DH Department of Health

New Horizons

Towards a shared vision for mental health

Consultation

Contents

Ministerial foreword

I am proud and pleased to present for consultation *New Horizons: Towards a shared vision for mental health*.

Good mental health is fundamental to the well-being and prosperity of our nation. And we know it is linked with good physical health and many other benefits for individuals and communities.

The radical reform of mental health services in England over the last 10 years has been a real success story – not only has investment in these services increased, accounting for almost one pound out of every seven that the NHS spends, but also the quality of care they offer has improved and is recognised internationally.

Our blueprint for this transformation has been the 1999 *National Service Framework for Mental Health* (NSF), but it is fast approaching the end of its 10-year lifespan. Now we need a new approach: one that builds on the NSF's successes by supporting the local development of higher quality, more personalised services, and that also moves the agenda on by building a cross-government, multi-agency alliance that can tackle the root causes of poor mental health and get support to people where and when they most need it. *New Horizons* sets out to do just that.

The world has changed since 1999, and we cannot depend on the scale of extra investment that followed in the wake of the NSF. We do not need to. In *New Horizons* we discuss how we could make enormous progress by raising our game on prevention, intervening earlier, being more innovative and collaborative, improving productivity and getting maximum value for individuals and communities from the resources we invest.

We are entering an exciting period in health and social care, when people will increasingly have more control over their health, their care and treatment. More and more, the job of professionals will be to support them in this. Our job in government is to help set this direction, while at the same time recognising the particular challenges in mental health.

I want *New Horizons* to make a big difference to the way we promote equality. There are inequalities in mental health and in access to services. People with mental health problems still experience unjustifiable discrimination and avoidable inequalities in their physical health. *New Horizons* will build on and extend the excellent work that has begun in those areas in recent years.

The process of developing *New Horizons* started almost two years ago, and I am immensely grateful to the coalition of partners in the professions, third sector, health services and local government whose help and advice have been essential in getting us to this point. I hope many more people will respond now with their views and ideas. Together, we can create a vision that guides us to a healthier, fairer and equal society.

Phil Hope, MP
Minister of State for Care Services

Key themes

For more than 18 months, the New Horizons team and I have been meeting with a wide range of people up and down the country. We've been listening to their hopes, ideas and aspirations for the future of mental health in England from 2010.

A wide spectrum of views and a huge number of good ideas have been forthcoming from people who use mental health services, from carers, commissioners, clinicians and many more besides. Combining this with growing evidence about well-being and resilience, as well as learning from the best services in the country today, we have produced this report as a basis for further consultation.

Already, a number of key themes are emerging:

- **prevention and public mental health** – recognising the need to prevent as well as treat mental health problems and promote mental health and well-being

- **stigma** – strengthening our focus on social inclusion and tackling stigma and discrimination wherever they occur

- **early intervention** – expanding the principle of early intervention to improve long-term outcomes

- **personalised care** – ensuring that care is based on individuals' needs and wishes, leading to recovery

- **multi-agency commissioning/ collaboration** – working to achieve a joint approach between local authorities, the NHS and others, mirrored by cross-government collaboration

- **innovation** – seeking out new and dynamic ways to achieve our objectives based on research and new technologies

- **value for money** – delivering cost-effective and innovative services in a period of recession

- **strengthening transition** – improving the often difficult transition from child and adolescent mental health services to adult services, for those with continuing needs.

We are keen to know what you think are the answers to the questions we face, so please spare some time, if you can, to respond to the consultation. See pages 121–123 for how to respond in writing, online or via a local or national organisation.

And thank you for your interest and involvement.

Louis Appleby
National Clinical Director
for Mental Health

Our vision

Our mental health, like our physical health, will vary throughout our lives – whether we're young or old, working or not, whatever we do and wherever we live. It is important that we all understand what we need to do to build and maintain good mental health right from the start, from infancy into adulthood and older age, for individuals, families and communities.

In 2020 most adults will understand the importance of mental well-being to their full and productive functioning in society, to their physical health, and to their ability to make healthy lifestyle choices. They will also understand some of the factors that affect their mental well-being, and will have developed their own everyday ways for taking care of it. Children will increasingly be taught in school about the importance of mental well-being and how to nurture and preserve it, and a range of local services will support their well-being so that problems are detected early. Mental health needs will be identified at an early stage so that, for example, treatment and support can be provided while the individual is an adolescent, thus reducing the chances that mental health problems will continue and adversely affect their adult life.

In 2020 physical health and mental well-being will be seen as equal priorities, and the links between them recognised as key to maintaining physical and mental health. Lifestyle and well-being services will be widespread. Psychological and family treatments will be available to all who could benefit from them. Drug treatments will be individually tailored so they have fewer adverse effects. Services will use innovative technologies to promote independent living and the effectiveness of treatment.

Personalised services

People with mental health problems, and those at risk, will receive personalised care packages designed to meet their individual needs. They will be able to make decisions about their care, treatment and goals for recovery, as well as to monitor their own condition.

