS-funded services by no later than 2013/14. These proposals will extend to mental health service users choices that are not currently available.
- 4.15 People of any age who have complex health needs may require highly specialist help. Some people need to be treated without their consent under the Mental Health Act. It can be difficult to offer full choice – for example, choice of provider – in these circumstances, but it remains important for clinicians to engage people in decisions about personalising their treatment, and to respect their wishes as far as possible, not least because this can make a real difference to outcomes.
- 4.16 Choice is fundamentally about the objectives and circumstances of treatment and care. It is just as relevant for children and young people as for adults. It includes treatment in age- and developmentally-appropriate settings, care designed to enable children and young people to be at home with their families as much as possible, and treatment that enables them to lead as normal a life as possible, at school or college and with their friends.
- 4.17 Personalised care budgets for long-term conditions are a way of giving people more choice and control over how their

support needs are met. *A Vision for Adult Social Care: Capable communities and active citizens* makes it clear that personal budgets, preferably delivered as direct payments, should be provided to all eligible people. The proposed partnership agreement, *Think Local, Act Personal*,⁵⁸ recommends how councils, health bodies and providers need to work more efficiently to personalise and integrate service delivery across health and adult social care. It is important that any personalised support package also considers the needs of children in the family to prevent them from taking on inappropriate caring roles.

4.18 The Government is piloting the application of the same principles when devising personal health budgets, including mental health budgets. Other pilot sites are developing plans to include people who are in transition from children to adult services in their programmes. The learning from the evaluation, due to report in October 2012, will inform the further roll-out of personal health budgets. Currently the law restricts direct payments of NHS funds to individuals, except in the pilot sites. The Government will take steps to extend as much as possible the availability of personal health budgets to people with mental health problems.

4.19 The Department of Health will be publishing its response to the consultation *Liberating the NHS: Greater choice and control* in the next few months. It will include detailed proposals for extending choice and control in mental health services.

The Mental Health Helplines Partnership (mhhp) is an example of collaborative working to provide a more professional, comprehensive and personalised service for people. Fifty helpline mental health providers including national, local and specialist helplines have come together to ensure anyone needing emotional and psychological support or experiencing distress can access help 24/7, 365 days a year. Innovative telephone, text, email and web chat services are available for individuals, carers and staff, whether volunteer or paid, at www.mhhp.org.uk.

Families and carers

4.20 Families and carers, young and old, often receive limited help and too often report that they are ignored by health professionals on grounds that they need to protect the confidentiality, and respect the wishes, of the service user. However, families and carers, including children, have detailed knowledge and insight and are often best placed to advise health and social care professionals about what may help or hinder the recovery of the person for whom they are caring. If they are well supported and listened to, families and carers can continue their caring responsibilities for longer and participate fully in decisions about services and how care is delivered. The refreshed carers strategy, *Recognised, Valued And Supported: Next steps for the Carers Strategy*,⁵⁹ sets out the actions that the Government will take over the next four years to ensure the best possible outcomes for carers and those they support. These include:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages;
- enabling those with caring responsibilities to fulfil their educational and employment potential;
- personalised support, both for carers and for those they support, enabling them to have a family and community life; and
- supporting carers so that they remain mentally and physically well.

4.21 In partnership with the Princess Royal Trust for Carers and the Acute Care Declaration consortium, the Government has published *The Triangle of Care – Carers included: A guide to best practice in acute mental health care*,⁶⁰ which sets out six key elements of good practice for mental health professionals working with carers:

- carers and the essential role they play are identified at first contact or as soon as possible thereafter;
- staff are 'carer aware' and trained in carer engagement strategies;
- policy and practice protocols on confidentiality and sharing information are in place;
- defined post(s) responsible for carers are in place;

- a carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway; and
- a range of carer support services is available.

Citizens, and neighbourhood and community groups

4.22 The Big Society agenda outlined by the Prime Minister will support better mental health outcomes. The three key strands are:

- **community empowerment** – creating neighbourhoods and communities that are in control and that pull together to shape the world around them. The evidence shows that cohesive communities foster better mental health;^{61,62}
- **public service reform** – getting away from central control; giving front-line staff and practitioners more freedoms and opening up public services to new providers, in particular to charities, social enterprises, mutuals and co-operatives. We know that much innovation in services has come from front-line staff working with service users in order to develop new approaches to better meet their needs; and
- **social action** – fostering and supporting social action, social inclusion and volunteering. Evidence shows that volunteering can improve wellbeing.^{63,64,65}

4.23 Empowered and cohesive communities foster better mental health. Services that offer greater choice and control and increased social action all have a positive impact on mental wellbeing.

4.24 *A Vision for Social Care: Capable communities and active citizens* sets out the Government's commitment to strengthening local communities and promoting active citizenship. Published in parallel, *Practical Approaches to Improving the Lives of Disabled and Older People through Building Stronger Communities*⁶⁶ sets out why building strong and resilient communities is a key component of social care transformation, outlines approaches currently being developed by councils with their public sector and community partners, and directs readers to useful materials. The new Big Society Bank will help to create an environment in which innovative approaches to social investment and social enterprise will flourish by working with intermediary organisations to increase access to finance for charities, social enterprises and other civil society organisations. The Government is keen to progress this project as quickly as possible, subject to the availability of dormant account funds.

4.25 *Equity and Excellence: Liberating the NHS* set out plans for local HealthWatch to ensure that views and feedback from carers, patients and service users are an integral part of local commissioning of health and social care services. Developed from Local Involvement Networks, these

local HealthWatch bodies will be funded by and accountable to local authorities. Through their national body, HealthWatch England, they will report, independent of local authorities, any concerns about the quality of local health or care services. Local authorities will be able to commission local HealthWatch or other independent organisations to provide advocacy and support for people with mental health problems and their families and carers so that they can make decisions and choices about local services. This will be in addition to statutory independent mental health advocates who are already available to most patients detained under the Mental Health Act and to patients on supervised community treatment or under guardianship. The advocate's role is to help these patients to understand how the Act applies to them, and what rights it gives them, and to support them in exercising those rights.

4.26 Furthermore, local voluntary and community organisations can draw on the wealth of experience of their local communities in meeting the needs of groups they work with, including those groups most excluded and/or experiencing poor mental health. Some of these organisations have experience of helping people to manage their own mental health better in the community – including through peer support services, user-led self-help groups, mentoring and befriending, and time-banking schemes, which enable service users to be both providers and recipients of support. Well-

managed and well-supported volunteering opportunities can help people to develop the skills and confidence to play a more active role in their own wellbeing and their community, and to influence the shape and scope of local services. Innovative approaches aimed at involving service users and the wider community can also help to break down barriers and reduce stigma. The Department of Health is currently refreshing its strategic vision for volunteering, which will highlight the benefits of volunteering and encourage good practice in promoting and supporting this more broadly.

Employers and businesses

4.27 Being employed is generally good for people's mental health and wellbeing. The workplace provides an important opportunity for people to build resilience, develop social networks and develop their own mental capital. 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.⁶⁷

4.28 As one of the world's largest employers, the NHS is leading the way through, for example, implementing Dr Steven Boorman's recommendations⁶⁸ for improving staff health and wellbeing. Across government we will look to take lessons from this work in the NHS.

4.29 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 relating to staff turnover, under-performance and untapped potential. There is a considerable 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.⁶⁹ A new Responsibility Deal with industry, non-governmental and other organisations will look at ways of improving the health and wellbeing of the working-age population to enable people to remain in employment and return to work after a period of illness.

Front-line staff across all sectors

4.30 The Government is committed to ensuring that front-line staff are enabled to put innovative ideas into practice. Ensuring that front-line staff are knowledgeable, motivated and supported is one of the keys to closing the gap between central policy ambitions and the changes that actually take place.

4.31 By adopting a personalised approach, practitioners working with service users, carers and their families will deliver the outcomes that individuals want. Improving co-ordination between mental health, drugs and alcohol services is important for improving outcomes for the most

vulnerable and excluded. Practitioners may also be involved in the design, planning and delivery of high-quality services and are well placed to help GPs and local partners in commissioning high-quality services.

4.32 Practitioners across all services and sectors can do a great deal to tackle negative attitudes to people with mental health problems and to challenge stigma and discrimination. However, they have to be valued in return. The Government wants staff in mental health services to be valued as much as all other NHS staff. Including mental health awareness in all core front-line professional training – in sectors such as healthcare, teaching, public health and the police – would help to ensure that all mental health problems are identified early across all health and social care settings, and appropriately managed. Increasingly, service providers are working in multi-professional teams, allowing a whole-family assessment and support plan to be put in place.

Improving information and communication through the use of technology

4.33 Information technology and telecommunications have the potential to offer new ways of working with people at risk of, or suffering from, mental health problems. While younger people are often the first to embrace new technologies, such approaches are likely to be equally applicable to adults of any age. Technology can be used to share information about

health online, put people in touch with others in similar positions, offer services such as computerised cognitive behavioural therapy and keep people in touch with healthcare professionals – for example, texting reminders of appointments. Use of technology can support innovation, increase choice and make services more accessible – for example, for deaf people – while being more cost effective. Technology can also offer a less stigmatising way of accessing support.

4.34 Improved use of information technology can also promote better and more systematic collection, analysis and use of information across all protected characteristic groups so as to improve delivery and measure outcomes.

Good practice example

The 5 Boroughs Partnership NHS Foundation Trust, covering the boroughs of Halton, Knowsley, St Helens, Warrington and Wigan, has introduced a 'Big Brother' booth where service users can give their views directly to staff and Trust board members in a way that is much more direct and compelling than using traditional feedback methods. Two simple requests are made: 'Tell us something you think we do well', and 'Tell us something you think we can improve'. The film footage is used to inform the Trust board, service users, carers and partner organisations. It is also used in staff training.

5: IMPROVING OUTCOMES IN MENTAL HEALTH: THE GOVERNMENT'S ROLE

5.1 This chapter sets out what government will do, at national and local levels, to keep people well, and to improve outcomes for people who develop mental health problems. It covers joint decision-making mechanisms at national and local levels, actions across government to improve outcomes and the reforms of the health and social care systems.

Joint decision-making mechanisms

5.2 The Coalition Government is committed to ensuring that mental health has a high priority across all government departments and that action across government is co-ordinated to best support local initiatives. The Government will only succeed in meeting the ambitions it has agreed if there are mechanisms to bring together all the relevant policies from across national and local government:

- at national level, the Cabinet sub-Committee on Public Health will oversee the implementation of the strategy, and the Cabinet Committee on Social Justice will tackle many of the underlying issues; a national Inclusion Health Board is being established whose key role is to champion the needs of the most vulnerable. It will provide expertise to prioritise action to address

health inequalities among the most disadvantaged; and

- at local level, the new statutory health and wellbeing boards will bring key partners together to carry out a joint strategic needs assessment (JSNA) of local needs, to ensure that the local health and wellbeing strategy responds to the identified needs, and to influence both public health and GP consortia commissioning.

Actions across government

5.3 Mental health is a priority across government. The ambitions are shared by government departments from the Ministry of Defence to the Department for the Environment, Food and Rural Affairs and the Department for Education. Indeed, most government departments have plans of action that will improve mental health outcomes. The Cabinet sub-Committee on Public Health is where these plans are brought together, and where the Government will oversee progress on this strategy. The Cabinet Committee on Social Justice will also help to ensure that there is effective cross-government action to address many of the social causes of mental health problems.

5.4 In addition to stigma and discrimination, the critical priority areas will include:

- the early years, children, young people and families;
- Improving Access To Psychological Therapies (IAPT);
- reduction in drug misuse;
- employment;
- homelessness;
- the mental health of veterans;
- the mental health of offenders; and
- co-ordinating, promoting and supporting research.

The early years, children, young people and families

5.5 The Government has pledged to increase the health visitor workforce by 4,200 to offer all families support when they become parents and are caring for young children. Health visitors will lead and deliver the Healthy Child Programme, linking with maternity services, general practices and Sure Start children's centres, and the evidence-based Family Nurse Partnership programme, thereby helping to give all children the best start in life. Pregnancy is often the time when pre-existing and developing mental health conditions surface. Some parents will require additional support to manage anxiety and depression during pregnancy and the child's early years, which can have an adverse effect on their child's development.

