



The Sainsbury Centre

for Mental Health



## POLICY PAPER

# The Future of Mental Health: a Vision for 2015

## Introduction

The Local Government Association, the NHS Confederation, the Sainsbury Centre for Mental Health (SCMH) and the Association of Directors of Social Services have worked together over the past year to produce a vision of what mental health will be like 10 years from now.

The project aimed to set out the best case scenario, based on where we are now, of what it will be like to experience mental health problems in 2015. We hope it will help to shape the direction of policy over the coming decade and inform local authorities, the NHS and other public services in offering better support to people with mental health needs and better ways of promoting mental wellbeing among all the people they serve.

## The Vision for 2015

By 2015, mental wellbeing will be a concern of all public services. Undoubtedly there will still be people who live with debilitating mental health conditions, but the focus of public services will be on mental wellbeing rather than on mental ill health. The balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individual who uses, or even chooses, them.

Schools will include emotional literacy in curricula and will support students experiencing problems. Employers will compete to become 'Wellbeing Workplaces' which demonstrate good practice in supporting staff who experience problems and in positively recruiting those who have had mental health conditions.

Mental health services will be integrated into ordinary health and other services: in libraries, GP surgeries and schools. People seeing their GP with mental health problems will be able to choose from a range of treatment options based on authenticated research evidence without facing long waiting times. For those with the most serious problems, acute care will be available in crisis houses or even 'hotels' as well as hospitals. They will receive care that is well planned and that aims to support them in achieving their personal goals for recovery. They will have a comprehensive care plan, with the option to buy their own services through direct payments or an individual budget, and will be advised by an 'associate' with expertise in employment, benefits and housing as well as treatment and care.

Individuals will make appointments at times that suit them rather than being told when to turn up. Someone will explain the reformed incapacity benefits system to them and make sure they are getting all of their entitlements, and they will be advised on any personal financial situations they need help with.

**Box 1: Jill, 2015**

Jill's story illustrates what could happen in 2015.

Jill was 20 when she started to hear voices. She had seen a documentary on television explaining that this happens to a lot of people, and while the voices were frightening she knew that she could get help. In her last year at school she had been taught how important it was to look after your mental wellbeing, and that it was important to talk to someone before things got worse.

She knew there was a place at the local leisure centre where she could get help. She dropped in and a worker immediately arranged for her to see a psychiatrist.

The doctor talked to Jill about her symptoms and about the different options for treatment. She explained that cognitive behavioural therapy (CBT) could be helpful, but suggested that medication could be a quicker way of alleviating the symptoms if they were very troubling. She gave Jill some information on different medications and their benefits and side effects, but also talked through other options and gave her written information and website addresses.

The worker she had talked to initially signed her up for relaxation and exercise classes. He discussed the stresses she had been under that might have triggered the voices and said that the local authority could give her advice on her debts

and rent arrears as well as finding more suitable accommodation for her and her child. He talked about child care options and advised her about direct payments.

Jill and the key worker put together a care plan for herself and her daughter, which she could access online. She was taught how to book appointments for herself. The key worker gave her a 24-hour number to call if she urgently needed someone to talk to, but explained that he would be available during working hours and could visit her at home or meet her somewhere convenient.

When she made a decision to start a course of antipsychotics, Jill was given a full physical health check to make sure the drugs wouldn't cause her any health problems. She was concerned the medication might make her put on weight, so she signed up for the free exercise and nutrition programme at the leisure centre. This was convenient because she could see her key worker at the same time.

Jill's key worker arranged for her to study part time at a local college that had a mental health support worker, and went with her to see a vocational adviser who visited the leisure centre weekly. He suggested she work two days a week, and told her about several job vacancies with accredited 'Wellbeing Workplace' employers.

Offenders with mental health conditions will, where appropriate, be diverted from prison; and those who are in prisons will be offered equivalent care to that which would be offered outside, or transferred promptly to an appropriate NHS secure bed.

The physical health of people with mental health conditions will be a priority for primary care. Help to prevent weight gain and stop smoking, and advice on regular exercise will be freely available. The Government will lead in continued efforts to combat prejudices about mental health and make discrimination difficult.

**How can it be achieved?**

The Vision for 2015 requires some very significant shifts in the way mental health services work and in public policy as a whole. Some of the key

challenges for public services to implement the vision include:

- ❖ Look at where services are located and how accessible they are.
- ❖ Examine how health and local government work together and with the voluntary and independent sectors.
- ❖ Diversify provision of acute care.
- ❖ Reduce the number of people from Black and minority ethnic communities being admitted to hospital, especially compulsorily.
- ❖ Extend the use of direct payments for social care.
- ❖ Review their own employment practices to extend opportunities for service users and ensure discrimination is tackled.
- ❖ Find creative new ways of recruiting, retaining and skilling staff.

## Where do we start?

While this is an ambitious agenda, it has to start from where we are today. There are positive moves that policymakers, commissioners and service providers can make now that will take us in the right direction. They include:

- ❖ Improving use of the care programme approach (CPA) to ensure that care planning is comprehensive, and fully involves people who use services and their carers.
- ❖ Implementing the GP contract to ensure health checks are offered to those with severe mental health problems and enhanced services for depression are developed.
- ❖ Investing in employment support, talking therapies, exercise, and other alternatives to conventional medical treatment.
- ❖ Developing a fully-funded national programme to combat stigma and discrimination.
- ❖ Creating local leadership to make change happen through effective strategic planning.

## Where are we now?

About one in six people in England has a mental health problem at any given time. The majority experience a 'common mental health condition' such as depression or anxiety. About one in 100 has a 'severe mental health condition' such as schizophrenia or bipolar disorder (manic depression). Nearly a third of GP consultations are related to mental health problems (SEU, 2004). Those problems are likely to be medicated at a total cost of over £600 million a year: £401 million for antidepressants and £219 million for medication to treat psychoses and related disorders (DH, 2005c). The full cost of mental illness in England is an estimated £77 billion a year (SCMH, 2003a).

Some 91% of people with a mental health condition are treated entirely in primary care (Hague & Cohen, 2005). For most, although by no means all, a course of antidepressants combined with counselling is enough to help them recover.

Specialist mental health services work mostly with those who have severe mental health problems. Over the past 10 years the experience of people using those services has changed markedly. The publication of *Modernising Mental Health Services: Safe, sound and supportive* (DH, 1998)

was the precursor to the *National Service Framework for Mental Health (NSF)* (DH, 1999) setting out seven priorities and an ambitious agenda for changing the way services are provided (see Box 2).

### Box 2: The seven standards of the National Service Framework for Mental Health

*Standard 1* – mental health promotion and discrimination/exclusion

*Standards 2 and 3* – primary care and access to services

*Standards 4 and 5* – services for people with severe mental health problems

*Standard 6* – support for carers

*Standard 7* – action to reduce suicides

(DH, 1999)

After the NSF was published, the *NHS Plan* (DH, 2000) set out specific targets for improving mental health care across the country. They included the creation of three new kinds of specialist team:

- ❖ assertive outreach – which provides ongoing support for people living in the community with severe and enduring mental health conditions;
- ❖ crisis resolution/home treatment – which offers emergency care for people in a crisis and will in time 'gatekeep' admissions to hospital wards;
- ❖ early intervention in psychosis – which supports people aged 14-35 in their first episode of a severe mental health condition such as schizophrenia.

Following the NHS Plan, investment in mental health rose from £3.3 billion in 2001/02 to £4.5 billion in 2004/05 (Mental Health Strategies, 2005). This is a very considerable investment, but has not kept pace with the investment needed to implement the NSF in full (SCMH, 2003b). It has also, crucially, been insufficient to tackle the longstanding shortage of staff in mental health services, as a result of which new developments have either been limited in size and scope or have been implemented at the expense of existing services, denuding them of key staff (Philip, 2005).