Equality

In 2020 all individuals will be treated with respect in an inclusive society, whatever their age, background or circumstances. Public services will recognise the importance of environments, services and amenities that maximise independence and opportunities for older people to participate and contribute as equal, active citizens. Services will be attuned to the needs and wishes of individuals and communities and will actively promote equality. Inequalities for black and minority ethnic groups in access to and experience of mental health care will have disappeared.

Stigma and understanding

In 2020 the stigma attached to mental health will have declined dramatically. People will know that mental health problems can affect anyone, at any time, and they will also understand that these problems have causes and can be treated, just like physical illnesses. People will know some of the signs to look out for in themselves and in their friends and families and will have a better understanding of how an interplay of several factors can lead to psychological, social and physical difficulties. They will know that treatments give most chance of recovery if help is sought early. They will know that people who have had, or have, mental health problems are no different from people with a physical health problem; with the right amount of practical and emotional support from friends, family, colleagues and employers, they can live independently, enjoy a fulfilling family life, participate fully in their community, earn their living and contribute to society. People will know how to access support and information so they too can play their part in supporting others with mental health problems. Families and carers will be welcomed as partners by services and will be listened to and supported by professionals.

High-quality care for all

In 2020 services to treat and care for people with mental health problems, including personality disorder, will be accessible to all who need them, will be based on the best available evidence, and will be aimed at regaining hope and recovery of psychological and social functioning and good physical health. The effectiveness and acceptability of services will be assessed frequently, against indicators agreed between individual clinicians and their patients, and used to help the service user plan their next steps towards recovery, as well as to monitor their progress. Recovery-based services will ensure that people unable to work because of mental health problems will have opportunities to take part in meaningful activities and to contribute to and participate in society.

No health without mental health

In 2020 people with mental health problems will no longer be at greater risk of physical ill health than the rest of the population. For example, rates of smoking, obesity, cardiovascular disease and diabetes will have reduced to levels closer to those of the general population.

We know there is an association between poverty and mental and physical health inequalities in some groups and communities. In 2020 this interaction will be better understood and addressed. Local and national programmes to improve employment, housing, education, transport and health services will be based on a good understanding of the needs, assets and special characteristics of each community. Local and national government will take into account the impact of all policies and programmes on the mental health of individuals and communities, and seek to redress social inequalities.

Mental health is everyone's business. In 2020 mental health will be seen as an important asset for our society, one in which we all have an investment and to which we all – individuals, employers, the third and statutory sectors, local authorities, the health services and all government departments – have an important contribution to make.

New Horizons

Better mental well-being and better mental health care for all individuals, families and communities in England

Introduction and executive summary

This document forms a crucial part of the consultation on a new cross-government vision for mental health and well-being in England for 2010 onwards – a consultation that began in late 2007. While it describes some clear principles and ideas that have emerged during those discussions, it is not a complete and final text. There are a number of important questions still to be resolved and the response to those and the rest of our proposals will have a strong influence on the final version. All the aspirations expressed in New Horizons should be seen in the context of the financial constraints that the Department of Health and the National Health Service will face over the next three to five years.

New Horizons will form a programme of action to advance the twin aims of:

• improving the mental health and well-being of the population

• improving the quality and accessibility of services for people with poor mental health.

The programme takes a life-course approach, from laying down the foundations of good mental health in childhood through to maintaining mental resilience into older age; from prevention of mental health problems, through effective treatment to recovery.

This consultation document forms an important part of the New Horizons programme. It sets out:

• the continued high profile of mental health as a Department of Health priority

• an agreed set of key values and principles for the NHS, local authorities and other government departments to guide service design and delivery

• what we have learnt from the National Service Framework (NSF) and its implementation over the past 10 years.[1, 2]

It seeks, through consultation, to discover:

• how these improvements can be maintained and developed further in a new era of devolved systems and World Class Commissioning,[3] and in the current economic climate

• how we can use the new emphasis on personalisation, choice, quality and empowerment to improve access to services and reduce inequalities in outcomes

• how we can use our experience of partnership working and multi-disciplinary approaches to extend our work to tackling the causes of mental health problems still higher upstream, at primary prevention level

• where the opportunities for innovation are

• how good mental health and well-being can become a priority across government.

Building on the *National Service Framework for Mental Health*

In the 10 years since the NSF was published, mental health services have seen many improvements. The World Health Organization, reviewing mental health care in European countries, concluded recently that services in England are increasingly seen across Europe as the model to follow.[4] The key changes have been:

- reform of community care – over 700 assertive outreach, crisis resolution and early intervention teams have been set up. National and local evaluations have demonstrated reduced hospital admissions, improved service user and carer satisfaction, and reduced costs (see Better mental health care for adults, section 4)

- suicide prevention – the suicide rate has fallen to the lowest on record, and one of the lowest in Europe. Following a 25-year rise, suicide in young men has fallen for the past seven years;[5] and suicide in mental health inpatients is down by 30 per cent[6]

- additional resources – from 1999 to 2008, increases have occurred in several staff groups – psychiatrists (46 per cent), mental health nurses (24 per cent) and clinical psychologists (61 per cent). Over the same period investment in mental health has increased by over £2 billion.[7,8]

- inpatient care – many inpatient units have been rebuilt or refurbished to a modern design, informed by the views of staff and patients; at least 70 per cent of inpatient beds are now in single rooms;[9] wards are smoke-free – a sign of greater attention to physical health

- modern treatments – the use of modern antipsychotic and antidepressant drugs has greatly increased in response to patient preference.[10] The availability of psychological therapies is now being expanded[11]

- patient opinion – the national patient survey shows that 79 per cent of patients receiving treatment in the community view their care as good, very good or excellent. Around 90 per cent report positive views of how they are treated by staff, for example being listened to and treated with respect.[12]

Separately, as part of the *National Service Framework for Children, Young People and Maternity Services*, a CAMHS (Child and Adolescent Mental Health Services) Standard was published in 2004.