5.6 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 identify and help parents, infants, children and young people who need support with 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.

5.7 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 areas and those in affluent areas. This will be done as part of government's broader approach to Payment by Results, for example, through the Early Intervention Grant. From April 2011 schools will have further funding to support children from low-income families via the Pupil Premium.

5.8 The Department of Health has created a focus on how the NHS reforms can contribute to improved outcomes for children and young people through an engagement document, *Achieving Equity and Excellence for Children*,⁷⁰ to address key issues identified with children's health services, including those arising from Professor Sir Ian Kennedy's report⁷¹ on children's health services.

5.9 The Department for Education has introduced an **Early Intervention Grant**, which will provide a substantial new funding stream for early intervention and preventative services for children, young people and families. It is not ring-fenced, enabling significantly greater freedom at local level, to respond to local needs and drive reform, while supporting a focus on early intervention in the early years and up through the age range. It 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, and the Early Intervention Grant includes funding for targeted mental health support for children and young people.

5.10 TaMHS, 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 from 5 to 13) and their families. This can involve one-to-one work, group work or work with parents and carers.

5.11 For adolescents, multi-systemic interventions that involve young people, parents, schools and the community have been shown to reduce conduct disorder, improve family relationships and reduce costs to the social care, youth justice, education and health systems. Families often experience multiple problems,

such as substance misuse or mental health problems, parenting problems, child neglect and behaviour problems in school, or involvement in offending. Evaluation of family intervention has shown reductions in mental health problems, drug or substance misuse and domestic violence.⁷² More details are given in *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

Supporting families with multiple problems

5.12 A national campaign to turn around the lives of families with multiple problems is under way. Around 2% of families in England (117,000) have at least five or more problems, which often include mental health problems. There are three strands to the campaign:

- Invest 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 area will focus on helping adult members of families with multiple problems gain access to employment.
- Learn from success – 'mentor' areas with a track record of successfully supporting families will receive government support to become dissemination hubs to help other areas apply high-quality evidence of what works.
- Break down barriers – from April 2011 local agencies in the first 16 areas (28 local authorities) will be able to create

a Community Budget freeing up money to be spent on innovative types of family intervention services that address the needs of the whole family. More details are given in *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

Improving Access to Psychological Therapies

5.13 The Government is investing around £400 million over the Spending Review period to ensure that adults with depression and anxiety in all parts of England have access to a choice of psychological therapies. This investment will also enable the expansion of psychological therapies in children and young people's services. The Government will also explore:

- how older adults and their carers can better be supported by psychological therapies; and
- the application of psychological therapies to people with severe and enduring mental illness, people with physical long-term conditions and those with medically unexplained symptoms.

5.14 At local level, employment support providers and psychological therapy services will work together to improve the way that working-age people with mental health problems receive help to work or to get back to work when problems arise.

A supporting document, *Talking Therapies: A four-year plan of action*, has been published alongside this strategy.

Reduction in drug misuse

5.15 A new drug strategy to tackle drug dependence and promote a recovery-led approach to help people rebuild their lives was published in December 2010.⁷³ A clear association exists between mental illness and drug and alcohol dependence. People experiencing mental ill health have a higher risk of substance misuse. Like mental health problems, behavioural problems, including substance misuse, frequently start early in life. For young people, emotional and behavioural disorders are associated with an increased risk of experimentation with, misuse of and dependence on drugs and alcohol.⁷⁴ The approach adopted by this strategy, of promoting mental wellbeing, preventing mental illness and early intervention as soon as the problem arises, will also help to reduce the risk of substance misuse across the population. Dual diagnosis (co-existing mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need. The Government will continue to actively promote and support improvements in commissioning and service provision for this group, their families and carers.

* 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 the broad range which sometimes includes play and non-verbal activities.

Alcohol Misuse

5.16 Alcohol misuse is one of our main public health challenges, with 1.6 million people dependent on alcohol in 2007. As one of a number of documents setting out our new public health approach in more detail, we will publish an alcohol strategy document in summer 2011. The Public Health Outcomes Framework, under consultation to March 2011, includes a proposed indicator on alcohol-related hospital admissions. In our new strategy, we will set out how we propose to tackle the burden of illness, injury, and death from alcohol misuse.

Employment

5.17 The Government is working to help people with mental health problems to enter, stay in and return to employment. It is also supporting employers to promote the wellbeing, resilience and mental health of their staff.

5.18 We know that early intervention can improve employment outcomes, including helping people to stay in work. 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 should be enabled to 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 services. Other people will need long-term rehabilitation 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;⁷⁵
- employers' and individuals' beliefs that the individual can perform the job and that their condition is manageable in the workplace;
- the interaction between appropriate work and wellbeing; and
- employers making appropriate recruitment decisions and managing workplace health.

5.19 The Department for Work and Pensions is reforming the 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. It 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 customers, and customers who were recently in receipt of Incapacity Benefit.

5.20 Programmes to help people include Work Choice, which will help disabled people with complex barriers to employment find and stay in work (including self-employment); and Access to Work, which provides financial support for individuals and employers 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 also 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.

5.21 Cross-government action is also helping people to stay in work. The Government's innovative Fit for Work Service pilots are multi-disciplinary projects delivered by local providers, focusing on early intervention and designed to get workers on sickness absence back to work faster and to keep them in work. The programme is being evaluated and the results, due in late 2011, will enable us to determine what works and in what circumstances.

5.22 The new 'fit note' was introduced in April 2010, allowing GPs and individuals to focus on how to get people on sick leave back into work. Central government will support the NHS to embed this and

implement the fit note electronically in GP surgeries as soon as possible.

The Government is also examining the incentives in the sickness absence system, with a view to reducing the number of people who fall out of work because of health conditions and who end up on benefits.

5.23 Included in the IAPT commitment is the provision of funding to ensure that every area has an employment co-ordinator who will work in conjunction with local Jobcentre Plus offices, employers and occupational health schemes. This money will also go towards funding provision of employment advice in IAPT services. The children and young people's IAPT programme will learn from these initiatives and consider the applicability of these principles to supporting children and young people with mental health problems in education.

5.24 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.

Homelessness

5.25 People who are homeless have 40–50 times higher rates of mental health problems than the general population. They are also 40 times less likely to be registered with a GP. It is therefore essential that we improve access to and take-up of

mental health services among homeless people, and ensure that such services are designed with the particular needs of these groups in mind and that such services take account of the very diverse range of mental health needs and dual diagnosis, and include an outreach element.

- 5.26 The JSNA and the new health and wellbeing boards are key to ensuring that commissioning of primary care health 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.
- 5.27 If mental health and accommodation services are not properly integrated, people can be discharged from acute mental health wards when they have no place to live. This harms people's recovery, leading to further treatment and potential re-admission.
- 5.28 Homeless people need good-quality housing to facilitate recovery and independent living. The Government is continuing its investment in the Places of Change programme to help improve the quality of hostel accommodation, and to help providers to deliver more appropriate services to rough sleepers and to help them

to make the transition into a settled home, training or employment.

- 5.29 In addition, the Government has established a Ministerial Working Group on Preventing and Tackling Homelessness to deal with the complex causes of homelessness. Improving access to mental health services is critical to the Government's objective of ending street homelessness. Homelessness outreach teams often need the involvement of mental health teams to take entrenched rough sleepers off the streets. Mental health services need to be delivered in close co-ordination with drug and alcohol services if they are to offer effective support for adults with complex, multiple needs, building on established good practice, such as the New Directions Team in Merton.

The mental health of veterans

- 5.30 The Military Covenant provides the basis for government policy aimed at improving the support available to the armed forces community. Mental health services have a key role to play in fulfilling this covenant.
- 5.31 Ways to provide additional help are being explored through six joint Ministry of Defence/NHS mental health pilots. The findings will assist other mental health services to make special provision for veterans during 2011/12.

5.32 As set out in September 2010, the Department of Health has committed to provide funding to ensure the best treatment possible for veterans with mental health problems by:

- creating further veterans therapist posts in NHS trusts;
- exploring the use of online counselling services;
- extending the Combat Stress helpline to function 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.

5.33 The Department of Health has provided grant funding to Combat Stress to enable it to work directly with mental health trusts to ensure that the services it provides are accessible to and appropriate for military veterans. There is more information on this work in *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

5.34 In addition, a number of sites involved in the talking therapies programme are tailoring their services to the needs of veterans.

The mental health of offenders

5.35 Recommendations from Lord Bradley's report on improving mental health and learning disability outcomes for offenders⁷⁶ have been acted upon with the aim of ensuring that offenders have the same access to mental health services as the rest of the population and that mental health issues are picked up as early as possible in their interaction with the criminal justice system. Lord Bradley's report also proposed rolling out a national liaison and diversion service, which was agreed by Government for implementation by 2014.

5.36 The Ministry of Justice Green Paper⁷⁷ has supported this approach. The Department of Health, the Ministry of Justice and the Home Office are working with the NHS, which has funding and commissioning responsibility for diversion services. Together, they will identify a number of diversion pathfinders from existing services that will help to shape best practice, quantify the benefits and develop appropriate quality standards. In addition, further work will support development of mainstream service capacity to treat those referred by diversion services. We will aim to evaluate the pathfinder work by 2012 and, subject to positive results, roll out a national implementation programme. This work will include diversion services for young people.

5.37 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 1983. Many, but not all, will be convicted offenders.

5.38 As discussed in the Ministry of Justice Green Paper, we intend to reshape services for offenders with personality disorder. The implementation plan for these changes will be the subject of a separate consultation to be published shortly. The main objective of the Offender Personality Plan is to increase capacity, thereby enabling more of the most high-risk prisoners to be appropriately managed and reduce the risk of them committing further serious or violent offences.

Co-ordinating, promoting and supporting research

5.39 High-quality research is vital to improving our understanding of the causes of mental ill health and the treatment and care of those with mental health problems. Research, including mental health research, in the UK is supported by a wide range of organisations from the private, charity and public sectors.

5.40 The Department of Health, through the National Institute for Health Research (NIHR) and the Policy Research Programme, has invested significantly in mental health research and will continue to support high-quality mental health research. The NIHR will also continue to work with research councils and other funders to co-ordinate

research efforts, consistent with the recently published MRC *Review of Mental Health Research*.⁷⁸

Reforms to the health and social care systems

5.41 A new architecture and approach for the NHS, public health and adult social care was set out in the NHS White Paper *Equity and Excellence: Liberating the NHS*, the public health White Paper *Healthy Lives, Healthy People* and in *A Vision for Adult Social Care: Capable communities and active citizens*.

5.42 Some of the key components of the new architecture are:

- an outcomes approach (rather than top-down process targets);
- local leadership via health and wellbeing boards; and the role of local authorities in commissioning for public health, including public mental health;
- a new integrated public health service – including Public Health England;
- an independent NHS Commissioning Board;
- GP commissioning consortia;
- HealthWatch England – an independent consumer champion within the Care Quality Commission (CQC);
- local HealthWatch to represent the views of patients, carers and the public

to commissioners and provide local intelligence for HealthWatch England; and

- a range of ways of improving quality of services and meeting the aspirations of service users – including NICE Quality Standards, the CQC, Payment by Results, Quality Accounts and a more competitive market for providers.

An outcomes approach

5.43 Three outcomes frameworks have been developed: for the NHS, public health and adult social care. Together they will provide a coherent and comprehensive approach to tracking national progress against an agreed range of critical outcomes. The NHS Outcomes Framework will be refined on an annual basis to make sure that the outcomes that matter to patients are included and that the indicators being used best capture those outcomes. The Public Health and Adult Social Care Outcomes Frameworks are currently subject to consultation. This strategy will inform the development of outcome indicators over the lifetime of these frameworks. The mental health objectives are critical to the delivery of all of the three outcomes frameworks.

5.44 The development of meaningful, high-level outcomes for children and young people is still at an early stage. The Department of Health is very aware of the need to develop a considered way forward – working with its partners in the Department for Education and elsewhere – building on the

learning from, for example, the proposed Adult Social Care Outcomes Framework.

5.45 It will be a priority to agree key outcome measures with service users, including children, young people and their families, and with the sector as a whole.