### Box 3: Christopher, 2005

Christopher was 24, when he started to feel depressed. At first he didn't know what was wrong. He found it hard to get up, bickered with his wife for no reason, didn't want to play with their toddler, and found it more and more difficult to concentrate at work. He stopped wanting to see his friends, and dropped out of the social football team he had enjoyed. Under pressure from his wife, he went to see his GP who prescribed a course of antidepressants. When things didn't get better, the GP signed him off work for six weeks, but Christopher didn't want to tell his boss he had a mental health problem, so he took leave instead. As his depression deepened, Christopher's relationship broke down. When his wife couldn't cope any more and left him, he saw no hope for the future and tried to take his own life. He was admitted to an acute psychiatric ward under the Mental Health Act.

While in hospital Christopher lost his job. His wife said she didn't want him to come back to their flat. When he was ready to be discharged he was sent to the local Homeless Persons Unit with a letter stating his psychiatric diagnosis and asking the local authority to house him. He was sent to a hostel for people with mental health conditions

where he lived for seven months until he was offered a council flat. He didn't feel comfortable with the flat because it was on the sixth floor of a high rise block. His psychiatrist had warned that for safety reasons he should be housed in low-rise accommodation, but he was afraid that if he told the housing worker this he would go back to the bottom of the waiting list.

For the first time, Christopher was reliant on state benefits, but he wasn't sure of his entitlements and was too ashamed to seek advice. He couldn't afford to keep up with his friends, and soon his only social contacts were with the people he met at the day centre he attended. Christopher found some of the activities at the day centre helpful – he enjoyed the relaxation classes and took part in an anxiety management group – but he wanted to get back to work. However, he was scared that he would be unable to cope with the pressures of working, and this made him depressed again. He was worried that if he went back to work he would give up his benefits, and if he couldn't hold down a job would be back in the same situation he was before.

Christopher wanted to get his life back again, but he didn't know how.

### Current policy developments

A number of current and forthcoming policy developments form an important starting point to the next 10 years for mental health.

An integrated community health and social care White Paper will be published shortly. It will cover all aspects of care that people need in the community. It is likely to focus on providing services closer to people's homes or workplaces, bringing health and care services together, meeting people's needs at different stages of their lives, using new technologies, helping people to help themselves and involving people in shaping local services. The Government has indicated that further work on social care will take place outside the White Paper including links to Derek Wanless' spending report for the King's Fund, due in Spring 2006, and reports on Department of Health (DH) pilots on individual budgets, culminating in a submission to the Treasury's Spending Review in 2007.

The Government has described the strategic agenda to bring together health and local government as "a marriage, not a treaty", promising

"reform and improvement on the ground" (Byrne, 2005). It has committed the Care Services Improvement Partnership (CSIP), which now incorporates the National Institute for Mental Health in England (NIMHE), to work with the Local Government Improvement and Development Agency (IDeA) to develop the first joined-up national improvement strategy for adult social care.

Further structural change to the NHS is also on the horizon. The creation of free-standing NHS Foundation Trusts has already begun and will in 2006 be extended for the first time to mental health service providers. Foundation Trusts have distinct governance arrangements to make them more accountable to local people and increased financial freedoms to invest in new services. By 2008 the Government plans for all NHS trusts to have the opportunity to attain foundation status.

Commissioning of health and social services is already changing. It is unclear how this will work in the short term, let alone by 2015. The impending reorganisation of PCTs is likely to approximately halve their number, while day-to-day responsibility for commissioning will gradually be transferred to individual GP practices through the new 'practice-based commissioning' system. The Department

of Health believes that devolving commissioning power will improve patient care and give GPs more say in what services they buy for their patients. How much provision of community services will remain with PCTs is unclear, though previous suggestions that all such provision would be removed have since been modified.

The arrival of the new Payment by Results system of paying providers for their services will also have a major impact. The benefits of such a system – that it focuses commissioning decisions on quality rather than cost – could be considerable, yet the challenge of making a system designed for short episodes of surgical treatment in hospital work in mental health will be great (SCMH, 2004a).

The Government plans to introduce a revised Mental Health Bill this parliamentary session, i.e. before October 2006. Among other changes to the current law, the proposed legislation would introduce powers to enforce psychiatric treatment in the community, rather than only in hospital. The legislation is also likely to ease the obligation on local authorities to provide free aftercare to patients following detention under the Mental Health Act, but will require that individuals subject to compulsory treatment orders in the community receive adequate standards of care.

The Government has stated its intention to pass the legislation despite criticism from a Parliamentary Scrutiny Committee and pressure from the Mental Health Alliance, a group of 75 voluntary and public sector bodies who have combined to challenge the Bill.

As it stands, the Bill would have major workforce implications for both health and social care bodies. There is no international evidence that introducing community detention cuts hospital admissions, so potentially it could result in higher care costs if, as predicted by the Mental Health Alliance, the numbers of people detained increases.

The new Bill will also have major implications for people who also fall under the Capacity Act, passed in 2005. This Act provides for people who do not have decision-making capacity and has significant overlaps with the Mental Health Bill that will need to be considered by services.

## Mental health services in 2015

Our vision for mental health in 2015 includes some far-reaching changes to the way services are managed and delivered. This section sets out some of the main changes that are required to achieve the vision. It focuses on services for people of

working age. Those for children and older adults face many similar challenges but also very specific issues to which this paper cannot do justice.

## Mental health promotion

At the heart of our vision for 2015 is the premise that the focus of services will be shifting from mental health care to promoting mental wellbeing. Promoting mental wellbeing has, to date, been low down the policy agenda.

The Government's *Choosing Health* white paper (DH, 2004a) made passing reference to mental health promotion, promising to work on improving mental health "because mental wellbeing is crucial to good physical health and making healthy choices; because stress is the commonest reported cause of sickness absence and a major cause of incapacity; and because mental ill health can lead to suicide". Yet there was no commitment to how this will be achieved.

Before that, the *National Service Framework for Mental Health* (DH, 1999) identified mental health promotion and tackling the stigma and discrimination that accompany a diagnosis of mental ill health as its top priority, yet of the total £4.5bn primary care trusts planned to spend on mental health services in 2004/05 just £2.4 million was earmarked for mental health promotion (Mental Health Strategies, 2005). Investing more in mental health promotion was one of the priorities listed in the Department of Health's five-year review of the NSF (DH, 2004b).

**Mental wellbeing must be put on the agenda of schools if we are to see a new generation of emotionally-aware young adults in 2015.** While most school age children learn about emotional health and wellbeing as part of the Personal, Social and Health Education programme, there is no requirement on schools to include mental health in this curriculum. Education in social, emotional and behavioural skills is being piloted in some primary schools and many voluntary sector organisations are actively working in education.

Mental health promotion also needs to become a mainstream part of the role of local authorities. **Programmes to reduce crime or regenerate physical environments, for example, should by 2015 consider mental and emotional wellbeing a fundamental part of what they do.** Indicators of quality of life should be developed, and considered in all areas of service provision both for people with identified mental health conditions and the general population.

#### Box 4: Mental health promotion in Scotland

Scotland has made advances in mental health promotion with its three-year National Programme for Improving Mental Health and Well-Being, in which it has invested substantially. The programme has two aims: to change the way in which people think and act about their own mental health and that of others; and to improve the quality of life, wellbeing and social inclusion of people who experience mental health conditions.

The programme's action plan states: "Being able to provide the basic building blocks of a good quality of life in local communities is an essential part of improving mental health and wellbeing. This involves the provision of good quality housing, quality built environments, environmental policies that have communities' wellbeing at the core of their actions, good transport infrastructure, safe parks and recreational areas and facilities, cultural activities, play areas, clean streets, responsive policing, tackling speeding and drug dealing." (Scottish Executive, 2003.)