Through Public Service Agreement 12 (to improve the health and well-being of children and young people), the Government is committed to improving the mental and emotional health and well-being of children and young people. The independent CAMHS review made recommendations to improve children and young people's mental health and psychological well-being. The National Advisory Council is advising Government on implementing the recommendations and will hold Government to account on delivery.

An amended Mental Health Act came into effect in 2007.[13] It introduces:

• a power to require patients in the community who are at high risk to receive treatment (supervised community treatment)

• removal of the 'treatability test' for patients with personality disorders; these patients can now be treated under the Act if appropriate therapies are available

• an explicit requirement for treatment to have a therapeutic purpose

• a duty on mental health trusts to provide age-appropriate accommodation for people under 18 who require hospital admission

• a duty on trusts to provide specialist advocacy support for patients detained under the Act.

Building on these developments means maintaining the momentum of reform, improving access to and the quality of services for all adults of all ages, extending policy and practice to include prevention, promoting mental health and building mental resilience and well-being.

What is mental health?

Good mental health is more than the absence or management of mental health problems; it is the foundation for well-being and effective functioning both for individuals and their communities.

Mental well-being is about our ability to cope with life's problems and make the most of life's opportunities; it is about feeling good and functioning well, as individuals and collectively.

Mental health problems generally refer to difficulties we may experience with our mental health that affect us in our everyday lives. Mental health problems can affect the way we feel, the way we think and the way we function. Mental health problems include conditions described as personality disorders and also dementia. They can be mild or serious, fleeting or long-lasting.

Mental illness refers to more serious mental health problems that often require treatment in specialist services. Someone with a serious mental illness may have long periods when they are well and are able to manage their illness. Many people with mild and serious mental health problems are able to live productive, fulfilling lives.

Someone can have a mental health problem and still enjoy good mental well-being, just as people with a physical illness or long-term disability can live a productive life and enjoy good well-being. Equally, someone can have poor mental well-being, but have no clinically identifiable mental health problem.

No health without mental health

Building mental resilience in individuals, families and communities is everyone's business. Mental well-being is fundamental to a person's quality of life. It is linked to good physical health and many other benefits, for individuals and communities. These include better cognitive and physical functioning, increased productivity, better interpersonal relationships, longer life expectancy and greater capacity to deal with stress and adversity.[14]

Communities and environments that support mental well-being are good for all of us, including people with mental health problems.[14, 15]

The causes of mental ill health are complex but their impact can be reduced by intervening quickly and effectively when people are showing early signs of problems. This can be done by identifying and providing appropriate support to those at higher risk of mental health problems, and by the provision of timely and good quality services when people do become unwell. There is also increasing evidence of the importance of resilience as the foundation on which is built the capacity of individuals and communities to cope with and support each other through life's adversities.[14, 15]

As set out in the NHS Constitution, promoting mental well-being is at the very heart of the NHS.[16]

'The NHS belongs to the people. It is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limit of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matters most.'

Why New Horizons?

In 1999 the Government published the *National Service Framework for Mental Health*. Much progress has been made and has transformed the experience of many people affected by severe mental health problems.

New Horizons aims to build on these foundations by setting out the next stage in the Government's strategy for improving mental health in England. It will take a cross-government approach and looks to the wider health service, local authorities, employers, education and criminal justice agencies to play their part in achieving its aims. We should not see mental health as the responsibility solely of the Department of Health or mental health services. New Horizons also recognises the potential for reducing the burden and long-term consequences of mental health problems by setting out a framework for early intervention and promoting well-being across society.

New Horizons aims to:

- take forward what we have learned in the lifetime of the NSF about what works, and broaden our scope to include all groups in society, including children and young people and older people

- build on the principles and values set out in the NHS Constitution

- support the delivery of the NHS Next Stage Review (the Darzi report[17]) and its vision of local commissioners working with providers, the public and service users to devise local approaches to mental health and mental health care

- use the growing understanding of the wider determinants and social consequences of mental health problems and mental well-being to influence priorities in other parts of central and local government

- reinforce commitment to key mental health policy aims, including delivering race equality and improving access to psychological therapies.

A public mental health framework

In addition to supporting the continued transformation of specialist services for people with mental health problems, New Horizons sets out the Government's commitment to promoting whole population mental health and well-being.

A public mental health framework has been developed to support this work (see Figure 1).