5.46 The outcomes frameworks are not, as a whole, disease-specific. They apply equally to mental and physical health, and will be understood as such by the NHS Commissioning Board, Public Health England and local government. For example, Domain 2 in the NHS Outcomes Framework: ‘Enhancing quality of life for people with long-term conditions’ focuses on generic outcomes that matter most to people with any long-term condition. We know not only that some mental health problems are long term but also that the rates of mental health problems in people with long term physical illness are high. To improve quality of life for this group of people means that their mental health needs should be identified and met. This domain contains two improvement areas of specific relevance to mental health:

- enhancing the quality of life for people with mental illness – employment of people with mental illness; and
- Enhancing the quality of life for carers – 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

5.47 In the proposed Public Health Outcomes Framework, all the five proposed domains include elements relevant to mental health and wellbeing and will contribute to the delivery of mental health priorities. For example, in Domain 2: 'Tackling the wider determinants of ill health', **all** the proposed indicators measure determinants of mental ill health. In turn, reducing mental ill health will contribute to the improvement of overall health and wellbeing.

5.48 *Transparency in Outcomes: A framework for adult social care* sets out a strategic approach to quality and outcomes in adult social care. It includes a number of outcomes with direct relevance to mental health, grouped within four areas:

- 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.

5.49 All of the frameworks will develop over time. Moreover, the NHS Commissioning Board will need to look at more detailed indicators in order to develop guidance for local commissioners. Local commissioners may also need specific indicators for local priorities. Such development work is particularly necessary in both adult mental

health services and CAMHS. For example, the Government needs appropriate outcome measures for recovery, and the NHS Outcomes Framework already commits the Department of Health to develop an indicator for improving children and young people's experiences of healthcare.

5.50 At the moment few standardised outcome indicators in mental health are routinely collected. However, a large number of potential measures are available. The Outcomes Compendium,⁷⁹ published in 2009, gives details of the many measures already in use which support the local development of best practice. The NHS information architecture is being developed to support better routine outcome measurement across all mental health services. The use of the HoNOS is becoming widespread. This is a widely accepted outcome measure for severe mental illness collected through the Mental Health Minimum Dataset and is being used in the roll-out of Payment by Results in mental health.

Local leadership

5.51 Local government will play a central role in ensuring that local partnership arrangements can deliver the shared mental health objectives. Partners will include social care, education, the police and criminal justice system, housing, the environment, employers, charities and voluntary organisations, as well as health.

- 5.52 *Healthy Lives, Healthy People*, the public health White Paper, gives a new, enhanced role to local government and local partnerships in delivering a new approach to public health and recognises that mental health is intrinsic to health and wellbeing.
- 5.53 The creation of local health and wellbeing boards will ensure that local partnerships work effectively together. These boards will be expected to tackle the wider economic, social and environmental determinants and consequences of mental health problems. This strategy sets out why the Government believes that local areas, through their health and wellbeing boards, will want to treat mental health as a priority.
- 5.54 The boards will be required to bring together elected members of local authorities, GP consortia, directors of public health, adult social services, children's services and local HealthWatch representatives. In order to engage more effectively with local people and neighbourhoods, boards may also choose to invite participation from local representatives of the voluntary sector and other relevant public services. Boards will also want to ensure input from professionals and community organisations to advise on and give voice to the needs of vulnerable and less-heard groups. This is of particular importance to mental health.
- 5.55 The core purpose of the new health and wellbeing boards is to develop a high-level, public, joint health and wellbeing strategy covering the NHS, public health and social care. Subject to Parliamentary approval, commissioners will be under a legal obligation to have regard to the joint health and wellbeing strategy. They will also provide a statutory forum for co-ordinated commissioning to secure better health and wellbeing outcomes, better quality care for patients and care users, and better value for the taxpayer.
- 5.56 At the heart of this role is the development of the JSNA. This provides an objective analysis of the current and future needs of local adults and children, and brings together a wide range of quantitative and qualitative data, including user views. The JSNA will include assessment of mental health needs across the life course. Subject to Parliamentary approval, there will be a new legal obligation on GP consortia and local authority commissioners to have regard to the JSNA in carrying out their commissioning functions.
- 5.57 The Government is working closely with the Local Government Group to support health and wellbeing boards to lead a new generation of JSNAs. This includes a national best practice guide to strengthen the 'JSNA challenge', for example, around disadvantaged or excluded groups, such as those with mental health needs, as well as across rural and inner city areas.
- 5.58 Joint NHS and social care commissioning of mental health services is likely to be the best way to develop and improve the full range of prevention, early intervention and treatment approaches.

5.59 The health and wellbeing boards will provide a key mechanism for using joint commissioning and pooled budgets. The boards could also agree funding allocation and strategies for place-based budgets to address cross-cutting health issues. Pooled budgets and other flexibilities for joint working are particularly important for mental health. GP consortia and local authorities, through their local health and wellbeing board, will have to consider how to make best use of these flexibilities. The NHS Commissioning Board will also have a duty to promote their use.

5.60 These arrangements will promote further integration of health with adult social care, children's services (including education) and wider services, including disability services, housing, employment support and the criminal justice system. This has the potential to meet people's needs more effectively and promote the best use of public resources.

A new public health service

5.61 Half of all lifetime mental health problems are already present in adolescence. Early years experiences lay the basis for mental wellbeing in later life. Reducing mental ill health and increasing mental wellbeing requires a public health approach that prioritises early years.

5.62 *Healthy Lives, Healthy People* aims to intensify the focus on early intervention and prevention of physical and mental illnesses. It recognises the importance of

strengthening self-esteem, confidence and personal responsibility throughout our lives. It is built around five priorities across the life course that are vital for good mental health: starting well, developing well, living well, working well and ageing well.

5.63 *Healthy Lives, Healthy People* places a new focus on pregnancy, the first years of life and childhood through to adolescence, when the foundations are laid for lifetime good health and wellbeing. The proposed health and wellbeing boards and the JSNA will be able to provide high-quality public health input into commissioning health visiting services and will be able to strengthen links with, for example, early years services, including Sure Start children's centres, maternity services and primary care.

5.64 *Healthy Lives, Healthy People* commits to ring-fencing public health funding. Local authorities will take statutory responsibility for improving the health and wellbeing of their populations, funded by a new ring-fenced public health grant made available to upper-tier and unitary local authorities. The consultation document *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health* proposed that public mental health activity should be funded from the new public health budget and commissioned by local authorities in their new public health role.

NHS Commissioning Board

5.65 *Equity and Excellence: Liberating the NHS* sets out the Government's long-term vision for the NHS. The Government will create an autonomous NHS Commissioning Board, accountable to the Secretary of State, but free from political interference. It will take responsibility for securing world-class health outcomes.

5.66 The NHS Commissioning Board will come into being in shadow form by April 2011 and, subject to Parliamentary approval, will go live in April 2012. It will provide leadership for quality improvement through commissioning guidance and hold GP consortia to account for their performance and quality. It will allocate and account for resources. The Board will also promote involvement in research and the use of research evidence. Commissioning guidelines will be developed, based on clinically approved Quality Standards developed by NICE, to promote joint working across health, public health and social care.

5.67 The Secretary of State for Health will set a formal mandate for the NHS Commissioning Board. This will be subject to consultation and Parliamentary scrutiny, including scrutiny by the Health Select Committee. This mandate will include specific measures of improvement that will be compared against a small number of indicators set out in the NHS Outcomes Framework. As explained above, the framework not only includes some key

mental health indicators; action will also have to be taken to improve mental health outcomes in order to achieve improvement in the high-level outcome domains.

GP consortia

5.68 Poor-quality mental health services are often associated with poor commissioning. GP consortia will replace primary care trusts in commissioning most mental health services. A small number of specialist, high-cost, low-volume services, such as secure mental health services, will be commissioned directly by the new NHS Commissioning Board.

5.69 GP consortia are well placed to understand the broad range of mental health problems experienced by people in the local population and to commission high-quality services across primary and secondary services. The consortia will work closely with secondary care and other healthcare professionals, and with community partners to design joined-up services – and optimal care pathways, taking into account NICE Quality Standards – that make sense to patients, families and the public. GP consortia will have flexibility to seek commissioning support and enter into joint commissioning arrangements, including with local authorities and charities, particularly for services that cross boundaries, such as mental health.

5.70 GP consortia will have to take account of the local JSNA and the local health and wellbeing strategy. They will be

able to influence decisions about local health improvement, addressing health inequalities and promoting equality, and social care. They will be free from top-down managerial control, and supported and held to account by the NHS Commissioning Board for the outcomes they achieve.

5.71 A GP consortia pathfinder programme will test the different elements involved in GP-led commissioning, exploring some of the issues that will ensure effective implementation across the country. A number of pathfinders are focusing specifically on the commissioning of mental health services, including CAMHS.

5.72 The NHS Commissioning Board will have responsibility for authorising a GP consortium, if it is satisfied that the consortium will be able to discharge its statutory functions. It is intended that such authorisation is seen as the culmination of a prior process of development support. The shadow NHS Commissioning Board, working with strategic health authorities and primary care trusts, will ensure that consortia have the support to prepare for their statutory establishment.

5.73 The Government is working with the Royal College of General Practitioners, the Royal College of Psychiatrists, the Association of Directors of Adult Social Services and the NHS Confederation to develop guidance and support for GP consortia in commissioning effective

mental health services. In addition, there will be opportunities for the voluntary and community sector and for-profit organisations to provide specialist commissioning advice on mental health to GP consortia.

5.74 The Quality and Outcomes Framework (QOF) is the main way in which GPs are held to account for high-quality care. *Healthy Lives, Healthy People* proposed that a greater proportion of the QOF will be devoted to the provision of evidence-based primary prevention indicators and secondary prevention advice and support. It is proposed that by 2013 15% of the QOF will be devoted to prevention. Health checks for people with severe mental health problems are particularly important, given the poor physical health and high health risk behaviours of this group.

HealthWatch England and role of the Care Quality Commission

5.75 The CQC will continue its role as a quality inspectorate for privately and publicly funded health and social care. With Monitor (the independent regulator of NHS foundation trusts), it will operate a joint licensing regime and the CQC will have powers to carry out inspections of mental health services. The CQC will also continue its special role under the Mental Health Act – protecting the rights and interests of patients by monitoring the way that the Mental Health Act is used and by managing the second opinion appointed

doctor service. Within the health reforms, Monitor's functions will extend from being the current regulator of foundation trusts to become the economic regulator for health and social care. Monitor's general duties are consistent with this strategy, in that it will be required to protect and promote the interests of people who use health, including mental health, services.

5.76 A new consumer champion, HealthWatch England, will be created within the CQC. It will help to ensure that the voices of people with mental health problems, including children, young people and their families – who can often be marginalised – are central to the assessment of quality in specialist mental health services and in health services more generally. Health and wellbeing boards will provide leadership and support to local HealthWatch who will be able to provide advocacy services on their behalf, if requested by the local authority. HealthWatch will advise the Health and Social Care Information Centre on which information will be of most use to patients to help them to make choices about care. It will provide advice to the Secretary of State and the NHS Commissioning Board and will have powers to propose investigations by the CQC of poor services.

Local HealthWatch

5.77 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 seldom heard, such as offenders, gypsies and travellers.

Improving quality: NICE Quality Standards

5.78 A suite of NICE Quality Standards will support the delivery of outcomes, including those relevant to mental health.

5.79 Quality Standards provide an authoritative definition of what high-quality care looks like for a particular care pathway or service. They act as a bridge between the outcomes that the NHS and public health and adult social care services will be aiming to deliver and the processes and structures that are needed to make delivery possible. They are developed by NICE, working in partnership with patients, clinicians, social care professionals, commissioners, leading experts and healthcare specialists in the relevant area, drawing on the best available evidence and practice. Subject to Parliamentary approval, NICE will also have responsibility for providing Quality Standards and other guidance in the field of social care.

5.80 The Department of Health currently commissions NICE to produce these standards. Subject to the successful passage of the Health Bill, this commissioning function for Quality Standards will transfer to the NHS Commissioning Board once it is established (and, for social care and any public health

Quality Standards, will remain with the Secretary of State for Health). The Secretary of State for Health and the NHS Commissioning Board will be under a duty to have regard to Quality Standards in carrying out their functions, particularly their new statutory duty to improve service quality. The Board will also use Quality Standards in developing the commissioning guidance that GP consortia will have to have regard to.