Box 4 shows what the Scottish Executive is aiming to achieve in its National Programme for Improving Mental Health and Well-Being. Local authorities in the rest of the UK should work vigorously to promote wellbeing in their communities, taking a position of leadership to coordinate action across statutory and voluntary services.

#### Primary care

If services are to genuinely prioritise wellbeing and prevention of mental health problems then resources need to be shifted to primary care. This could ensure that children and young people have early access to services that address social, emotional and behavioural issues, and that people's continuing needs for care and support are met as they get older. Recent guidance from the National Institute for Health and Clinical Excellence (NICE) on the treatment of common mental health conditions in adults and children should help to set a framework for this (NICE 2004, 2005).

#### More accessible services

Depression and anxiety can be among the most debilitating health conditions a person can experience. While individuals are frequently

told that talking therapies – including cognitive behavioural therapy (CBT), counselling or psychotherapy – would be beneficial they are warned that the waiting lists are so long it will be months or even years before they will be offered a place. This should be tackled by extending the availability of psychological therapies to people with a range of mental health conditions. This could include the network of 250 therapy centres Lord Layard set out in his SCMH Lecture in September 2005 (Layard, 2005) but also work to empower existing NHS staff to practise their talking therapy skills, for example in acute psychiatric wards, where the shortage of staff currently makes this practically impossible.

The development of intermediate mental health teams – currently being piloted in five PCTs in England – also promises to provide an important new tier of treatment and support for individuals who need more than primary care services can provide but who do not qualify for specialist care from mental health trusts (Hague & Cohen, 2005). This development has the potential to provide an important new role for the cadre of 1,000 new 'graduate' primary care mental health workers introduced in the NHS Plan (DH, 2000).

**By 2015 primary care services should encompass a range of alternatives and better links with social care.** Some primary care teams already work with local authority community services and services in the non-statutory sector, as well as secondary services, to ensure social needs are met. The Department of Health has said that "model" primary care teams may, for example, have close links with Citizens Advice Bureaux and benefits and housing agencies. The Care Services Improvement Partnership (CSIP) is also working on finding ways to make primary care a gateway to social inclusion for people with mental health problems.

#### Community services

Community-based services for people with severe mental health problems have advanced more than any other aspect of mental health care in the past two decades. First through the establishment of community mental health teams (CMHTs) and then through the creation of the more specialised crisis resolution, assertive outreach and early intervention teams, a national network of community services has emerged.

Once the new teams have had time to establish themselves, the big issue over the next decade will be how far they can build a culture in which people have more choice over the care and support they are offered and in which it is delivered where and when they need it.

For the most part, mental health services currently stand on their own in dedicated clinics – sometimes in psychiatric hospital buildings. Whatever effort is made to disguise these, individuals using the services feel conspicuous. It is as if mental health has been separated out from the rest of their life and has become a defining part. People who use services say they want mental health care where they use other community services – at libraries, leisure centres, or faith centres. If mental health is to be kept in a medical setting, it should be within a health centre that includes GPs and other auxiliary medical services (Rankin, 2005).

Work practices are changing and progressively we are moving towards a 24-hour society and away from traditional 9-5 services. Mental health services will have to adapt to this. Increasingly, GP surgeries offer appointments outside of traditional working hours, and the NHS has promised to allow people to use services closer to their place of work when appropriate.

The NHS is already introducing ‘Choose and Book’, which will give patients with physical health needs the opportunity to choose the hospital at which they are treated and book appointments at times that suit them, including making electronic bookings. Mental health is one of the very few areas where this will not be introduced across the country. However, extending ‘Choose and Book’ to mental health care ought to be achievable by 2015 through improved information technology.

One of the major challenges facing social services will be to reconfigure day services away from the current building-based model to provide support for everyday living in mainstream or ordinary settings. This is likely to be a difficult process that will need to be carried out sensitively given the impact it will have on service users and their families, particularly in the early stages.

### Acute inpatient care

Many people with severe mental health problems still require hospital treatment when they are most unwell. There are currently 566 wards in England. Currently, the average ward has 100% bed occupancy (SCMH, 2005a).

The number of acute mental health inpatient beds will almost certainly be lower by 2015 due to the creation of crisis resolution teams, but there will still be beds when people need them. Most acute care will be provided at home, or in short-stay crisis houses and respite homes but it is almost certain that there will be individuals who need to be in hospital.

Inpatient stays should be shorter, not least

because the problem of ‘bed blocking’ should have been resolved with improved housing and housing support and better care planning.

It is unclear what impact the proposed Mental Health Bill will have on hospital admissions. The Department of Health intends that the introduction of compulsory treatment in the community will reduce the need for inpatient beds. While data is patchy, international experience, including in a recent Cochrane review, is that this is not necessarily the case (Kisely *et al.*, 2005).

The move towards small, short-stay crisis houses may also see the use of private or voluntary facilities more tailored to particular needs. It has been suggested that by 2015 an individual needing time and space may be put up in a hotel rather than admitted to hospital. Private facilities for drug and alcohol rehabilitation, eating disorders and therapeutic facilities for people with personality disorders are already used, and this may also become more commonplace in the next 10 years.

### Dual diagnosis

Many people with mental health conditions have a range of other health and care needs. People who use substances as well as having a mental health condition (who are described as having a ‘dual diagnosis’) often find they do not get a well-integrated service. Very often drug and alcohol services are provided separately to mental health services and individuals are labelled according to their ‘primary diagnosis’. This prevents them receiving the care and support that meets their full needs.

Department of Health guidance now stipulates that mental health services should take the lead in providing services to this group of people (DH, 2002). **By 2015 people with a dual diagnosis should have access to integrated care across mental health and substance use services.**

### Race equality

In January 2005 the Department of Health published *Delivering Race Equality in Mental Health Care* (DH, 2005a), promising to tackle the “significant and unacceptable inequalities” in access to mental health services, the experience of services and the outcome of services for people from Black and minority ethnic communities. The report committed the NHS to reducing the disproportionate rates of hospital admission and compulsory detention of people from Black and minority ethnic backgrounds by 2010. It also instructed PCTs to ensure that staff are representative of demographics and said NHS

trusts would be assessed to ensure this is happening.

The Delivering Race Equality action plan should lead to a reduction in the discrepancy in diagnosis and treatment that exists between ethnic groups in England. Among the major changes to come, 500 new 'community development workers' will soon be appointed. It is important that these workers are not lone voices in pursuing race equality but are given the necessary resources and freedom to work with local communities and re-shape services according to those groups' needs and wishes (Seebohm *et al.*, 2005). It is also vital that progress in achieving the action plan is monitored thoroughly as part of the routine inspection and assessment of mental health services.

### Prisoners' mental health care

Prisoners with mental health problems face especial difficulties getting access to help. Rates of mental health problems in prisons are far higher than in the general population. An estimated 90% of prisoners have some kind of mental health or substance use problem or a personality disorder, while rates of severe mental health conditions are up to 20 times those in the general population (PRT, 2005).

Prison mental health services are currently undergoing considerable change with the shift of responsibility for health care from the prison service to the NHS and with the development of prison in-reach services for those with the most serious problems. There is considerable evidence to suggest that many prisoners do not receive adequate help for their mental health problems, with the recently established prison inreach services forced to limit attention to those with the most severe problems and transfers to NHS secure units taking many months to complete in some cases.

There are two major agendas to be tackled. First, it is important that mental health care for people in prison is brought up to the standard that would be offered to anyone outside prison. Second, people with severe mental health problems should wherever possible be diverted from prison. From the point at which a person is brought into police custody, their mental health should be monitored and alternatives to prison should be readily available. The Home Secretary recently stated his intention to see more alternatives to prison for people with mental health problems and to reduce the number who go to prison.