The framework can be adapted at local or regional levels to facilitate partnership working. It draws on established public health, ecological and psychological principles. It identifies the root causes of poor mental health to identify the key risk factors and at-risk groups on which we need to focus to address inequalities in health. It also sets out the evidence base for interventions and promising approaches that can be adapted to suit different settings.

The public health framework for mental health supports and is supported by the Department of Health's overall approach for promoting health and well-being, outlined in Figure 2.

Figure 1: A framework for developing well-being

The vision
To create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities.
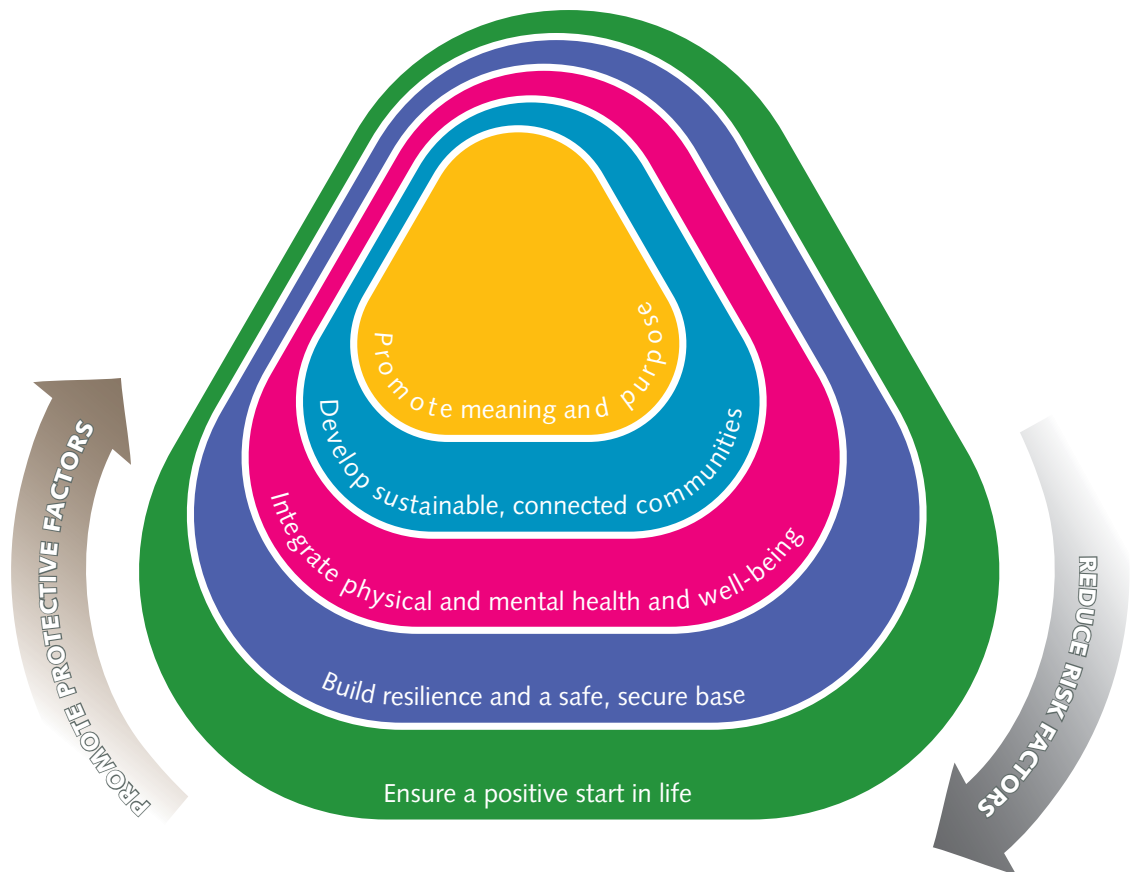
Figure 2: An approach to tackling mental health problems and risky behaviours, such as smoking and obesity

Tackling lifestyle changes

We aim to be comprehensive and strategic in our approach, and to get the balance right between 'state' and 'no state'.

We have developed an approach with four areas of activity, as action on many fronts is needed to tackle problems such as obesity, smoking and alcohol misuse.

Informing and supporting people to make healthier and more responsive choices

Creating an environment in which the healthier and more responsible choice is the easier choice

Identifying, advising and treating those at risk

A delivery system that effectively prioritises and delivers action to reduce harmful behaviours

The continuing need to improve mental health services

Mental health problems are extremely common: one in six adults will have a mental health problem at any one time, and for half of these people the problem will last longer than a year.[18] For some people, mental health problems last for many years, particularly if inadequately treated.

The social and financial costs of mental health problems are immense.[19] The burden on individuals, families, communities and society as a whole includes the psychological distress, the impact on physical health, the social consequences of mental health problems, and the financial and economic costs.

The NHS spends 14 per cent of its annual budget on mental health services.[20] Recent estimates put the full economic cost at around £77 billion, mostly due to lost productivity.[19]

Improving mental health brings benefits to individuals and society and we know a great deal about what works. There is a clear association between good mental health and better outcomes across a number of domains: years of life, physical health, educational achievement, criminality and employment status.[14]

There is now increasing evidence that investment in particular interventions – in psychological therapies, for example, and tackling childhood conduct disorder – can produce much greater savings over time.[21]

Mental health, equality and human rights

'The circumstances in which people are born, live, work and age are the fundamental drivers of health and health inequity.'[22]

There are inequalities in mental health, inequalities in experience of mental health care and inequalities that arise from having a mental health problem. Government and public services share a duty – moral and legal – not just to avoid widening these damaging and divisive fault-lines but to act to reduce them. New Horizons is mindful of that duty.