5.81 Within the next five years, NICE will produce a broad library of standards that cover the majority of NHS activity to support the NHS in delivering the outcomes in the NHS Outcomes Framework. Quality Standards have already been produced for dementia services and are being developed for a number of services relating to mental health problems in adults, including problems such as depression, schizophrenia and bipolar disorder, and to cover the patient experience, as well as for services relating to bipolar disorder in children and young people. Given the interdependencies between mental health outcomes and the NHS Outcomes Framework, it is envisaged that NICE will be commissioned to develop Quality Standards for services relating to other mental health conditions as part of the broad library. It is likely that some of the Quality Standards for other care pathways or services will contain mental health elements.

5.82 Often, with children and young people, there is no single or clear diagnosis. In such circumstances, providers can supplement

existing NICE guidance (for example, on attention deficit hyperactivity disorder or depression) with other evidence-based interventions for treating mental health problems in these age groups.

Improving quality: Payment by Results

5.83 The Government is developing a system of Payment by Results for adult mental health services. Initially the rates of payment or tariffs will be determined locally. However, the currencies or groups of service users for whom payments will be made will be agreed and made consistent nationally.

5.84 The principles on which Payment by Results will work have been developed to facilitate appropriate high-quality care:

- the currencies are based on the needs of users requiring healthcare and other support, which makes the allocation of resources more efficient and appropriate, with better quality and productivity;
- the currencies are not setting-dependent, so there is no incentive for providers to keep people in hospital longer than is necessary;
- payments will progressively reflect the quality of the service as demonstrated in outcome and other quality indicators. Payment by Results will provide a much stronger incentive to maintain and raise quality of care; and
- local commissioners and GP consortia will be responsible for ensuring that the

mental health needs of the whole of their local populations are met by service provision.

- 5.85 Payment by Results for children's mental health services will also be introduced to improve incentives in the system. A national CAMHS dataset is in development for collecting and analysing information that is already recorded at local level. The dataset will support improvements in clinical practice and help to inform those who are planning or commissioning services locally about local priorities and needs.

Improving quality: Quality Accounts

- 5.86 Quality Accounts are public reports produced by NHS organisations about the quality of healthcare services they provide. The reports are a mechanism for helping providers to identify and focus on the issues that will make the biggest difference to quality of care. They can also be used to explain to commissioners, patients and the public which issues have been prioritised and how the organisation will address them.
- 5.87 All providers of NHS mental health and learning disability services have now published their 2009/10 Quality Accounts on the NHS Choices website. Evaluation of the accounts in acute trusts demonstrates that they have proved to be an effective tool for raising the profile of quality improvement and engaging boards. As organisations, including mental health

providers, gain experience in this type of reporting, their Quality Accounts will be better able to explain to users how key services, such as in the area of mental health, are being improved.

Improving quality: a more competitive market for providers

- 5.88 There is already a plurality of providers of mental health services, including many from the private and voluntary sectors. The Government wants to go further to ensure that patients and service users will be able to choose 'any willing provider' on the basis of quality. 'Any willing provider' will be subject to NHS prices and quality. This is of particular relevance in the area of mental health, where the needs of individuals are very diverse and where different and innovative approaches may be necessary for ensuring that even the most excluded can be helped to get the care and support they need.

6: IMPROVING OUTCOMES IN MENTAL HEALTH: PROMOTING EQUALITY AND REDUCING INEQUALITY

6.1 Tackling health inequalities and promoting equality, as enshrined in the Equality Act 2010, is vital if the Government is to deliver health outcomes that are among the best in the world. As the Marmot Review demonstrated, the social gradient in many health outcomes for people in disadvantaged groups and areas accounts for England's poorer health outcomes in comparison with other similar countries.⁸⁰ Aspects of people's identity and experiences of inequality interact with each other. For example, people from black and minority ethnic (BME) groups are more likely to live in deprived areas and have negative experiences, both as a result of their ethnic identity and because of their socio-economic status and living environment.

6.2 Promoting equality refers to the inclusion and equitable treatment of protected groups and a need to eliminate discrimination, advance equality of opportunity and foster good relations within communities.

6.3 Effective approaches to reducing differences in access, experience and mental health outcomes are built from the best available evidence on why and how these variations occur. Marmot

showed that, among other factors, poor childhood, housing and employment (and also unemployment) increase the likelihood that people will experience mental health problems and that the course of any subsequent recovery will be affected. These factors vary across different sections of society, with the result that some groups suffer multiple disadvantages.

6.4 The Equality Act 2010, informed by consultation with stakeholders from all sectors of the community and a major review of evidence on inequality, replaced the three existing public sector equality duties – pertaining to disability, race and gender – with a new Equality Duty. It covers nine **protected characteristics**, and there is a public sector duty to advance equality and reduce inequality for people with these protected characteristics, which are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

- 6.5 The Analysis of the Impact on Equality (AIE, formerly called an Equality Impact Assessment (EqIA)), which accompanies this strategy, considers the evidence of the differential impact of these characteristics and sets out an action plan to address these issues. There is also an extensive set of evidence of different types annexed to the AIE which underpins it. The Analysis also sets out actions for promoting equality.
- 6.6 There are three aspects to reducing mental health inequality:
- tackling the inequalities that lead to poor mental health;
 - tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
 - tackling the inequalities in service provision – in access, experience and outcomes.
- 6.7 *Healthy lives, healthy people* makes clear the Government's ambition to reduce health inequalities and improve the health of the poorest, fastest.
- 6.8 That has not always been the effect of previous initiatives, and there are some significant inequalities, both in the differing rates of mental health problems across different groups and in people's access to, experience of and outcomes from mental health services. Some of the evidence is summarised here. More is set out in the AIE that accompanies this strategy.
- 6.9 A fundamental principle in tackling inequality is that all protected characteristics should be considered so as to avoid unjustifiable discrimination. At local level, needs assessment will determine the areas of greatest inequality that local strategies will need to address.
- 6.10 Reducing inequalities requires a multi-stranded approach that tackles the economic, social and environmental determinants and consequences of mental health problems. Such an approach needs to take into account the fact that people have more than one protected characteristic. Approaches must also take into account people's living environments and social circumstances, which are critical to the onset and course of their mental health problems. This approach is embedded in both this strategy and other cross-government initiatives. Tackling the determinants is a key strand of *Healthy Lives, Healthy People*. It stressed the importance of both universal approaches and targeted interventions aimed at those facing the greatest disadvantage in society, so that their health can improve most quickly. *Healthy Lives, Healthy People* emphasised the need to start early, so as to ensure that all children have the best start in life and continue to develop well.
- 6.11 Inequalities that arise for people with protected characteristics are compounded by the stigma and discrimination surrounding mental ill health. That is why the Government has taken action to tackle public attitudes towards mental illness, one

of the key objectives of this strategy. This is covered in Chapter 3 above (objective (vi)).

- 6.12 One of the cornerstones of tackling inequalities in service provision is delivering a truly personalised approach that identifies the specific needs of each individual and their family and carers, so that they have more control over the support they receive.
- 6.13 The Government is working to close the equality gap for all people with protected characteristics. It has also identified a number of other groups that are known to have reduced access to mental health services, for example homeless people, veterans, people with personality disorder and offenders.
- 6.14 In this chapter we consider the specific groups protected by the Equality Act 2010. Research evidence⁸¹ has highlighted the challenges. Strategic solutions should be informed by current positive practice and other new and emerging research.

Improving outcomes for older people with mental health problems

- 6.15 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 sometimes short-lived, but for some may develop into a clinical depression. Some 11% of older people will have minor depression and 2% a major depression.⁸² Older people with physical

ill health, those living in residential care and socially isolated older people are at higher risk.⁸³ 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.⁸⁴ As well as the impact on quality of life, untreated depression in older people can increase need for other services, including residential care. However, older people can respond very well to psychological and medical treatments. This includes carers of people with dementia, so that they are better supported to manage challenging behaviours. As the Department of Health completes 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.

- 6.16 Improving the quality of care for people with dementia and their carers is a major priority for the Government. For every 10,000 people over the age of 65, 500 have dementia, with 333 not having this diagnosed. The Government is

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*⁸⁵ (September 2010) – the revised, outcomes-focused implementation plan for the National Dementia Strategy. More information on the mental health of older people is provided in the companion document to this strategy, *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

backgrounds, socio-economic status and experiences in wider society. People from BME groups often have different presentations of problems and different relationships with health services. Some black groups have admission rates around three times higher than average, with some research indicating that this is an illustration of need. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

6.17 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 of improving the recognition of depression in older people in primary care. A new training programme will be made available shortly.

6.18 From 2012 the NHS and local government will be required to comply with the Equality Act 2010 and its provisions on discrimination on grounds of age.

Improving outcomes for black and minority ethnic people with mental health problems

6.19 The evidence on the incidence of mental health problems in BME groups is complex. The term BME covers many different groups with very different cultural

6.20 African-Caribbean people are particularly likely to be subject to compulsory treatment under the Mental Health Act. South East Asian women are less likely to receive timely, appropriate mental health services, even for severe mental health conditions.

6.21 Tackling the inequalities for BME communities has been a central focus for a number of years. However, the outcomes have in some ways been disappointing.

6.22 *Race Equality Action Plan: A five-year review*⁸⁶ looks back at the work of the Delivering Race Equality in Mental Health Care programme and describes some of the key challenges, successes and learning. It provides a strong base from which

commissioners and service providers can make improvements. These will rely on:

- local collection and monitoring of information on ethnicity and culture;
- better use of these data to inform commissioning and provision in health and social care;
- a focus on outcomes that work for individuals and communities;
- monitoring and evaluating effectiveness of service delivery, especially around equality needs; and
- establishing mechanisms that allow local user groups to engage with providers and commissioners, and that empower and support them so that they can engage effectively.

6.23 This will be underpinned by the new statutory responsibilities of the NHS Commissioning Board and GP consortia. In addition, Department of Health research and analytical staff will continue to make best use of research in developing effective approaches for reducing race inequality in mental health.

Improving outcomes for disabled people with mental health problems

6.24 There are two aspects to the consideration of the outcomes for disabled people with mental health problems:

- people with mental health problems meet the criteria within legislation for disabled people; and

- disabled people with mental health problems may face barriers, either barriers to physical access or communication barriers (particularly in the case of deaf people). This is critical in mental health provision, which relies heavily on communication and relationships for supporting improved outcomes. Also, an estimated 25–40% of people with learning disabilities have mental health problems.

6.25 Commissioners and service providers will need to continue to ensure that mental health services are accessible to all disabled people. Arrangements need to be in place for deaf people so that they are able to communicate, and have equitable experiences of and outcomes from services.

6.26 The special educational needs and disability Green Paper will consider, among other things, how to make sure that there is better early intervention to prevent later problems for children with special educational needs and disabilities, including those who have underlying or associated mental health problem.

6.27 There are two important aspects to the improvement of mental health services for people with learning disabilities and autism:

- inclusivity of mainstream mental health services for people with learning disabilities who have mental health problems; and

- development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities and autism (recognising the increased risks of a range of physical and mental health problems for this group).

sexual orientation is patchy, making it less easy to develop tailored service responses. A priority action for securing improved outcomes is to achieve routine local monitoring of access to services, experience and outcome by sexual orientation.

6.28 People with autism may be refused support because they do not fit easily into mental health or learning disability services. This has been a long-standing problem. The autism strategy, *Fulfilling and Rewarding Lives*, and the recent statutory guidance *Implementing 'Fulfilling and Rewarding Lives': Statutory guidance for local authorities and NHS organisations to support implementation of the autism strategy*,⁸⁷ outlined priorities for improvement, including:

- the development of diagnostic services and pathways to care and support;
- the availability of mental health services for people with autism, where appropriate; and
- greater awareness of autism among healthcare and social care professionals.

Improving outcomes for lesbian, gay and bisexual people with mental health problems

6.29 People who are lesbian, gay and bisexual all have a higher risk of mental health problems and of self-harm.⁸⁸ They also suffer more attacks and violence. Experiences of mental health services are reportedly poor, and monitoring of

Improving outcomes in relation to gender inequality

6.30 There are many differences in the rates and presentation of mental health problems between men and women, and boys and girls. Improved awareness of these issues among staff is important.⁸⁹

Women

6.31 Recorded rates of depression and anxiety are between one and a half and two times higher for women than for men. Rates of deliberate self-injury are two to three times higher in women than men. Women are at greater risk of factors linked to poor mental health, such as child sexual abuse and sexual violence – an estimated 7–30% of girls (3–13% of boys) have experienced childhood sexual abuse. Around one in ten women have experienced some form of sexual victimisation, including rape. Studies have shown that around half of the women in psychiatric wards have experienced sexual abuse.