Only a small minority of prisoners do not return to their communities. Most spend only a few weeks or months in prison. **By 2015, offenders with mental health problems should receive assistance from the outset to return to**

**their communities.** This should include not only effective mental health (and if necessary drug or alcohol) treatment but support towards employment, help staying in touch with families and assistance with finding or keeping a home.

### Carers and families

The carers of people with mental health conditions are frequently ignored by services. They have valuable expertise that is often left untapped as well as health and care needs of their own that are not always met. Recent changes in policy and official guidance should help to improve their position.

Standard 6 of the *National Service Framework for Mental Health* states that carers of people with severe mental health problems should have an assessment of their caring, physical and mental health needs at least annually, and have their own written care plan which is implemented in discussion with them (DH, 1999).

People who care for a person with a mental health problem can experience much of the same stigma as the people they support. Fear of stigma can stop a carer from seeking the support they need, which can in turn undermine their own mental health. **By 2015 there should be no 'hidden' mental health carers, with services ensuring that carers are identified and supported and that their role is valued in the creation of care plans** (especially when using the Mental Health Act).

An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulty themselves, and having a parent with a mental health problem may lead to bullying at school (SEU, 2004).

**By 2015 support with parenting should be built into the CPA system and implemented.** Good childcare should be available to enable adults with mental health problems to pursue vocational activities, and children of people with mental health problems should have their needs as young carers assessed and receive appropriate support. The new Children's Trusts will need strong connections with specialist mental health services to make this effective.

### Physical health care

The general health of people with severe mental health problems is considerably worse than average in the UK. A person with schizophrenia can expect to die 10 years sooner than average (SEU, 2004). They are more likely to have heart disease and diabetes and more than twice as likely to die from respiratory infections like flu. Yet the early results

of a Disability Rights Commission formal inquiry into health care for people with mental health problems indicates that they receive less support for their physical health than average (DRC, 2005).

Smoking, for example, is more prevalent in people who use secondary mental health services than in the general population, and many people with mental health problems die from smoking-related illnesses such as cardiovascular and respiratory diseases, the rates of which can be twice as high among people with schizophrenia as in age-matched control populations (McNeill, 2001). Cigarette smoking is linked with a wide range of psychiatric diagnoses including anxiety, agoraphobia and panic disorder but especially with depression (ASH, 2004).

People with mental health conditions should be given appropriate psychological and physical support to help quit smoking and to stay away from tobacco.

The recently published Health Improvement and Protection Bill effectively exempts psychiatric wards from the ban on smoking in all public buildings by classifying them as 'residential' facilities.

Many mental health facilities have already limited smoking to small rooms which are frequently crowded, dirty and poorly ventilated. There is an argument that mental health facilities should be entirely smoke free, and while it is feasible that this could be achieved eventually, there will need to be preparation to make this possible. This should include the offer of tailored smoking cessation support to all people with severe or enduring mental health problems.

Smoking is just one example of the more general health needs of people with mental health problems, all of which need to be addressed. **By 2015, people with mental health problems should be offered appropriate support for their physical health**, including annual flu vaccinations and regular check-ups with their GP for those with severe mental health conditions.

### The mental health workforce

No vision of better mental health services will be successful without investment in the workforce available to deliver it. Radical new approaches to the mental health workforce are required not only to overcome current shortages of staff but to respond to the changing needs of people who use services. Current work being undertaken by NIMHE and the Royal College of Psychiatrists to establish new ways of working for psychiatrists is one important facet. The Chief Nursing Officer's review of mental health nursing in England and a national consultation on the social work contribution to mental health services, are two others.

But action is also required locally to put in place more strategic approaches to workforce planning both across health and social care and more widely with partners such as housing and advocacy services. These need to begin from what kind of staff are required to meet local needs and then look at what skills and competencies are available and which need further investment (SCMH, 2003c). Much of this can be achieved by seeking relatively untapped sources of future staff, for example those currently using services, and by working closely with local schools and colleges to boost the profile of mental health work.

### Choice

Local authorities are already able to offer people direct payments for social care. The social care green paper (DH, 2005b) made it clear that greater use of direct payments will be encouraged in future and that individual budgets will be developed as an alternative for those unable or unwilling to hold their own budgets themselves. This can be developed by local authorities immediately. The NHS could begin to examine how it could also move towards offering those with long-term mental health conditions more choice in a similar way so that individuals get to manage all of the services that support them in an integrated fashion.

Care planning should also be targeted as an immediate priority for improvement. The Care Programme Approach can be an effective method of involving people in making decisions about their care and ensuring their full range of needs are addressed. Ensuring services across the country implement a comprehensive CPA system is an important task.

### Direct payments and individual budgets

Individual, or personalised, budgets and direct payments are seen as two ways of meeting people's broader needs, giving an individual the scope to choose and purchase their own services, potentially picking from an array of services offered by the voluntary and private sector as well as statutory services. This has the potential to give people with mental health problems greater autonomy over how they manage their condition and their life, in particular if the scope of the current direct payment arrangements is extended to include NHS services.

At present, direct payments to people with mental health problems were forecast at just over £3 million for 2004/05, slightly lower than the previous year (Mental Health Strategies, 2005) and well below the level for other groups of social care

users. Lack of staff awareness and their perceptions of service users' capacity to operate them has been cited as a reason for this low take up (Newbigging & Lowe, 2005).

In its response to the Government *Independence, Wellbeing and Choice* consultation, the Inter Agency Group (IAG) on adult social care, a coalition of national health and social care bodies, noted that "those who take up direct payments are willing in effect to run a business, including recruitment, payroll and workforce management" (IAG, 2005). When people choose to take control of their own care they need support and advice. It also needs to be considered what will happen when an individual's choices do not have the desired outcome and they end up needing different help. Will they be penalised for having made the 'wrong' choice, or will it be recognised that in the current system patients are often treated in many different ways until the 'right' solution is found?

There are also concerns about whether the most vulnerable people will have the capacity to manage their own budget or make the most of direct payments, and about the costs to services of administering the system. The impact of direct payments on existing services will also need to be considered – especially for services that see a drop in demand or which find it hard to maintain service levels with no guarantees of future funding.

There are extra complications for people who have been subject to compulsory treatment, particularly in the community.

While some people with mental health conditions have a vision of totally managing their own care by 2015, health and social care managers tend to be more circumspect. Some commentators would like to see people offered services through conventional routes first and watch the progress they make before allowing them to manage their own health care budget. Others see direct payments as an immediate way to get a choice of therapy and treatment. But all agree that commissioners need to start thinking about this now. **By 2015 individuals should have more autonomy over their care through more sophisticated mechanisms of choice.**

### Care plans, advocates and 'navigators'

Every person in secondary mental health services should currently have a care plan, setting out what care, treatment and support they require. This is established under the Care Programme Approach (CPA), introduced in 1990. A good care plan is the key to integrating health and social services, and can ensure that an individual's mental health and social needs are met.

The Healthcare Commission 2005 national mental health service user survey found that only a half were given (or offered) a copy of their care plan, while one-third did not know who their care coordinator was (HCC, 2005). A subsequent SCMH/Mental Health Act Commission survey of people detained more than once under the Mental Health Act, found a range of shortcomings in the ways care plans were written, recorded and used (SCMH, 2005b).

**By 2015 not only should everyone have a comprehensive, tailored care plan and be receiving the services stipulated in it, but they should have taken the lead in determining how they want their needs met.**

A well considered care plan is a vital first step, but an individual will still need to be supported to make sure that it is implemented. This could be accomplished through an 'associate' or 'care navigator' who will work across health and social services, with close links to benefits agencies, housing providers, vocational advisers and the education sector, for example. The associate would help the individual identify their needs and how they want these to be met, and then act as a liaison point between various agencies to ensure this is acted on. Their role would be comparable with the existing 'care coordinator' role but much broader, freeing up clinical staff to focus on their core roles in providing health and social care.