The links between poverty, social deprivation and mental health problems are clear. There is also a strong association between income inequality – relative poverty – and poor mental well-being and health.[15] People with mental health problems tend to have fewer qualifications, find it harder to get work, have lower incomes, may well be homeless and are more likely to live in areas of high socio-economic deprivation. Fifteen per cent of children in the lowest socio-economic group develop mental health problems, compared with just 5 per cent of children in the highest.[23] Life for many in black and minority ethnic communities can be more difficult than for the majority population, and that too is reflected in the incidence of mental health problems.

Women are more likely to experience common mental health problems such as depression and anxiety – around 20 per cent of women at any one time compared with about 12.5 per cent of men.[24] Men, however, have higher rates of suicide and addictions. There is emerging evidence that lesbian, gay, bisexual and transgender people are at higher risk of some mental health problems[25] and that services for older people are lagging behind those for younger adults.[26]

Physical health affects our mental health, and vice versa. The most mentally healthy people also have the lowest rates of cardiovascular disease.[27] Conversely, people with a physical illness are more likely to develop a mental health problem – an estimated 70 per cent of general hospital beds are occupied by older people, of whom up to a half are assessed as suffering from cognitive problems and a third with depression.[28]

People with severe mental health problems die younger than other people. Some studies have shown that on average it is 25 years earlier.[179,103] Such people also develop illnesses such as strokes and coronary heart disease before the age of 55 more often. They can also find it harder to access screening services and other primary care services.[29]

Many of the root causes of inequality are beyond the direct control of the health and social care sectors, and some present continuing challenges to Government as a whole. That is not to say that we are powerless to intervene – on the contrary, New Horizons aims to show how the NHS, social services and partners across government can respond to these challenges and work towards a healthier, fairer and more equal society.

The approach to consultation

This document draws on a large body of work, including information from a number of engagement and listening events held across the country and involving a great number of different stakeholders. It builds on the 'visions' for mental health produced by the Strategic Health Authority Clinical Pathway Groups and has been enriched by many other reports, reviews and studies. These include the Future Vision Coalition discussion paper *A Future Vision for Mental Health*[30] (published July 2009); *Moving Forwards*, the Next Stage Review Mental Health Care Pathway Group report and the SHA vision reports; the Health Care Commission's national study of older people's mental health services, *Equality in Later Life*; the forthcoming cross-government Ageing Strategy, due to be published in 2009; the *Healthy Lives, Brighter Futures* strategy for children and young people's health;[31] the first ever cross-government National Mental Health and Employment Strategy, due to be published in 2009; and *Mental Capital and Well-being*, the report of the Foresight Project.[14]

Guide to sections

1. Guiding values
Mental health is about equality and social justice. In this section we describe the underpinning values that will guide a high-quality mental health service that both takes a lead on promoting and protecting mental health across all age groups and provides safe, effective, equitable and acceptable treatments to people with mental health problems.

2. Laying the foundations
This section outlines approaches to promoting positive mental health among infants, children and young people in order to lay sound foundations for mental health and well-being into adulthood and older age.

3. Transition from adolescence to adulthood
Transition from childhood to adulthood presents multiple challenges for mental health and well-being. Here we explore approaches to improving services and support for young people at this critical time.

4. Better mental health and well-being for adults
How we care for and are able to safeguard our mental health and well-being is central to our adult lives. This section outlines what we can do, as individuals and as a society, to improve the mental well-being of all adults.

5. Better mental health care for adults

This section builds on the achievements of the NSF towards high-quality, inclusive mental health care for adults with mental health problems. It describes care pathways that respect the autonomy and dignity of individuals, families and carers and that support recovery.

6. Older adults

The sections on better mental well-being and mental health care apply to all adults of all ages. This section describes additional approaches to promoting the mental health and well-being of older adults and to providing high-quality, non-discriminatory mental health care.

7. How we will get there

In this final section we outline the levers and enablers that will ensure we have a high-quality mental health service and a public mental health framework that supports mental well-being across all communities and all ages.

Consultation questions and how to respond

Finally, we are keen to hear your views on a number of issues. At the back of this document we outline important questions, the answers to which will help shape New Horizons. Please see page 121.

Guiding values

The guiding values underpinning New Horizons are based on feedback from a wide range of stakeholders – service users (individuals, families and communities) and service providers. As shared values, they are woven through and reflected in each of the policy directions set out in the chapters that follow.

These guiding values are:

• equality, justice and human rights

• reaching our full potential

• being in control of our lives

• valuing relationships.

These guiding values are all equally important in achieving good mental health and well-being. As Figure 3 suggests, they form a central 'round table' rather than a hierarchy. In the wider circle are the key areas for action and intervention that both flow from and are informed by the values.