6.32 Sexual safety in inpatient and residential environments is particularly important. This includes the provision of women-only day areas in mental health service buildings and adherence to NHS policy on mixed-sex accommodation. Staff need to be

supported so that they can appropriately explore with women whether they have had experience of sexual violence. Issues relating to pregnancy and maternal health are dealt with in Chapter 5 and in the AIE.

Men

6.33 Three-quarters of people who commit suicide are men. Men are three times more likely than women to be dependent on alcohol and more than twice as many men in psychiatric units are compulsorily detained.⁹⁰ Services should be sensitive to the ways in which men present mental health problems.⁹¹

Improving outcomes in relation to gender reassignment

6.34 This strategy uses the definitions set out in the Equality Act 2010. Gender reassignment refers to, among others:

- people who plan to, or have undergone, physiological change or other attributes of sex; and
- people who are referred to as transsexual.

6.35 People who identify with this protected characteristic are subject to some of the greatest discrimination in our society. They are at increased risk of alcohol and substance misuse, suicide and self-harm.⁹² It is important that staff in health, social and education services are aware of the raised risks in these groups. The issue of increased suicide risk will be covered in

more detail in the forthcoming suicide prevention strategy.

Religion or belief

6.36 Inequalities arise in mental health services, in relation to religion or belief, in four main ways:

- The relationship with other aspects of identity (for some cultures ethnicity and religion are virtually inseparable). Service data show that more people from BME backgrounds identify themselves as religious. By failing to address religion, services disproportionately affect people from BME backgrounds.
- Potential for people who hold religious or other beliefs to have poorer experiences of services because core aspects of their identity are overlooked or they have no means of religious expression (for example, prayer rooms). This may cause anxiety and prove detrimental to their recovery.
- Evidence indicates that religion may be protective, particularly in relation to suicide.
- The role of religion or belief in people's explanations for their mental health problems – different conceptualisations and language between an individual and services will affect engagement and success of treatment and care.

6.37 If positive outcomes are to be achieved, services will need to incorporate religion and belief into the assessment of individuals. Local services will achieve

better outcomes if they make resources and facilities available for people to express their religion or belief.

The role of government in reducing health inequalities

6.38 The Department of Health has made tackling health inequalities a priority. It is under a legal obligation to promote equality across the characteristics protected in the Equality Act 2010. Subject to Parliamentary approval, the NHS Commissioning Board and GP consortia will be under a specific statutory obligation to reduce inequalities in healthcare provision.

6.39 One of the underpinning principles in the development of the NHS Outcomes Framework has been the need to promote equality and reduce inequalities in health outcomes. From 2012/13, the framework will be used by the Secretary of State for Health to hold the NHS Commissioning Board to account, and to achieve levels of ambition where they have been agreed. Levels of ambition will, where possible, take into account the variation and inequalities in outcome indicators, such as equalities characteristics, disadvantage and where people live. The framework will help the NHS Commissioning Board to play its full part in promoting equality in line with the Equality Act.

6.40 The Department of Health has created an Equality and Diversity Council, chaired by the NHS Chief Executive, to raise the profile of equality and diversity issues

across the NHS and to support the NHS in implementing the Equality Act. The Council reports to the NHS Management Board and is working to develop and deliver change to make the NHS more personal, fair and diverse. Goals include creating a framework that encourages NHS organisations and staff to work closely with the communities they serve, and ensuring that managers consider equality and diversity issues and champion good practice.

6.41 The Council has commissioned work to develop an Equality Delivery System for the NHS, which will draw on current good practice. This system is being designed to improve the delivery of personalised, fair and diverse services to patients, and to provide working environments where staff can thrive. So far, over 660 people from NHS organisations, patient groups and other interest groups have provided feedback on the proposals.

6.42 The question of equality in mental health raises highly complex – and often highly sensitive – issues. The Department of Health will continue to work with people affected, carers, families, communities and relevant agencies to refine its understanding of the issues. The Department will reconvene the Ministerial Advisory Group on equality in mental health, where the leading organisations in the field will be invited to work with the Minister of State for Care Services on progress.

7: IMPROVING QUALITY AND MAKING THE MOST OF OUR RESOURCES

7.1 Mental health problems cost both individuals (and their families) and the economy an enormous amount. There is a growing body of evidence that some approaches to addressing mental health issues can produce better outcomes while achieving significant reductions in costs. This is of particular relevance at a time of economic constraint. Although the NHS as a whole was protected from cuts in the Spending Review, rising demand means that the NHS has to find up to £20 billion in efficiency savings by 2014. As nearly 11% of England's annual secondary care health budget is allocated to mental health care, the mental health sector cannot be exempt from having to make savings. There are many interdependencies between physical and mental health, so any efficiencies in mental health services need to be carefully thought through so that false economies and greater costs elsewhere in the health and social care system are avoided. The Coalition Government has made it clear that it expects parity of esteem between mental and physical health services.

7.2 It is for local commissioners to ensure that when services are decommissioned or commissioned, the needs of the whole population and the best evidence of what works are taken into account.

7.3 There are four main ways of increasing value for money in mental health services:

- improving the quality and efficiency of current services;
- radically changing the way that current services are delivered so as to improve quality and reduce costs;
- shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and
- broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

7.4 These are not mutually exclusive and elements of all may be considered when planning and designing local solutions. Local commissioners and providers should also consider joining together with non-clinical agencies such as employment or housing support services. Further details are contained in the supporting document, *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

7.5 It is important to identify when and where benefits will be realised, and over

what timescale. For example, investment in different health and educational approaches when dealing with vulnerable children and families may result in reduced costs in the medium and long term for the criminal justice system and for the Department for Work and Pensions, through reduced crime and increased employment and economic productivity.

7.6 Fostering innovative practice, supporting research and ensuring good evaluation are critically important if the Government is to continuously maintain high-quality and efficient services.

Improving the quality and efficiency of current services

Quality, Innovation, Productivity and Prevention

7.7 At a time of financial and demographic pressure, improving quality while increasing productivity and effectiveness will be vital for any improvements in care. The Quality, Innovation, Productivity and Prevention (QIPP) programme within the NHS is designed to address this challenge. A number of local NHS plans for delivering QIPP include mental health provision, reflecting both the importance of mental health services and the resources currently committed to providing them. In line with this, the Government has initiated work at both national and local levels, with the aim of delivering improvements over a two-year period from 2011/12.

7.8 There are three workstreams:

- the acute care pathway – avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided (for example, by action to tackle delayed discharges);
- out of area care – getting better quality and better value through ensuring that appropriate in-area care is available where this is a better solution and commissioning effectively so that care is managed well, in terms of both care pathways and unit costs; and
- physical and mental health co-morbidity – getting better diagnosis and treatment of mental health problems for those with long-term physical conditions, and getting identification and treatment of anxiety or depression for those with medically unexplained symptoms. One example is the use of a ‘collaborative care’ approach when treating depression in people with type 2 diabetes in primary care. It has been estimated that introducing this nationally has the potential to save the NHS and social care around £3.4 million in four years, with a further £11.7 million of benefits to individuals from improved productivity.

7.9 The recent vision for adult social care emphasised that the additional £2 billion of funding made available in the Spending Review to support the delivery of adult social care must be accompanied by re-design of services to deliver efficiencies. This could include:

- better joint working with the NHS;
- helping people to stay independent for longer, with a focus on re-ablement services, and more crisis or rapid response services;
- more streamlined assessment; and
- a general presumption that responsibility for commissioning and providing services should be separated.

7.10 In addition, as the *Use of Resources in Adult Social Care*⁹³ highlighted, there remain dramatic differences between councils in their proportion of spend on long-term nursing and residential care. Councils are expected to look closely at how they can reduce spend on residential care and increase community-based provision.

7.11 The Department of Health will be issuing best-practice guidance and ‘cost calculators’ so that commissioners will be able to estimate savings in all three QIPP workstream areas later this year.

7.12 These workstreams align closely with the objectives of this strategy. The QIPP approach will be a powerful means of delivering much of the agenda. Further

details are set out in the supporting document *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health*.

Radically changing the way that current services are delivered so as to improve quality and reduce costs

7.13 Two examples of more radical reforms are as follows:

- Medically unexplained symptoms have been shown to cost the NHS in England £3 billion every year. A review of a large number of studies found that cognitive behavioural therapy is very effective for those with identified mental health problems.*
- Early Intervention in Psychosis services for young people aged 14–35 with the first onset of psychosis have been shown to benefit individuals, reduce relapse, improve employment and educational outcomes, and reduce risk of suicide and homicide. A recent study has shown that providing an early intervention approach rather than standard mental health care could deliver savings of £38,000 per person over 10 years (about 20% of these costs were incurred in NHS services). Early detection services for people with even earlier symptoms of psychosis (at-risk mental state) have also been estimated to deliver savings – in this case around £23,000 per person over 10 years (about 25% of these costs were incurred in the NHS).

* See *No Health Without Mental Health: The economic case for improving efficiency and quality in mental health*.

Shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises

7.14 There are many examples of effective early intervention. Two examples that demonstrate a strong evidence base are as follows:

- Intervening early for children with mental health problems has been shown not only to reduce health costs but also to realise even larger savings from improved educational outcomes and reduced unemployment and crime. These approaches not only benefit the individual child during their childhood and adulthood but also improve their capacity to parent. They can therefore break cycles of inequality running through generations of families.
- Conduct disorder is the most common childhood mental disorder, for which parenting support interventions are recommended as first-line treatment.⁹⁴ A number of studies have shown that effective parenting interventions and school-based programmes can result in significant lifetime savings. Parenting interventions for parents who have children with conduct disorder cost about £1,200 per child. They have been shown to produce savings of around £8,000 for each child over a 25-year period (14% of the savings are in the NHS, 5% in the education system and 17% in the criminal justice system).

Broadening the approach taken to tackle the wider social determinants and consequences of mental health problems

7.15 One example of this approach is providing face-to-face debt advice. Evidence suggests that this can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the NHS, savings in legal aid, and gains in terms of employment productivity, even before taking into account savings for creditors.

8: CONCLUSION

8.1 This strategy spells out the Coalition Government's commitment to improving mental health and mental health services. To achieve this, the Government has agreed six high-level objectives with partner organisations, which set out the joint determination to improve mental health outcomes for all. This strategy also describes a number of specific commitments to:

- improve the mental health and wellbeing of the population;
- keep people well; and
- ensure that more people with mental health problems regain a full quality of life as quickly as possible.

8.2 These outcomes will be delivered by putting more power into people's hands at local level to ensure effective planning and commissioning of services that meet locally agreed needs. Accountability is a key driver of the current reforms. The public sector, including the NHS, and public health and social care organisations, has a responsibility to the public and users of services that goes further than how services are provided. The public and service users will play an active part in decisions about how priorities are determined, how public money is spent and how discriminatory attitudes to mental health can be effectively challenged.

8.3 Local action will be supported by a sustained, cross-government approach. This will be led by the Cabinet Sub-Committee on Public Health, which will champion mental health across the whole of government. The approach will include actions that the Government can take to tackle stigma, as an employer, through its policies and partnerships, and by demonstrating leadership.

8.4 The Government will establish a Mental Health Strategy Ministerial Advisory Group which will work to realise this strategy. It will bring together the new NHS Commissioning Board and Public Health England with GP consortia, the Local Government Association, the Association of Directors of Adult Social Services, the Association of Directors of Children's Services, other government departments, the Care Quality Commission, Monitor, professional bodies, commissioners, mental health provider organisations, the voluntary and community sector, and people with mental health problems and carers.

8.5 Between 2011 and 2012, while the NHS Commissioning Board and Public Health England are being established, this group will identify actions in the transitional year for implementing this mental health strategy. The Government will review the function of this group for 2012 onwards, once the NHS Commissioning Board

and Public Health England are in place. However, the Government anticipates that it will become a focus for partners to discuss how implementation of this strategy will take place and review progress. The group may advise on improved indicators for tracking progress against the mental health objectives that could be used locally, by the NHS Commissioning Board, and potentially in future iterations of outcomes frameworks.