Effectively, the associate would work in much the same way as, for example, a financial adviser who has knowledge of products available and can work with a client to make choices about the best package of services and to facilitate or arrange these. A mental health associate would work in a similar way but provide advice and support around health, social care, vocational and housing services.

The associate role would require new ways of working, but would build on the experience of the Supporting People 'floating support' worker role (SCMH, 2004b) and the idea of the 'care navigator' mooted in the social care green paper (DH, 2005b)

### The internet and new technology

Technology has changed the way people work over the past decade, and in the next 10 years change is likely to be even more rapid. Mental health services have generally been slow to invest in information technology. The majority of mental health trusts still rely on paper patient files backed up by relatively new electronic systems. On wards, access to electronic CPA documentation is often very limited, especially for the many temporary staff who are required to make up for gaps in the workforce (SCMH, 2005a).

Imaginative thinking about new technology has the potential to change the way services are delivered as well as giving individuals more control over their own care. Individuals will in future have electronic access to their care plan and the ability to update it. Already people with mental health problems who have internet access use online groups for mutual support, information sharing and campaigning. Computer programmes are used in some places to deliver brief therapies. Before too long, text messaging could be used to remind people of appointments, or even to remind people when to take medication. Email can also be useful to communicate quickly with clinical staff.

The potential for information technology to change mental health care is considerable. It could become a useful tool for clinicians, for example to audit their work; a means of better informing service provision, for example by producing accurate information on length of stay, delayed discharges, etc; and to support Payment by Results. It can be a means of understanding the workforce and a way of providing care in a more seamless way, for example through electronic patient records that mean teams do not need to transfer bits of paper and service users do not have to keep repeating information.

### Service user involvement

In some respects, mental health services lead the health and social care sector in taking direction from service users. In 2003 the Commission for Health Improvement noted that service users are often involved in service planning and development, and staff recruitment and training, and identified examples where user involvement is embedded in the principles and practices of trusts at every level (CHI, 2003). However, it noted that the people influencing services tend to be the most articulate and active individuals, who are not always representative of the diverse base of people who use the services.

Primary care trusts provide little financial support to develop groups of people with mental health conditions whose common experience could be fed back through elected representatives – the forecast investment in service user groups in 2004/05 was less than £5 million (Mental Health Strategies, 2005).

Genuine involvement of people who use services either directly or as a carer depends on the existence of viable networks at local level (HASCAS, 2005). A national survey of the service user movement found more than 500 groups in existence, most of which had fewer than 50 members. Many had been set up as recently as five

years ago and three quarters received some funding (mainly between £20,000 and £40,000) for which they had to apply each year (Wallcraft & Bryant, 2003).

While the number of people with mental health problems represented on decision making panels has increased, this may not always result in meaningful input. People using services may feel intimidated in expressing views to managers and clinicians.

Meaningful involvement of people with mental health conditions in shaping services requires proper access to information technology, training and administrative help and, if necessary, emotional support.

By 2015, all NHS trusts will very probably be Foundation Trusts. To become a Foundation Trust, an organisation must create membership schemes for local people, service users and staff. People who use services and their carers will make up a proportion of the governing committee, with everyone who uses services entitled to vote for governors. Mental health trusts will have to find positive and effective ways of engaging service users as members if this is to work and in coming years models of good practice will emerge. **By 2015 people who use services should be routinely involved in all health and social care provision and governance.**

Involving people in services also entails a much bigger role for individuals and communities in self-care and mutual support systems. From the development of the expert patient programme to the creation of the new Community Development Workers to foster closer links between mental health services and Black and minority ethnic groups, people who use services can expect a more active role in those services over the next decade. If such initiatives are given the freedom and resources to develop, they offer great potential to make radical changes to local services (Seebohm et al., 2005).

Commissioners in PCTs and local authorities should ensure there is investment in developing and sustaining networks of people who use services and their carers at local level. This is needed most urgently among Black and minority ethnic communities. Commissioners must also give sufficient importance to service user and carer involvement in their commissioning function and also in what they are commissioning from specialist mental health trusts and other organisations. Newly established Mental Health Foundation Trusts need to build a guaranteed place for people who use services and their carers into their governance arrangements but also to protect existing involvement processes alongside the new system.

## Equality and inclusion

As well as improving mental health services, our vision for 2015 looks at the lives of people with mental health problems. This section summarises the key areas where progress is needed to achieve greater fairness in society as a whole for people experiencing mental distress.

### Stigma

A more tolerant and understanding society by 2015 would bring about the biggest improvement in the lives of people with mental health problems. **By 2015 public fear and intolerance should be minimised: people should see no difficulty with the prospect of people with mental health problems being their neighbours, colleagues or friends.**

The media are often blamed for conveying an exaggerated link between violence and mental health conditions. A recent report for the Shift programme confirmed to some extent that the media do indeed focus disproportionately on violence in their coverage of severe mental health problems, but that coverage of common mental health problems was not dissimilar to that of most other health conditions (CSIP, forthcoming).

Nationally, the Department of Health has established the five-year Shift programme to tackle stigma and discrimination. Begun in 2004, its priorities are people and organisations listed by those with mental health conditions as being the most likely to stigmatise or discriminate against them:

- ❖ Young people
- ❖ The public sector
- ❖ Private employers
- ❖ The media.

The Shift programme is currently funded at £1 million a year. This investment includes its spending on mental health promotion and currently equates to less than 1.5 pence per head of population. Scotland's 'See Me' campaign, meanwhile, is funded at about 13 pence a head (Gale *et al.*, 2004).

There is no doubt that, to achieve its goals, England will need to spend more on tackling stigma and discrimination, and implement a legislative framework to tackle discrimination.

Local bodies also have an important role in tackling stigma. International evidence shows that work at local level that increases social contact

with individuals has the most impact in changing attitudes and behavior towards people with mental health conditions (Gale *et al.*, 2004). PCTs need to work with Shift and with local voluntary sector organisations and service user and carer groups in their own communities.

Stigma is often seen as how society views individuals with mental health problems, but just as important can be the way people view themselves. Loss of self esteem leads to loss of aspiration, holding people back from doing the things they want to do in life. The stigma associated with mental ill health not only stops people from getting treatment and seeking support, it stops people from going to university, from getting jobs, from joining sports teams, from making friends. Often it is the expectation of stigma that stops people from enjoying life. This 'self stigma' needs to be addressed as a routine part of mental health and social care.

Improving public tolerance towards people with mental health problems is not just about spending money on formal anti-stigma programmes. Some people who use services say that if they were able to see professionals in the places they go anyway – council leisure centres, libraries or even churches and other faith centres – this would take away some of the fear that the public feels about mental health services. Similarly, if mental health services were to open their facilities to the public – allow day centres to be used for evening classes, hospital sports facilities to be open to the public out of hours, or make rooms available for meetings such as book clubs or diet groups, this would bring people into a mental health environment in a non-threatening way.

It is debatable how far stigma can be challenged within 10 years. To achieve genuine change, increased investment in mental health promotion will be vital, but so will attitudinal change within services, among employers and in society as a whole.

### Discrimination

The prejudices attached to mental ill health are most problematic when they lead to individuals experiencing discrimination in their everyday life. From being denied job opportunities to being harassed in their neighbourhoods, people with mental health conditions complain of frequent discrimination.

Recent legislation has improved the rights of people with mental health conditions to seek redress when they face discrimination. They need to be made aware of their rights under the Disability Discrimination Act and encouraged and supported in exercising them. **By 2015 there**

**may need to be further legislation that puts discrimination and harassment on the grounds of mental ill health in line with the laws on race, gender and disability equality.**

A single Commission for Equality and Human Rights by 2009 will replace the existing Disability Rights Commission. It could provide the Government with an opportunity to commit to tackling discrimination on grounds of mental health.