In practice, any one guiding value may have to be weighed against one or more of the others, in an open, honest way. For example, safety is an important aspect of a high-quality service, but this may sometimes have to be balanced against self-determination, expressed here as 'being in control of our lives'. In some situations, safety may be the overriding consideration; in others, the ability of the individual to make their own decisions and feel in control of their life will be more important to their mental health and well-being.

Equality, justice and human rights

'It's about people who happen to use mental health services being treated as people.'

Social inclusion

Improving mental well-being and mental health care is about improving outcomes for everyone in society, reducing inequalities and increasing social inclusion. This will include approaches that:

• address the factors that cause and are the consequence of poor mental health and well-being

• improve people's experience of mental health services, including access, delivery and outcomes of all services for different groups within society

Figure 3: The Guiding Values
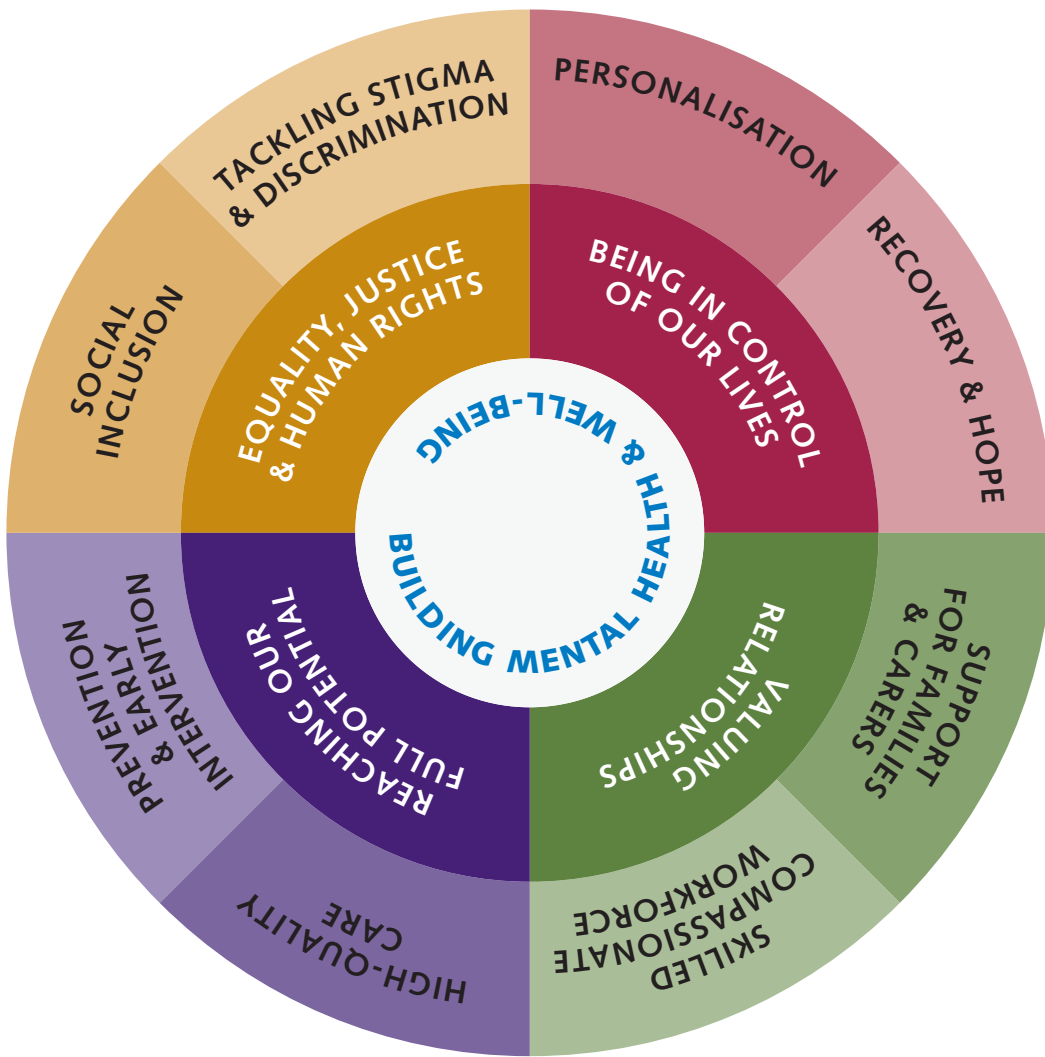
- address individual needs and choices
- address the related inequalities in physical health outcomes for people with poor mental health.

Social exclusion is both a cause and a consequence of mental health problems. Excluded people have poorer mental health outcomes, less access to services, less involvement in decisions about their own care and treatment and less information about what services are available to them. Social exclusion drives inequality.

There is strong evidence of inequalities between (among others) rich and poor, men and women, young and old, and between the white population and black and minority ethnic groups. The AESOP study,[32] for example, suggests that the incidence of psychosis among African Caribbean communities in England is nine times higher than for white people – even though the incidence in the Caribbean is comparable to the overall rate in the UK.

People with learning disabilities and older people with mental health problems deserve the same access to care and high-quality services as others.

People with severe mental health problems experience inequalities in their physical health that can reduce their average life expectancy by several years.