- 8.6 Action at local and national levels to implement this strategy will only be effective if there is sustained partnership working across all sectors. The Ministerial Advisory Group will be the locus for achieving this.

ANNEX: A HOW WILL WE KNOW IF THINGS HAVE IMPROVED?

(See the supporting document *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages* for further details under each objective.)

The Public Health Outcomes Framework

1. The Public Health Outcomes Framework consultation document proposes a number of national-level indicators to help local health and wellbeing boards and local communities track progress. While the domains will remain unchanged over the next few years, the indicators within each domain will develop over time. 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 are:

- healthy life expectancy
- differences in life expectancy and healthy life expectancy between communities.

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

Proposed indicators include:

- comprehensive, agreed, interagency 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

All the indicators in this domain are relevant to mental health and wellbeing. They include:

- 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
- the proportion of people with mental illness and/or disability in employment ^{*}, ^{**}
- the proportion of people with mental illness and/or disability in settled accommodation^{**}
- employment of people with long-term conditions
- 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 relevant to mental health and wellbeing include:

- smoking prevalence in adults (over 18)
- incidence of low birth weight of term babies
- rate of hospital admissions as a result of self-harm
- rate of hospital admissions per 100,000 for alcohol-related harm
- number leaving drug treatment free of drug(s) of dependence
- the 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 relevant to mental health and wellbeing include:

- 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)
- 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 relevant to mental health and wellbeing include:

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

* Shared responsibility with the NHS.

2. An equivalent to 'economic participation' 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.

The NHS Outcomes Framework

3. The NHS Outcomes Framework outlines a number of national-level outcome goals that can be used to measure progress. The domains will stay the same but the indicators will develop over time. For 2011/12 the indicators include the following:

Domain 1: Preventing people from dying prematurely

Improvement area

Reducing premature death in people with serious mental illness

Indicator is:

- under-75 mortality rate in people with serious mental illness.*

* Shared responsibility with Public Health England.

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 term 'recovery' is used in both the NHS and Social Care Outcomes Frameworks. When used here it refers to clinical recovery and is not being used in the specific way in which it is used in mental health services. However, the indicators suggested are relevant to mental health outcomes.

Domain 4: Ensuring that people have a positive experience of care

Improvement area

Improving the experience of healthcare for people with mental illness

Indicator is:

- patient experience of community mental health services.

Domain 5 : Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

- patient safety incident reporting
- severity of harm
- number of similar incidents.

Applies to all NHS providers including mental health services.

4. We are committed to ensuring that outcomes for children and young people are fully reflected in the NHS Outcomes Framework as it develops over time to reflect advances in practice and data collection.

The Adult Social Care Outcomes Framework

5. *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 data sets 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.
6. The initial Outcomes Framework for adult social care sets out a number of available measures, many of which are relevant 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.
7. 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.
8. 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.*

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.

9. In addition, further outcome measures proposed in the other domains are of direct relevance to mental health objectives:

Domain 1: Promoting personalisation and enhancing quality of life for people with care and support needs

Outcome measure

Enhancing quality of life for people with mental illness

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

Quality measures

Promoting personalised services

- the proportion of people using social care who receive self-directed support.

Domain 3: Ensuring a positive experience of care and support

Overarching indicator

- overall satisfaction with local adult social care services.

Outcome measures

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.

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

Overarching indicator

- 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.

Other potential Indicators

10. There are a number of indicators that 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. Psychological therapies services already regularly measure outcomes of interventions and access to services by different groups. In addition, the implementation of Payment by Results will ensure that services use Health of the Nation Outcome Scales (HoNOS) regularly to measure outcomes in secondary adult mental health services. Other key national indicators of relevance to the mental health objectives include the following:

- The Office for National Statistics is consulting on national measures of wellbeing. Disaggregation of the data to local area detail will be useful for local planning.
- The adult and child Psychiatric Morbidity Surveys 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 12-item General Health Questionnaire (GHQ-12) is also collected by the Health Survey of England.
- The Labour Force Survey collects the sickness absence that is attributable to mental ill health.
- The new Life Opportunities Survey may potentially provide information on a range of outcomes, including: barriers to employment, accessing health services, and participation in leisure and social activities.

Quality Standards

11. The following Quality Standards relevant to the mental health objectives are currently in development:

- Drug use disorders in over-16s
- Schizophrenia
- Bipolar disorder in adults
- Bipolar disorder in children and adolescents
- Alcohol dependence
- Depression in adults
- Postnatal care
- Drug use disorders
- Dementia
- Patient experience (generic)

- Patient experience in adult mental health care
 - Safe prescribing
 - Falls in a care setting
 - Nutrition in hospital, including young people.
12. Further Quality Standards relevant to mental health will be considered shortly. The new approach to quality and outcomes in adult social care also describes an expanded role for NICE in preparing Quality Standards for social care, which have the capacity to increase the coverage across individual pathways. As part of its most recent selection process, the National Quality Board also identified long-term conditions/people with co-morbidities or complex needs as an important area for Quality Standard development, but additional work is required to assess the feasibility and scope of the standard before the topic can be recommended for referral to NICE.

Areas where there are fewer indicators currently available

13. There are several areas where there are insufficient indicators currently available – for example, measuring aspects of mental wellbeing – and there is also a lack of indicators covering all age groups. Some of these gaps are further detailed in the companion document *No Health Without Mental Health: Delivering better mental health outcomes for people of all ages*.

ANNEX B: SUMMARY OF COMMITMENTS OF GOVERNMENT DEPARTMENTS TO SUPPORT MENTAL HEALTH OBJECTIVES

The Cabinet Sub-Committee on Public Health will oversee the implementation of this mental health strategy. It will be supported by the Social Justice Sub-Committee, which will ensure effective cross-government action to address the social causes and consequences of mental health problems.

Mental health objective	Action	Status	Owner
Objective 1 More people will have good mental health <i>More people will have better mental wellbeing and good mental health and fewer people will develop mental health problems</i>	Help to prevent mental health problems by encouraging organisations to tackle the causes such as work-related stress and to promote the welfare of their staff	Under way	HSE
	Reform children’s centres, focusing on the most disadvantaged (coalition commitment (CC))	New, under way	DfE
	Investigate a new approach to help families with multiple problems (CC)	New, under way	DfE
	Recruit 4,200 new health visitors (CC)	New, under way	DH
	Provide free nursery care for pre-school children (CC)	Ongoing	DfE
	Maintain priority of health and wellbeing in schools, through reviews of guidance, curriculum and Schools White Paper. Identify and disseminate evidence on supporting school transitions	New, proposed	DH/DfE
	Develop the Healthy Schools programme with businesses and charities	New	DH/DfE
	Reduce teenage conceptions through the provision of high-quality sex and relationships education and access to contraception services, and supporting teenage parents	Ongoing	DfE/DH

Mental health objective	Action	Status	Owner
Objective 1 (continued)	Create School Games to promote competitive sport	New, under way	DCMS
	Produce guidance on public health for schools, colleges and further education establishments	New, proposed	DH/DfE
	Introduce a significant pupil premium for disadvantaged pupils (CC)	New, under way	DfE
	Determine appropriate steps to protect playing fields, including improvement and protection as part of the London 2012 mass participation sports legacy	New, under way	DCMS
	Consider whether action can be taken to improve the energy efficiency, accessibility and adaptability of new homes	New, proposed	CLG
	Support sustainable travel initiatives (CC), including the new Sustainable Transport Fund	Ongoing and new	DfT
	Introduce a mass participation/community sport Olympic legacy programme	New, under way	DCMS
	Introduce a 'Green Deal' to support home energy improvements (CC)	New, proposed	DECC
	Produce practical guidance to support community groups in ownership of public spaces and community assets	New, under way	CLG
	Develop, with CLG, proposals for a new designation to protect green areas of particular importance to local communities	New	Defra
	Through the National Planning Policy Framework, explore how national planning policy might consider issues of health and wellbeing	New	CLG
	Set up an inter-ministerial working group to tackle the complex causes of homelessness	New, under way	CLG
	The Coalition Government made a commitment to train 5,000 community organisers over the course of this Parliament. They will be independent of government and led by the needs of their local community (CC)	New	Cabinet Office
	Abolish the default retirement age (CC)	New, under way	DWP
	Protect key benefits for older people (CC)	Ongoing	DWP

Mental health objective	Action	Status	Owner
Objective 1 (continued)	Continue the Active at 60 programme	Ongoing	DWP
	Work with the Fitness Industry Association to explore ways of utilising spare capacity in their facilities to offer activities for older people	New, proposed	DWP
	Explore potential to develop a social isolation toolkit	New, proposed	DWP
	Avoid significant adverse impacts on health and quality of life through the effective management of noise,* as set out in the Government's Noise Policy Statement for England (www.defra.gov.uk/environment/quality/noise/policy/index.htm)	Ongoing	Defra
	Ensure that the interests of people, businesses and communities in rural areas are fully and fairly recognised in all government policies and programmes and that rural communities themselves are free and able to address their own needs through locally driven initiatives	Ongoing	Defra

Mental health objective	Action	Status	Owner
Objective 2 More people with mental health problems will recover <i>More people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education and employment and a suitable and stable place to live</i>	Extend psychological therapies to children and young people, those with serious mental illness, older people and those with medically unexplained symptoms	New, under way	DH
	Publish the MoJ Green Paper on improved mental health for offenders	Under way	DH/MoJ
	Increase access to personal health budgets to people with mental health budgets	New	DH
	Commission an independent review of DWP's specialist disability employment programmes	Under way, due to report summer 2011	DWP
	New Offender Personality Disorder Plan	Planned for consultation early 2011	DH/MoJ
	Carry out welfare reform, including the Universal Credit, the Work Programme and Work Choice (CC)	New, under way	DWP
	Reinvigorate and reform informal adult and community learning to support the Big Society and reach out to those most in need of help	Under way	BIS
	Consider next steps for the Carers Strategy	Under way	DH/DWP/ BIS/DfE/ CLG/GEO
	Help elderly people to live at home for longer, through solutions such as home adaptations and community support programmes (CC)	Ongoing	DH/CLG
	Maintain preventative housing programmes: Supporting People, Disabled Facilities Grant and Decent Homes	Ongoing	CLG
	Encourage data sharing between A&E and other partners to identify violence	New, proposed	Home Office/DH
	Increase the number of rape crisis centres and put them on a sustainable footing	Ongoing and new	MoJ
Improve mental health of service personnel and veterans	Ongoing and new	MoD/DH	

Mental health objective	Action	Status	Owner
Objective 3 More people with mental health problems will have good physical health <i>Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health</i>	Food policy, for instance development of Government Buying Standards for food which will seek to improve nutritional standards in public sector catering services as well as their sustainability	New, under way	Defra
	Changes to alcohol licensing and pricing (CC)	New, under way	Home Office
	Work with the Fitness Industry Association to explore ways of utilising spare capacity in their facilities to offer activities for older people	New, proposed	DWP
	Act on the various commitments in the public health White Paper to improve physical health, including that of people with mental health problems	New	DH and other departments
	Develop a Tobacco Control Plan	Planned for early 2011	DH
	Develop a long-term conditions (LTC) strategy to improve health and wellbeing of people with LTCs, including those with severe mental health conditions (more at risk of developing another LTC) and those with an LTC such as diabetes who have depression, anxiety and/or other emotional problems. Key strands are supporting people to self-care, and increasing choices to meet wider holistic needs through personalised care planning	Under way	DH
	Develop an Alcohol Plan	Planned for 2011	DH
	Publish a Public Health White Paper follow-up document on obesity	Planned for spring 2011	DH