Before that, the Government should vigorously monitor the new public sector duty to ensure equality of opportunity for disabled people. To do this it will need to monitor disability by impairment to ensure that access is not defined by the need for physical adjustments and that people with psychiatric impairments have genuine equality of opportunity.

### Schools

The National Healthy School Standard, jointly funded by the Department of Health and the Department for Education and Skills (DfES), aims to improve standards of health and education, to promote social inclusion and to tackle health inequalities. While the Government aims for half of schools to meet the criteria of the National Healthy Schools Programme by 2006, with the rest working towards Healthy School status by 2009, mental wellbeing is not among the criteria of this programme. Putting this right would be a major step towards creating a mentally healthy population in the coming decades. **By 2015, mental wellbeing should be a major concern for schools**, from dedicated classroom time to the overall approach of the school towards its pupils and staff.

### Housing

A breakdown in mental health is a frequent catalyst for housing problems. When people lose their jobs, their relationships end or they have to go into hospital, the likelihood of losing their home is high. Difficulties with debt and problems managing finances can lead to rent or mortgage arrears and result in eviction. This feeds into a cycle of social exclusion, with the impossibility of holding down a job or maintaining relationships without secure housing.

A lack of suitable housing – supported or mainstream – can result in delays to hospital discharge. People with mental health problems may be left in hospital or be placed in temporary accommodation because there is nowhere to go. The Social Exclusion Unit found it was not uncommon for people to spend more than five

years in temporary accommodation while waiting for suitable housing (see Box 5). In the meantime, people are likely to become more dependent on services and staff are likely to become less focused on helping them to regain autonomy.

#### Box 5: Housing and mental health

Compared with the general population, people with mental health problems are:

- ❖ one and a half times more likely to live in rented housing, with higher uncertainty about how long they can remain in their current home;
- ❖ twice as likely to say that they are very dissatisfied with their accommodation or that the state of repair is poor; and
- ❖ four times more likely to say that their health has been made worse by their housing.

(SEU, 2004)

Most people with mental health conditions live in ordinary housing, with less than 20% in supported housing or other specialist accommodation. There is a legal requirement that people with mental health conditions who are homeless are considered to have a 'priority need' for accommodation by the local housing authority. Around 9% of applicants accepted by local housing authorities in England are in this category.

Estimates of the prevalence of mental health conditions among homeless people range from 8 to 50 times the level among the general population (Mental Health Foundation, 1996). It is estimated that half of young homeless people have a treatable psychiatric disorder. Complex needs and chaotic lifestyles can be a factor, with multiple substance use and involvement with the criminal justice system frequent factors.

It can be argued that early access to suitable accommodation with appropriate support could help avoid longer-term problems for people whose mental health conditions are first developing. Increased support in managing rent or mortgage arrears could also prevent deterioration of mental health conditions.

Because of the lack of stock, many housing authorities operate a 'one offer' policy for people on housing waiting lists, with a very short period in which to accept an offer or return to the back of the queue. It can be frightening for people with mental health conditions, who may have to accept an offer of unsuitable accommodation. This can be

overcome with good advice or advocacy, but too often this is not available. A move to 'Choice Based Lettings' means that by 2010 all social housing tenants should have more say over where they live.

Social housing is likely to continue to play an important role in providing appropriate accommodation for people with mental health problems, but local authorities will have to think more creatively about this if there is to be sufficient supply and if the housing provided is to genuinely enhance the wellbeing of the individual who needs it.

The Social Exclusion Unit reported a form of 'residential sorting' that has meant people with mental health problems end up in the same few local neighbourhoods and estates. People can be easily identified as having mental health problems in these areas and this can lead to increased stigma.

The profile of social housing is changing, with increasing pressure on property developers to integrate social housing into even luxury developments as well as incentives for property owners to be 'social landlords', effectively using local authorities as letting agents.

Moving people with mental health conditions away from traditional large council estates into private sector accommodation could be an important step to social inclusion. Individuals would be less identifiable as needing local authority assistance because of a mental health problem, and could be less isolated with shops and facilities nearby.

The Office of the Deputy Prime Minister has announced that low-cost and shared-ownership housing will be made available to key workers and other people on low incomes (ODPM, 2005). Similar initiatives are needed specifically targeted at people with mental health problems. This would need to be accompanied by support and advice for individuals who have taken on a mortgage to ensure they are able to manage their payments, as mortgage arrears are even more likely to add to stress and exacerbate mental distress than rent arrears.

There is little information on how many people with mental health conditions own their own homes, or could do so. Shared ownership has been identified as a way of moving towards owner-occupation for people who are unable to take on large mortgages or who receive welfare payments. Local authorities could work with the private sector to enable people with mental health conditions to move into partial home ownership, either through government, housing association or private initiatives.

## Housing support

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Many people with mental health conditions are now helped to stay in their own homes through the Supporting People programme. Supporting People is a government programme to offer services to a wide range of people who need assistance to live in their own homes or in sheltered accommodation. It has now been fully operational since April 2003, costing some £1.8 billion in England alone in its first year. At least £250 million of Supporting People money has been spent on people with mental health problems, compared with £412 million for people with learning difficulties and £330 million for older people (SCMH, 2004b).

The scheme has been positively appraised for the help it offers people to stay in their homes (SCMH, 2004b; Audit Commission, 2005). However, the level of funding has been reduced this year – to £1.72 billion – and will further reduce to £1.7 billion in 2006/07.

Nonetheless, in coming years there is likely to be an increased emphasis on helping people stay in ordinary housing through the Supporting People scheme. Well supported temporary accommodation may become an alternative to hospital admission for people who are unable to cope at home. Half of people with mental health conditions who live in mainstream accommodation live alone (SEU, 2004), and this could be particularly important for them.

The Supporting People scheme has been a major success of the last five years. Sustained investment in Supporting People is vital, not just to give people the opportunity to pursue independence but also to make efficient use of public money in a scheme that has great potential to reduce people's need for more expensive services.

## Benefits and employment

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Less than a quarter of people with severe mental health conditions have a job. The number of people claiming Incapacity Benefit because of mental health conditions has almost doubled in the past decade to nearly 850,000, with about 50,000 more claiming severe disablement allowance. It is unclear how many people with mental health conditions claim Jobseekers Allowance (SEU, 2004). Yet an inflexible benefits system is seen as one of the biggest barriers for people with mental health conditions who want to work.

In its evidence to the Social Exclusion Unit consultation, Citizens Advice said that while the benefits system should underpin people's security, it often fails to recognise and make allowance for their illness. It said that forms

that have to be completed and the procedures used for assessing capacity to work do not make appropriate provision for mental health problems. Claimants with mental health conditions have full responsibility for complying with procedures and time limits and failure to do so can mean benefits are stopped (Citizens Advice, 2004).

Those who rely on benefits are wary of moving back into paid employment in case they are unable to maintain their jobs due to recurring ill health. Incapacity Benefit does not always accommodate the fluctuating nature of mental health conditions, and “permitted work rules” can also make a scaled return to work difficult (Seebohm & Scott, 2004).

The system of incapacity benefits will have changed considerably by 2015. Reforms being developed currently are likely to create two levels of Incapacity Benefit itself and increase the support people judged able to return to work are offered to move off benefits. This will be provided through the Pathways to Work scheme, currently being piloted in parts of the country. It offers people added financial help when starting work as well as support to manage their condition. It is hoped that these reforms will tackle some of the disincentives to work created by the current system, though there are also serious concerns about how the new system will work in practice and whether the support available will be enough to prevent some groups of disabled people from being disadvantaged.