The population of England has grown much more diverse over the last 10 years, and that trend seems likely to continue. The average age of the population is rising. Changes such as these offer real benefits and can strengthen society; in 2007 only 40 per cent of clinical staff in mental health trusts described themselves as white British.[33] This increase in diversity means that offering a 'standard' of provision to an unequal society is not an acceptable model for the future. Uniformity simply guarantees unequal results. The commissioning and provision of services need to be more sophisticated, based on a more highly developed understanding of local populations and on more direct participation of local communities.

These are complex and sensitive issues, but we have learned much since 1999 and – while there is still a lot more to learn – services have demonstrated that they can rise to the challenges. These issues inform and underpin New Horizons and its development. Its specific aim

is to reduce, and ultimately end, inequalities in access to, experience of and outcomes from services.

Tackling stigma and discrimination

'I told my close friends and family immediately and they understood and have been very supportive, but in my working life I have learned to keep it quiet. There is a certain amount of shame attached to it and I just can't be candid and open.'

Stigma and discrimination can have negative effects on mental well-being in a number of ways. They can occur for many reasons, including age and race. Some people will experience discrimination for more than one reason: for example, older people with mental health problems and physical disabilities.

Stigma can:

• discourage people from seeking help when they suspect something might be wrong, which may delay diagnosis and intervention

- make it difficult for people to discuss mental health problems with friends and family, leading to social isolation, which can of itself exacerbate mental health problems

- act as a mechanism of social exclusion once someone has been diagnosed with a mental health problem, which hampers recovery

- create barriers to recovery such as reduced employment and education opportunities

- result in poorer quality physical healthcare and higher morbidity and mortality rates.

Tackling stigma and discrimination, through social marketing campaigns, education and information and legislation, is a fundamental element of strategies to achieve social justice and equity for people with mental health problems.

Reaching our full potential

Improving mental well-being, preventing mental health problems and improving mental health care are vital for all of us to reach our full potential. Mental health problems can be long-lasting and cause significant impairments to people's lives, general health and ability to live independently and achieve their hopes and ambitions. Intervening early can reduce these long-term adverse effects.

Prevention and early intervention

In many types of mental health problems, the quicker that problems are identified and tackled, the better

the prognosis and the quicker a person will be able to return to and pick up their life again. Tackling problems that emerge in childhood and adolescence has the potential to improve lifelong mental health.

Prevention requires collaboration across different local agencies; a decent standard of housing and local environment, for example, can be key to promoting and protecting mental well-being and reducing risk of mental health problems in a community. A well-managed and rewarding working life can also play an important role in developing well-being and resilience in individuals. These things are important in helping people with a mental health problem recover and regain their independence.

High-quality care

'I want the services to provide me with somewhere I can go to help guide me through my thoughts and feelings when they are at their worst. I want to feel as though I can express my emotions. I want to be listened to and heard, and I would like to be able to leave feeling good about myself.'

When someone needs the support of services and professionals beyond their family and friends, they should expect it to be of high quality. High-quality care, as defined in the *Next Stage Review,*[17] is:

- clinically effective

- personal

- safe.

Clinically effective – clinical effectiveness in mental health care and treatment should mean not only improvement in functioning and relief from disabling and distressing symptoms, but also effectiveness in tackling the causes or addressing the antecedents of the mental health problem, resulting in better quality of life outcomes.

Personal – care and support should be based on the needs and expressed wishes of an individual, and not on existing structures and to suit professional convenience. A personal approach should be the norm, from appropriate methods of access, to choice of treatment and the involvement of families and/or carers in the process of recovery.

Safe – mental health care, whether in acute or secure settings or in the community, requires robust risk procedures embedded in the care pathway. Safety includes risks to the patient, their family and the wider public.

When decisions are made about which set of interventions should be chosen, effectiveness, risk and safety, personal preferences and autonomy have all to be considered in a well-informed, balanced way. In addition, the Next Stage Review Mental Health Care Pathway Group[34] has highlighted the importance of a focus on improving the outcomes that service users and carers value:

'Effective use of the evidence-based care pathways is the best way of improving quality and equitability. Service users and their quality of life must be at the core of service design and delivery. Their views plus the views of carers, the public and staff must shape care pathway outcome measures and performance frameworks must increasingly focus on these outcome measures.'

Being in control of our lives

'Recovery involves talking, group intervention and the application of the word "hope"… And the big one … acceptance and partnership working with the individual affected.'

Personalisation

'I'd like my opinion to be considered in the progression of treatment, with mutual decisions between provider and client.'

Personalisation and self-determination:

'… will reflect a move from care as something which is done to service users by the system, towards a system of support built by the person and their advocates.'

We are aiming for a model of care in which service users can determine their own route to recovery and the role of the professional is to support them in achieving this.

It reflects a more general move towards personalised public services, but has particular resonance in mental health, where autonomy and control are in themselves important factors that contribute to, and are a measure of, recovery.

Some of the mechanisms to facilitate self-determination and personalisation through users having control of resources are already in development. For example, a proposed change in the law will allow the piloting of personal health budgets within the NHS. Users of social care services are already able to arrange their own care and support through direct payments schemes.