Mental health objective	Action	Status	Owner
Objective 4 More people will have a positive experience of care and support <i>Care and support, wherever it takes place, will 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</i>	Implement the recommendations of <i>A Vision for Adult Social Care: Capable communities and active citizens</i> (2010)	Ongoing	DH
	Implement the recommendations of <i>Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy</i> (September 2010)	Ongoing	DH
	Refreshed Carers Strategy <i>Recognised, Valued and Supported: Next steps for the Carers Strategy</i> (2010)	Ongoing	DH
	Implement the Equality Act 2010	Ongoing	All
	Abolish the default retirement age (CC)	New, under way	DWP
	Protect key benefits for older people (CC)	Ongoing	DWP
Objective 5 Fewer people will suffer avoidable harm <i>People receiving care and support will have confidence that the services they use are of the highest quality and at least as safe as any other public service</i>	Publish the MoJ Green Paper on improved mental health for offenders	Under way	DH/MoJ
	Encourage data sharing between A&E and other partners to identify violence	New, proposed	Home Office/DH
	Increase the number of rape crisis centres	Ongoing and new	MoJ
	Implement recommendations of <i>Call to End Violence Against Women and Girls</i> (November 2010)	New and under way	Home Office
	Develop a new national suicide prevention strategy	Planned for spring 2011	DH and across government

Mental health objective	Action	Status	Owner
Objective 6	Implement the Equality Act 2010	Under way	All
Fewer people will experience stigma and discrimination <i>Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will reduce</i>	Include mental health as an intrinsic aspect of wellbeing within <i>Healthy Lives, Healthy People</i> (the public health White Paper), and related cross-government actions	Under way	All
	Work with Time to Change and other partners to reduce stigma for people of all ages and backgrounds	Under way	DH/All
	Work with Time to Change to agree the best ways to assess improvements in attitudes to mental health over the lifetime of this strategy, including an annual attitudes survey	Under way	DH/All

ANNEX C: GLOSSARY

At-risk mental state	A state in which a person may have brief or slight symptoms of psychosis, but is not so seriously affected by the symptoms that they can be said to have a major mental illness.
Bipolar disorder	A severe mental illness with a long course, usually characterised by episodes of depressed mood alternating with episodes of elated mood and increased activity (mania or hypomania). However, for many people the predominant experience is of low mood. In its more severe forms, bipolar disorder is associated with significant impairment of personal and social functioning.
Care Quality Commission	The independent regulator of health and social care in England. It regulates care provided by the NHS, local authorities, private companies and voluntary organisations.
Cognitive behavioural therapy	A type of therapy that aims to help people manage their problems by changing how they think ('cognitive') and act ('behavioural'), which can help them to feel better about life.
Commissioning	The process of assessing the needs of a local population and putting in place services to meet those needs.
GP consortia	Groups of GPs that will in future lead the commissioning of most healthcare services across England. GP consortia are to be statutory bodies accountable for commissioning.
Health of the Nation Outcome Scales	The most widely used routine clinical outcome measure employed by English mental health services, these scales measure behaviour, impairment, symptoms and social functioning. They form part of the English Mental Health Minimum Dataset.
Health Premium	A component of the new funding mechanism for public health that will reflect deprivation and reward progress against health improvement outcomes in local areas.

Improving Access to Psychological Therapies	A programme that aims to improve access to evidence-based psychological therapies in the NHS through an expansion of the workforce and services.
Joint Strategic Needs Assessment	An assessment that provides an objective analysis of the current and future health and wellbeing needs of local adults and children, bringing together a wide range of quantitative and qualitative data, including user views. Up until now, each area's assessment has been produced by the local authority in collaboration with the primary care trust. GP consortia and local authorities, including directors of public health, will in future have an obligation to prepare the assessment, and to do so through the arrangements made by their local health and wellbeing board.
Medically unexplained symptoms	Persistent physical complaints that do not have a readily recognisable medical cause. The pain, worry and other symptoms are nonetheless real and cause distress. People of all ages with medically unexplained symptoms present frequently to the NHS. Contacts with primary care clinicians may be at least 50% more frequent per person than in the general population, and they may also have up to 33% more secondary care consultations.
Mental capital	The entirety of a person's cognitive and emotional resources. It includes their cognitive ability, how flexible and efficient they are at learning, and their 'emotional intelligence', such as their social skills and resilience in the face of stress. It therefore conditions how well an individual is able to contribute effectively to society, as well as their ability to enjoy a high quality of life.
Mental disorder	A broad term covering mental illness, learning disability, personality disorder and substance misuse. It is more formally defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'.
Mental health	Good or positive mental health is more than the absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and for their communities.
Mental Health Minimum Dataset	A nationally defined framework of data on adult patients, held locally by mental health trusts. It is designed to show in detail the patterns of care received by patients looked after by specialist mental health care providers in England.

Mental health problem	A phrase used in this strategy as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest themselves in different ways at different ages and may present as behavioural problems (for example, in children and young people). Some people object to the use of terms such as 'mental health problem' on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative.
Mental illness	A term generally used to refer to more serious mental health problems that often require treatment by specialist services. Such illnesses include depression and anxiety (which may also be referred to as common mental health problems) as well as schizophrenia and bipolar disorder (also sometimes referred to as severe mental illness). Conduct disorder and emotional disorder are the commonest forms of childhood mental illness.
Multisystemic Therapy	An evidence-based, intensive family- and community-based intervention that helps high-risk young people to modify their conduct or address their emotional problems and improves long-term outcomes.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	A research project largely funded by the National Patient Safety Agency. Other funders are the Scottish Government and the Northern Ireland Department of Health, Social Services and Public Safety.
National Institute for Health and Clinical Excellence	An independent organisation that provides advice and guidelines on the cost and effectiveness of drugs and treatments.
NHS Commissioning Board	A proposed new body that will have powers devolved to it directly from the Secretary of State for Health. It will be responsible for allocating and accounting for NHS resources and for supporting the GP consortia and holding them to account in terms of outcomes, financial performance, and fairness and transparency in the performance of their functions.

Personality disorder	Any disorder in which an individual's personal characteristics cause regular and long-term problems in the way they cope with life and interact with other people and in their ability to respond emotionally.
Population mental health	A measure of the proportion of the population with different levels of mental health at any one time. The spectrum ranges from mentally ill and languishing through to moderately mentally healthy and flourishing.
Protected characteristics	Characteristics against which the Equality Act 2010 prohibits discrimination, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
Psychosis	Psychosis affects a person's mind and causes changes to the way that they think, feel and behave. A person who experiences psychosis may be unable to distinguish between reality and their imagination. They may have hallucinations or delusions. Psychosis is not a condition in itself; it is a symptom of other conditions. The most common causes of psychosis are mental health conditions such as schizophrenia or bipolar disorder.
Public Health England	A new body which, subject to passage of the Health and Social Care Bill, will be established within the Department of Health in 2012 and will set the overall Outcomes Framework for public health. It will be accountable to the Secretary of State for Health.
Public mental health	<p>The art and science of promoting wellbeing and equality and preventing mental ill health through population-based interventions to:</p> <ul style="list-style-type: none">• reduce risk and promote protective, evidence-based interventions to improve physical and mental wellbeing; and• create flourishing, connected individuals, families and communities.
Quality Accounts	Reports on the quality of services published annually by providers of NHS care. Quality Accounts are intended to enhance accountability to the public.
Quality Standards	A set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions, and published by NICE.

Recovery

This term has developed a specific meaning in mental health that is not the same as, although it is related to, clinical recovery. It has been defined as: 'A deeply personal, unique process of changing one's attitudes, values, feelings, goals skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life.'⁹⁵

Resilience

An important aspect of wellbeing and mental health: the ability to cope with adverse circumstances, either as an individual or in a community.

Schizophrenia

A major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perceptions, thoughts, affect and behaviour. Each person with the disorder will have a unique combination of symptoms and experiences.

Severe (or serious) mental illness

More severe and long-lasting mental illness associated with functional impairment. Someone with a severe or serious mental illness may nevertheless also have long periods when they are well and are able to manage their illness.

Tariff

In relation to Payment by Results, the calculated price for a unit of healthcare activity.

Wellbeing

(Sometimes referred to as mental wellbeing or emotional wellbeing.)
For the purposes of this strategy the following definition has been developed: 'A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.'

ANNEX D: LIST OF ACRONYMS

AIE	Analysis of the Impact on Equality
BIS	Department for Business, Innovation and Skills
BME	black and minority ethnic
CAMHS	child and adolescent mental health services
CBT	cognitive behavioural therapy
CC	Coalition commitment
CLG	Department for Communities and Local Government
CQC	Care Quality Commission
DCMS	Department for Culture, Media and Sport
DECC	Department of Energy and Climate Change
Defra	Department for Environment, Food and Rural Affairs
DfE	Department for Education
DfT	Department for Transport
DH	Department of Health
DWP	Department for Work and Pensions
HoNOS	Health of the Nation Outcome Scales
HSE	Health and Safety Executive
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
LTC	long-term (physical health) condition
MoD	Ministry of Defence
MoJ	Ministry of Justice
MST	Multisystemic Therapy

NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
ONS	Office for National Statistics
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
TaMHS	Targeted Mental Health in Schools

ANNEX E: REFERENCES

- 1 Department of Health (2010) *Healthy Lives, Healthy People: Our strategy for public health in England*, available at: <http://tinyurl.com/HealthyLivesHealthyPeople>
- 2 WHO (2008) *The Global Burden of Disease: 2004 update*, available at: www.who.int/healthinfo/global_burden_disease
- 3 The Prince's Trust (2010) *Macquarie Youth Index*, available at: <http://tinyurl.com/youth-index-2010>
- 4 McCrone P, Dhanasiri S, Patel A et al. (2008) *Paying the Price: The cost of mental health care in England*. London: King's Fund, 220–226.
- 5 McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social Care.
- 6 Green H, McGinnity A, Meltzer H et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Palgrave Macmillan.
- 7 Kim-Cohen J, Caspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* 60: 709–717; Kessler R, Berglund P, Demler O et al. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* 62: 593–602.
- 8 Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health* 29: 115–129.
- 9 Hawton K, Rodham K, Evans E and Weatherall R (2002) Deliberate self harm in adolescents: self report survey in schools in England. *British Medical Journal* 325: 1207–1211.
- 10 Andrews G, Poulton R and Skoog I (2005) Lifetime risk of depression: restricted to a minority or waiting for most? *British Journal of Psychiatry* 187: 495–496.
- 11 Gavin N, Gaynes B, Lohr K et al. (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynaecology* 106: 1071–1083.
- 12 Rees S (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. London: Crisis and Public Health Resource Unit.
- 13 Kim-Cohen J, Caspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* 60: 709–717; Kessler R, Berglund P, Demler O et al. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* 62: 593–602.

- 14 Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health* 29: 115–129.
- 15 McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. NHS Information Centre for Health and Social Care.
- 16 Brown S, Kim M, Mitchell C and Inskip H (2010) Twenty-five year mortality of a community cohort with schizophrenia. *British Journal of Psychiatry* 196: 116–121; Parks J, Svendsen D, Singer P et al. (2006) *Morbidity and Mortality in People with Serious Mental Illness*, 13th technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.
- 17 Chevalier A and Feinstein L (2006) *Sheepskin or Prozac: The causal effect of education on mental health*. Discussion paper. London: Centre for Research on the Economics of Education, London School of Economics, available at: <http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf>
- 18 Meltzer H, Bebbington P, Brugha T et al. (2010) Job insecurity, socio-economic circumstances and depression. *Psychological Medicine* 40(8): 1401–1407.
- 19 McManus S, Meltzer H, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. NHS Information Centre for Health and Social Care.
- 20 Rees S (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. London: Crisis and Public Health Resource Unit.
- 21 Cooper R, Boyko C and Codinhoto R (2008) DR2 – the effect of the physical environment on mental wellbeing. *Mental Capital and Wellbeing Project*. London: Government Office for Science, Foresight, available at: www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/ProjectOutputs.asp
- 22 McManus S, Meltzer H, Brugha T et al (2009) *Adult psychiatric morbidity in England, 2007. Results of a household survey*. Health and Social Care Information Centre, Social Care Statistics
- 23 Government Office for Science (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century – Final Project Report*, available at: <http://tinyurl.com/ForesightReportMentalCapital>
- 24 Health and Safety Executive (2009) *How to Tackle Work-related Stress: A guide for employers on making the Management Standards work*, available at: www.hse.gov.uk/pubns/indg430.pdf
- 25 WHO (2008) *The Global Burden of Disease: 2004 update*, available at: www.who.int/healthinfo/global_burden_disease
- 26 Department of Health (2009) *Departmental Report 2009: The Health and Personal Social Services Programmes*, available at: www.official-documents.gov.uk/document/cm75/7593/7593.pdf