If the Government’s desire to get more people with mental health conditions back into work is to be realised, mental health and social services are going to need to adapt to this. **By 2015 there will need to have been considerable investment in employment support for people with mental health problems and a shift in the role of health and social care professionals to develop the necessary skills.**

Existing employment programmes focus mainly on entry-level training or employment. Many people drop out of employment or higher education when their symptoms become overwhelming, but there is little support to enable them to return at the same level, even if they return part time. It should also not be assumed that work means traditional employment: **support for people who want to start up social enterprises or small businesses should also be widely available by 2015.**

Almost all services are currently structured around the assumption that individuals are not working, and that if they are well enough to work they will need less support. If people are to be encouraged back to work they will need support to maintain their health and retain their job. Direct payments could potentially be used to buy support such as a ‘life coach’, but basic services will also

have to be available at flexible times. Statutory health services will have to consider whether the aggregate needs of service users require developing weekend and evening services, including commissioning them from voluntary and private sector suppliers.

As well as getting people back to work, it is important also to prevent people losing their jobs (or missing their education) in the first place. A recent evidence review found that even brief cognitive behavioural therapy can help some groups of workers stay in employment (BOHRF, 2005).

**By 2015, evidence-based talking therapies should be made available speedily. From the moment they make contact with health services, people should receive practical support to stay in work or at school/college.**

A new award of ‘wellbeing workplace’ could be developed. Through it, employers would be recognised for meeting certain standards in promoting the wellbeing of staff and both recruiting and retaining people with mental health conditions. The NHS and social services departments should take a lead in establishing themselves as ‘wellbeing workplaces’ and showing the benefits they can bring to their organisations as well as to individual staff.

### Financial and legal support

Debt and financial hardship are common among people with mental health conditions, particularly those living on benefits. Citizens Advice has pointed out that high-pressure selling and the ease of obtaining credit are particular problems for people who are vulnerable when unwell (Citizens Advice, 2004).

The anxiety and stress that accompanies debt is known to impair health. Support and independent advice demonstrably contribute to reducing anxiety and health problems, and debt needs to be addressed early if it is not to become insurmountable and make a person’s condition worse. Research into how people deal with serious financial and legal problems found that those with mental health conditions were the least likely to take specific action to resolve the issue (SEU, 2004).

In some areas health and social care organisations fund independent advocacy groups to resolve practical difficulties around benefits and housing. However, in many areas there is little advice available to tackle debt issues.

In theory, the CPA process should identify the need for support on financial and legal matters. In practice, there is often very little advice or support provided, until an individual’s financial position is so precarious that it threatens to push them into a mental health crisis.

**By 2015 people should be routinely offered support to manage their finances so that debt is avoided, or at least addressed early.**

### Other public services

Mental health conditions should not limit people's opportunity to get access to the full range of public services. Support should be available to enable individuals with mental health needs to use facilities such as libraries or leisure centres. This could involve holding structured groups such as book clubs, creative writing classes or indoor football games at these locations.

The Social Exclusion Unit consultation found that many people with mental health conditions wanted to return to education, either formally to gain a qualification or through adult education classes to pursue hobbies and make friends. Many further education colleges already offer support for people with mental health conditions, but health and social services need to be more proactive in encouraging people to attend courses and persuading more educational establishments to take this approach.

Ideally a reduction in stigma would mean that by 2015 people with mental health conditions would feel less intimidated by using public facilities. Self confidence and motivation will still be issues though, and people should be supported to be involved in the community in any way they wish.

Promoting mentally healthy communities should be at the heart of community planning, urban renewal and similar projects. Focusing on the mental wellbeing of the community means ensuring that all voices are enabled and heard; actions should not just involve physical infrastructure but also recognise the importance of social networks and a sense of belonging to a community. Key to promoting mentally healthy communities are initiatives to build individual and collective confidence and self esteem, for example by enabling affordable access to sport and leisure, cultural, artistic and other activities.

For many people with mental health problems, particularly in rural areas, transport is a major issue. Physical isolation exacerbates psychological isolation. Some local authorities offer concessionary travel to people with mental health problems, in line with that given to other disabled people. This should be extended to ensure that all individuals at risk of isolation due to mental health problems receive concessionary travel.

Public transport is likely to be developed in new ways over the next decade to take account of environmental issues and the pressure of

congestion in inner city areas. Local transport plans and accessibility planning should reflect the needs of people with mental health problems to travel to the services they need, but also should consider general mental wellbeing, for example by making commuting to and from work less stressful.

## What do we do next?

The agenda set out in this paper is very ambitious. It represents our vision of what mental health could be like in 2015 in the best circumstances. But it is realistic if we start now. Among the key recommendations that can be begun immediately, and which will get us on the right track, are:

### **Developing more accessible services:**

extending the availability of psychological therapies to people with a range of mental health conditions and developing intermediate mental health care teams.

### **Building up the mental health workforce:**

putting in place more strategic approaches to workforce planning and seeking relatively untapped sources of future staff.

**Pursuing race equality:** full implementation of the Delivering Race Equality action plan, for example giving community development workers the freedom they need to make real changes locally.

**Supporting carers:** implementing the Carers (Equal Opportunities) Act 2004, through which carers' assessments must now include a consideration of whether the carer works or wishes to work or participate in any education, training or leisure activity.

**Piloting individual budgets:** the recent creation of 10 sites for piloting individual budgets should be the first step towards making these much more widely available.

**Better care planning:** Ensuring services across the country implement a comprehensive CPA system.

**Investing in service user groups:** commissioners, PCTs and local authorities should ensure there is investment in developing and sustaining networks of people who use services and their carers at a local level. This is needed most urgently among Black and minority ethnic communities.

**Monitoring of discrimination:** the Government should vigorously monitor the new public sector duty to ensure equality of opportunity for disabled people.

**Investing further in housing support:** sustained investment in Supporting People.

**Tackling smoking:** people with mental health conditions should be given appropriate psychological and physical support to help quit smoking and to stay away from tobacco as a precursor to an eventual ban on smoking in psychiatric wards.

## Strategic planning

The strategic and leadership role in assuring these changes happen locally lies with local authorities, who will need to work closely with an increasingly diverse range of health and social care providers, the voluntary sector and other kinds of private service suppliers.

Local Strategic Partnerships (LSPs), based in local authorities and bringing together a broad range of local organisations, are a natural vehicle to ensure strategic engagement and responsive delivery at the local level.

But while LSPs can assist with coordination and agreement about local priorities, the resource implications of this agenda are considerable. Whether or not ongoing increased funding is needed, bridging funds will be required to support change in service delivery. Existing funding will need to be redistributed to 'follow the services', which is likely to mean the emphasis on funding moves from acute care services to supporting people to stay well and into primary care. More funds are also needed for mental health promotion, which would have benefits across communities and society as a whole, as well as potentially easing the ongoing burden on mental health services. Yet experience to date shows that such 'bridging funds' are hard to come by, leaving new developments to be limited in scope or established at the expense of existing services.

In the *Independence, Wellbeing and Choice* green paper the Department of Health has recognised that "Alongside the challenge to improve the strategic commissioning of services is the task of improving their design and delivery. This will mean radically different ways of working, redesign of job roles and reconfiguration of services. This will call for skills in leadership, communications and management of change of the highest order" (DH,

2005b). This certainly applies to mental health, where new skills, training and leadership will be essential. The transformation of day services, for example, from their current nature to a more community-based model will require both strong leadership and effective service user, carer and staff involvement.

However, frequent organisational and structural change have dissipated skills and experience, and there is concern that this will continue to impede progress.

While significant progress has been made in some areas, there are still considerable gaps in services and in the mental health workforce. New approaches will be needed to fill these gaps, in particular to include 'hard to reach' groups and communities and those with complex or additional needs.

Integrating health and social care commissioning and partnership with the private and voluntary sector will require more integrated job roles and new ways of working. Significant progress has been made in the integration of mental health and learning disability services, but this needs to extend beyond health and social care and beyond traditional means of providing services. There will also need to be change in organisational cultures, better use of existing resources and an acceptance that new and additional resources will be needed.