- 27 McCrone P, Dhanasiri S, Patel A et al. (2008) *Paying the Price: The cost of mental health care in England*. London: King's Fund, 220–226.
- 28 Department of Health (2009) *Departmental Report 2009: The Health and Personal Social Services Programmes*, available at: www.official-documents.gov.uk/document/cm75/7593/7593.pdf
- 29 Sainsbury Centre for Mental Health (2003) *The Economic and Social Costs of Mental Illness*. Policy paper 3, available at: www.centreformentalhealth.org.uk/pdfs/costs_of_mental_illness_policy_paper_3.pdf
- 30 Centre for Mental Health (2010) *The Economic and Social Costs of Mental Health Problems in 2009/10*, available at: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf
- 31 Sainsbury Centre for Mental Health (2007) *Mental health at work. Developing the business case*, available at: http://www.scmh.org.uk/publications/publications_list.aspx?SortID=e
- 32 Department for Work and Pensions (2010) *Statistical Summaries*, available at: http://campaigns.dwp.gov.uk/asd/index.php?page=statistical_summaries
- 33 Department for Communities and Local Government (2010) *Decentralisation and the Localism Bill: An essential guide*, available at: www.communities.gov.uk/documents/localgovernment/pdf/1793908.pdf
- 34 Home Office (2010) *Drug Strategy 2010 – Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life*, available at: www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary
- 35 HM Government (2010) *A Call to End Violence Against Women and Girls*, available at: www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-paper?view=Binary
- 36 Department for Education (2010) *Green Paper: Children and young people with special educational needs and disabilities – Call for views*, available at: <http://tinyurl.com/SENDResponses>
- 37 Ministry of Justice (2010) *Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*, available at: www.justice.gov.uk/consultations/docs/breaking-the-cycle.pdf
- 38 Department of Health (2010) *Equity and Excellence: Liberating the NHS*, available at: <http://tinyurl.com/EquityExcellenceLiberatingNHS>
- 39 Department of Health (2010) *A Vision for Adult Social Care: Capable communities and active citizens*, available at: www.dh.gov.uk/en/Aboutus/Features/DH_121664
- 40 Anthony WA (1993) Recovery from mental illness: the guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal* 16(4): 11–23.

- 41 See, for example, Friedli L (2009) *Mental Health, Resilience and Inequalities*. Mental Health Foundation and World Health Organization (WHO) Europe, available at: www.euro.who.int/document/e92227.pdf
- 42 Department of Health (2010) *Healthy Lives, Healthy People: Transparency in outcomes – Proposals for a public health outcomes framework*, available at: <http://tinyurl.com/PublicHealthOutcomesConsult>
- 43 Department of Health (2010) *Transparency in Outcomes: A framework for adult social care – A consultation on proposals*, available at: <http://tinyurl.com/SocialCareOutcomesConsult>
- 44 Clark C, Candy B, Stansfield S (2006) A systematic review on the effect of the built and physical environment on mental health. Centre for Psychiatry, Wolfson Institute of Preventive Medicine, Queen Mary's School of Medicine and Dentistry, University of London.
- 45 Mykletun A, Bjerkeset O, Overland S et al (2009) Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry*, 195, 118-125.
- 46 Hemingway H and Marmot M (1999) Evidence based cardiology. Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. *British Medical Journal* 318: 1460–1467; Nicholson A, Kuper H and Hemingway H (2006) Depression as an aetiological and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146 538 participants in 54 observational studies. *European Heart Journal* 27(23): 2763–2774.
- 47 Parks J, Svendsen D, Singer P et al. (2006) *Morbidity and Mortality in People with Serious Mental Illness*, 13th technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.
- 48 De Hert M, Dekker JM, Wood D et al (2009) Cardiovascular disease and diabetes in people with severe mental illness. Position statement from the European Psychiatric Association. *European Psychiatry*. <http://www.easd.org/easdwebfiles/statements/EPA.pdf>
- 49 McManus S, Meltzer H and Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research, available at: www.natcen.ac.uk/media/601275/smoking_and_mental_health_-_final_report_revised%20and%20final.pdf
- 50 Green H, McGinnity A, Meltzer H et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Palgrave Macmillan.
- 51 NICE (2009) *Depression in Adults with a Chronic Physical Health Problem: Treatment and management*, NICE Clinical Guideline 91, available at: www.nice.org.uk/nicemedia/pdf/CG91NICEGuideline.pdf

- 52 Parry-Langdon N (ed) (2008) *Three Years On: Survey of the development and emotional well-being of children and young people*. Newport: Office for National Statistics.
- 53 NICE (2009) *Depression in Adults with a Chronic Physical Health Problem: Treatment and management*, NICE Clinical Guideline 91, available at: www.nice.org.uk/nicemedia/pdf/CG91NICEGuideline.pdf
- 54 NHS Confederation Mental Health Network and National Mental Health Development Unit (2009) *Acute Care Declaration*, available at: www.acutecareprogramme.org.uk/silo/files/acute-care-declaration-leaflet.pdf
- 55 Fortune S and Hawton K (2005) Suicide and deliberate self-harm in children and adolescents. *Current Paediatrics* 15: 575–580.
- 56 Government Office for Science (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century – Final project report*, available at: <http://tinyurl.com/ForesightReportMentalCapital>
- 57 Department of Health (2010) *New Horizons – Confident communities, brighter futures: A framework for developing well-being*, available at: <http://tinyurl.com/ConCommunitiesBrighterFutures>
- 58 Putting People First (2010) *Think Local, Act Personal: Next steps for adult social care*, available at: <http://tinyurl.com/ThinkLocalActPersonal>
- 59 Department of Health (2010) *Recognised, Valued and Supported: Next steps for the Carers Strategy*, available at: <http://tinyurl.com/NextStepsCarersStrategy>
- 60 The Princess Royal Trust for Carers and National Mental Health Development Unit (2010) *Triangle of Care – Carers included: A guide to best practice in acute mental health care*, available at: <http://its-services.org.uk/silo/files/triangle-of-care-carers-included.pdf>
- 61 Brugha T, Weich S, Singleton N et al. (2005) Primary group size, social support, gender and future mental health status in a prospective study of people living in private households throughout Great Britain. *Psychological Medicine*, 35(5): 705–714.
- 62 Melzer D, Fryers T and Jenkins R (2004) *Social Inequalities and the Distribution of Common Mental Disorders*. Maudsley Monograph 44. Hove: Psychology Press.
- 63 Brown S, Nesse R, Vonokur A and Smith D (2003) Providing social support may be more beneficial than receiving it: results from a prospective study of mortality. *Psychological Science* 14(4): 320–327.
- 64 Rabiner D, Scheffler S, Koetse E et al. (2003) The impact of the senior companion program on quality of life outcomes for frail older adults and their families. *Home Health Care Services Quarterly* 22(4): 1–26.

- 65 Wheeler J, Gorey K and Greenblatt B (1998) The beneficial effects of volunteering for older volunteers and the people they serve: a meta-analysis. *International Journal of Aging and Human Development* 47(1): 69–79.
- 66 Department of Health (2010) *Practical Approaches to Improving the Lives of Disabled and Older People through Building Stronger Communities*, available at: <http://tinyurl.com/CommunityCapacity>
- 67 Business in the Community (2009) Emotional Resilience Toolkit, available at: www.bitc.org.uk/resources/publications/emotional_resilience.html; Health and Safety Executive Management Standards, available at: www.hse.gov.uk/stress/standards/
- 68 Boorman S (2009) *NHS Health and Well-being: Final Report*. Department of Health, available at: <http://tinyurl.com/NHSHealthandWellbeing>
- 69 Mind (2010) *Taking Care of Business: Employers' guide to mentally healthy workplaces*, available at: www.mind.org.uk/assets/000/8387/EMPLOYERS_LZ.pdf
- 70 Department of Health (2010) *Achieving Equity and Excellence for Children*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449
- 71 Kennedy I (2010) *Getting It Right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119445
- 72 Department for Education (2010) *Monitoring and Evaluation of Family Intervention Projects to March 2010*. Statistical Release, available at: www.education.gov.uk/rsgateway/DB/STR/d000956/osr09-2010.pdf
- 73 Home Office (2010) *Drug Strategy 2010 – Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life*, available at: www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary
- 74 Green H, McGinnity A, Meltzer H et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Palgrave Macmillan.
- 75 Blonk R, Brenninkmeijer V, Lagerveld S and Houtman I (2006) Return to work: a comparison of two cognitive behavioural interventions in cases of work-related psychological complaints among the self-employed. *Work and Stress* 20(2): 129–144; Lagerveld S, Blonk R, Brenninkmeijer V and Schaufeli W (2010) Return to work among employees with mental health problems: development and validation of a self-efficacy questionnaire. *Work and Stress* 24(4): 359–375.

-
- 76 Bradley K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, available at: <http://tinyurl.com/TheBradleyReport>
- 77 Ministry of Justice (2010) *Breaking the Cycle: Effective punishment, rehabilitation and sentencing of offenders*, available at: www.justice.gov.uk/consultations/docs/breaking-the-cycle.pdf
- 78 Medical Research Council (2010) *MRC Review of Mental Health Research – Report of the Strategic Review Group*, available at: www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC006848
- 79 National Institute for Mental Health in England, Barts and The London School of Medicine and Department of Health (2009) *Outcomes Compendium: Helping you select the right tools for best mental health care practice in your field*, available at: <http://tinyurl.com/OutcomesCompendium>
- 80 Marmot M (2010) *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, available at: www.marmotreview.org
- 81 See NMH DU Fact File 5, available at: www.nmhdu.org.uk
- 82 Godfrey M, Townsend J, Surr C et al. (2005) *Prevention and Service Provision: Mental health problems in later life*. Leeds: Institute of Health Sciences and Public Health Research, Leeds University, and Division of Dementia Studies, Bradford University.
- 83 Craig R and Mindell J (eds) (2007) *Health Survey for England 2005: Health of older people*. Leeds: NHS Information Centre.
- 84 Chew-Graham C, Burns A and Baldwin R (2004) Treating depression in later life: we need to implement the evidence that exists. *British Medical Journal* 329: 181–182.
- 85 Department of Health (2010) *Quality Outcomes for People with Dementia: Building on the work of the National Dementia Strategy*, available at: <http://tinyurl.com/DementiaStrategyImplementation>
- 86 Department of Health (2010) *Race Equality Action Plan: A five year review*, available at: www.nmhdu.org.uk/news/race-equality-action-plan-a-five-year-review/
- 87 Department of Health (2010) *Implementing 'Fulfilling and Rewarding Lives': Statutory guidance for local authorities and NHS organisations to support implementation of the autism strategy*, available at: <http://tinyurl.com/AutismStatutoryGuidance>
- 88 Equality and Human Rights Commission (2010) *How Fair is Britain? Equality, human rights and good relations in 2010. The First Triennial Review*, available at: <http://tinyurl.com/EHRCTriennialReview>

- 89 Williams J and Paul J (2008) *Informed Gender Practice: Mental health acute care that works for women*. London: National Institute for Mental Health in England; National Mental Health Development Unit (2010) *Working towards Women's Well-being: Unfinished business*, available at: www.nmhd.org.uk/silo/files/working-towards-womens-wellbeing-unfinished-business.pdf
- 90 Wilkins D (2010) *Untold Problems: A review of the essential issues in the mental health of men and boys*. Men's Health Forum and National Mental Health Development Unit.
- 91 Wilkins D and Kemple M (2011) *Delivering Male: Effective practice in male mental health*. Men's Health Forum, Mind and National Mental Health Development Unit.
- 92 Equality and Human Rights Commission (2009) *Trans Research Review*, available at: <http://tinyurl.com/EHRCTransResearchReview>
- 93 Department of Health (2009) *Use of Resources in Adult Social Care: A guide for local authorities*, available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107596
- 94 NICE (2006) *Technology Appraisals: Conduct disorder in children – parent-training/educational programmes in the management of children with conduct disorder and implementation advice*, available at: www.nice.org.uk/TA102
- 95 Anthony WA (1993) Recovery from mental illness: the guiding vision of the mental health system in the 1990s. *Psychosocial Rehabilitation Journal* 16(4): 11–23.