Improved strategic planning is central to our vision for 2015. However it is organised, locally and nationally, strategic planning is essential to implement a truly holistic way for public services to respond to the needs of people with mental health problems.

## Conclusion

Our Vision for 2015 is for mental wellbeing to be on the agenda of all public services. Among the major developments we believe are achievable by 2015 are:

- ❖ All schools will promote mental wellbeing.
- ❖ Employers will compete to become 'wellbeing workplaces'.
- ❖ People seeing their GP with a mental health problem will have a range of effective treatment options.
- ❖ Mental health services will be integrated into ordinary health and public buildings: GP surgeries, libraries and schools.

- ❖ Individuals who need ongoing care and support will have a comprehensive care plan and the option of direct payments or an individual budget.

This is an ambitious but realistic vision. How far it is achieved depends on the changes that are happening now and will follow in health, social care and public policy. Some of the biggest immediate challenges are:

- ❖ The forthcoming health and social care White Paper.
- ❖ The Mental Health Bill.
- ❖ Expanded talking therapy provision.
- ❖ The development of Foundation Trusts and review of PCTs.
- ❖ The 2007 Spending Review.

These will all affect how far our best-case scenario can be implemented. But they do not negate it – they make it all the more necessary that we know what direction we want to travel in and what the result of it should be. Without that vision, however much it shifts over time, we cannot begin to plan for a better future.

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## References

- ASH (2004) *Factsheet 15: Smoking and Mental Health*. London: Action on Smoking and Health.
- Audit Commission (2005) *Supporting People*. London: Audit Commission.
- BOHRF (2005) *Workplace interventions for people with common mental health problems*. London: British Occupational Health Research Foundation.
- Byrne, L. (2005) *Dignity for Life: Next steps for Social Care Reform*. Speech delivered 21.07.05. (Available from [www.dh.gov.uk](http://www.dh.gov.uk))
- Chisholm, A. & Ford, R. (2004) *Transforming Mental Health Care. Assertive Outreach and Crisis Resolution in Practice*. London: The Sainsbury Centre for Mental Health.
- Citizens Advice (2004) *Out of the picture: CAB evidence on mental health and social exclusion*. London: Citizens Advice.
- CHI (2003) *What CHI found in mental health trusts*. London: Commission for Health Improvement.
- CSIP (forthcoming, 2006) *Shift Media Survey*.
- DH (1998) *Modernising mental health services. Safe sound and supportive*. London: Department of Health.
- DH (1999) *National Service Framework for Mental Health. Modern Standards and Service Models*. London: Department of Health.
- DH (2000) *The NHS Plan. A plan for investment. A plan for reform*. London: Department of Health.
- DH (2002) *Mental Health Policy Implementation Guide: Dual diagnosis good practice guide*. London: Department of Health.
- DH (2004a) *Choosing Health: making healthier choices easier. Public Health White Paper*. London: Department of Health.
- DH (2004b) *The National Service Framework for Mental Health – Five years on*. London: Department of Health.
- DH (2005a) *Delivering race equality in mental health care. An action plan for reform inside and outside services and The Government's response to the Independent Inquiry into the death of David Bennett*. London: Department of Health.
- DH (2005b) *Independence, Wellbeing and Choice. The Social Care Green Paper*. London: Department of Health.
- DH (2005c) *Prescription Cost Analysis 2004*. London: Department of Health.
- DRC (2005) *Equal Treatment: Closing the Gap - Interim Report of a Formal Investigation into Health Inequalities*. London: Disability Rights Commission.

- Gale, E., Seymour, L., Crepaz-Keay, D., Gibbons, M., Farmer, P. & Pinfold, V. (2004) *Scoping review on anti-stigma and anti-discrimination programmes and interventions*. Leeds: NIMHE.
- Hague, J. & Cohen, A. (2005) *The Neglected Majority. Developing intermediate mental health care in primary care*. London: The Sainsbury Centre for Mental Health.
- HASCAS (2005) *Making a Real Difference: Strengthening service user and carer involvement in NIMHE*. Leeds: NIMHE.
- HCC (2005) *National Mental Health Service User Survey 2005*. London: Healthcare Commission.
- Inter Agency Group on Adult Social Care (2005) *Response to Independence, Wellbeing and Choice*. London: LGA.
- Kisely, S., Campbell, L.A. & Preston, N. (2005) *Compulsory community and involuntary outpatient treatment for people with severe mental disorders*. The Cochrane Database of Systematic Reviews 2005 Issue 3.
- Layard, R. (2005) *Therapy for all on the NHS. The Sainsbury Centre for Mental Health Lecture*. 12.09.2005. Unpublished. (Available from [www.scmh.org.uk](http://www.scmh.org.uk))
- McNeill, A. (2001) *Smoking and mental health: A review of the literature*. London: NHS London Regional Office.
- Mental Health Foundation (1996) *Mental Health and Housing, Paper for Optimum Health Conference 1996*. London: Mental Health Foundation.
- Mental Health Strategies (2005) *The 2004/05 National Survey of Investment in Mental Health Services*. London: Department of Health.
- National Institute for Health and Clinical Excellence (2004) *Depression, Management of depression in primary and secondary care*. London: NICE.
- National Institute for Health and Clinical Excellence (2005) *Depression in Children and Young People*. London: NICE.
- Newbigging, K. & Lowe, J. (2005) *Direct payments and mental health*. Brighton: Pavilion.
- ODPM (2005) *Home Buy: Expanding the opportunity to own*. London: Office of the Deputy Prime Minister.
- Philip, M. (2005) The mental health workforce. In: Bell, A. & Lindley, P. (eds) *Beyond the Water Towers, The unfinished revolution in mental health services 1985-2005*. London: The Sainsbury Centre for Mental Health.
- PRT (2005) *The Prison Factfile, May 2005*. London: Prison Reform Trust.
- Rankin, J. (2005) *Mental Health in the Mainstream*. London: IPPR/Rethink.
- SCMH (2002) *Breaking the Circles of Fear. A review of the relationship between mental health services and African and Caribbean communities*. London: The Sainsbury Centre for Mental Health.
- SCMH (2003a) *Policy Paper 3: The Economic and Social Costs of Mental Illness*. London: The Sainsbury Centre for Mental Health.
- SCMH (2003b) *Money for Mental Health. A review of public spending on mental health care*. London: The Sainsbury Centre for Mental Health.
- SCMH (2003c) *A Mental Health Workforce for the Future. A planner's guide*. London: The Sainsbury Centre for Mental Health.
- SCMH (2004a) *Policy Paper 4: Payment by Results: what does it mean for mental health?* London: The Sainsbury Centre for Mental Health.
- SCMH (2004b) *Briefing 26: The Supporting People programme and mental health*. London: The Sainsbury Centre for Mental Health.
- SCMH (2005a) *Acute Care 2004. A National Survey of Adult Psychiatric Wards in England*. London: The Sainsbury Centre for Mental Health.
- SCMH (2005b) *Back on Track. CPA care planning for service users who are repeatedly detained under the Mental Health Act*. London: The Sainsbury Centre for Mental Health.
- Scottish Executive (2003) *National Programme for Improving Mental Health and Well-Being*. Edinburgh: Scottish Executive.
- Seebohm, P., Henderson, P., Munn-Giddings, C., Thomas, P. & Yasmeen, S. (2005) *Together we will change. Community development, mental health and diversity*. London: The Sainsbury Centre for Mental Health.
- Seebohm, P. & Scott, J. (2004) *Addressing disincentives to work associated with the welfare benefits system in the UK*. London: Social Enterprise Partnership.
- SEU (2004) *Social Exclusion and Mental Health*. London: Office of the Deputy Prime Minister.
- Wallcraft, J. & Bryant, M. (2003) *Policy Paper 2: The service user movement in England*. London: SCMH.

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