Recovery and hope

'Listen to me and actually pay attention. Start with small steps to engage me more in life. Support me when things go wrong. It's very easy to feel that my concerns aren't considered important, just because they seem small and inconsequential to others.'

'Personally, I don't like the word. I prefer to describe my son as "doing great".'

Recovery can be described as 'living a life beyond illness'.

In a high-quality service, the principles of recovery and the concepts of hope, self-determination and opportunity that come under its umbrella underpin the practice of all those offering care and treatment.

Partnership between service user and practitioner is fundamental to a recovery-focused approach.

'Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms and problems. Hope and the principles of recovery should explicitly guide the development and practice of all services and shape all interactions from childhood preventative services through to services for those with serious mental disorder in later years. Hope is central to recovery and can be enhanced by seeing how we can have more active control over our lives and by seeing how others have found a way through.'[35]

Recovery

Valuing relationships

Support for families and carers

Families and carers play a vital role in supporting those members of our society who, for whatever reason, are less able to take care of themselves. Many people with mental health problems do not need care from their families or friends and live independent lives. Many only require care and support occasionally. However, some families and carers provide considerable unpaid support. They are a vital resource and should be seen as equal partners with the mental health care team. They need access to all the information necessary to fulfil this important role.

Carers themselves experience high rates of mental health problems. They may need support to maintain their own mental health and to live fulfilling lives outside their caring role.

There is now a range of initiatives, both under way and planned, to support unpaid carers, under the broad aegis of the 10-year cross-government strategy *Carers at the heart of 21st-century families and communities*.[36] These include:

• long-term work towards legislative or other action to ensure that carers receive appropriate information – this has been started through Carers Direct

- demonstrator sites to test over two years which interventions provide the best outcomes for carers

- the Think Family approach being tested in pathfinder sites to improve co-ordination between adults' and children's services so that young carers are better supported[37]

- development of training modules for frontline health professionals on supporting carers and families.

Skilled, compassionate workforce

'… for them to be dependable, to help out of crisis, to help when we want help, to believe us, to motivate us, to leave some of the painful bits alone, to offer human contact, to go the extra yard to demonstrate it's more than just a job.'

Mental health practice[38]

Mental health practitioners need a wide range of skills, including basic therapeutic attributes such as empathy, acceptance and mutual affirmation. They also need to be highly skilled in both the assessment and treatment of the physical, psychological and social causes and consequences of mental health problems, including the ability to use modern, tailored psychological and pharmacological therapies. In a recovery-orientated service, they need to be able to work with the service user and others to formulate a shared understanding of the problem and a positive, forward-looking care plan, with clear, structured feedback on progress. They need also to be able to understand the experience of people from all sections of society – for example veterans, refugees and people from different cultural and religious backgrounds.

In a high-quality service the composition of the mental health workforce reflects the cultural diversity of the local population, and people using mental health services are able to choose to be treated by health professionals and staff of their own sex. Staff receive ongoing training and supervision and work in well-led teams within organisations

that share the same values and ways of working and have appropriate links across agency boundaries to facilitate smooth pathways of care.

Team working
Specialised teams – for example, assertive outreach, crisis resolution, early intervention, community and learning disability teams and primary care – now form the bedrock of modern adult mental health services. A key rationale for teams is that they can provide access to the range of specialist skills and expertise necessary to provide a comprehensive assessment of needs and a wide-ranging plan of treatment for people with multiple and complex problems. Employing people who have experienced mental health problems is an effective way to make services more responsive to the needs of service users.

Wider workforce
A vast range of agencies provide services to people experiencing mental health problems. They include primary care, social care, alcohol and substance misuse services, employment services, occupational health, the criminal justice system, education and housing. Their actions can help individuals regain a good quality of life, and their important contribution will be enhanced if staff have a good understanding of mental health and mental well-being issues.

Similarly, a broad understanding of mental health issues will help all social workers, employers, youth workers, teachers and other key frontline workers in the community to challenge stigma and discrimination and to recognise and intervene at an early stage if people with whom they are working have mental health difficulties.

Laying the foundations

Aim

To promote the mental health of all children by providing universal and targeted support for families and at-risk groups.

Key messages

Early intervention to build mental well-being and resilience in infancy and childhood can prevent mental health problems in adult life and lead to better outcomes in health, education, employment and relationships.

Early identification and treatment of mental health problems in children and their parents can lead to better outcomes.

Most successful interventions will be the result of effective multi-agency working.

The foundations for good mental well-being are laid in childhood. Ensuring children and young people have a positive start in life has the potential to improve individual outcomes in education, employment and relationships, and lead to a more fulfilling life. Further, it may lower the life-time risk of developing mental health problems. Building mental capacity and resilience in childhood can therefore lead to reduced health inequalities and contribute to improvements in the well-being of the overall population.[39]

New Horizons does not cover specialist child and adolescent mental health services (CAMHS). Nonetheless it recognises the importance of laying a good foundation early in life – in terms both of promoting mental well-being and of tackling mental illness.

The majority of adults with mental health problems experienced mental health difficulties in childhood.[40, 41] These problems not only persist through adulthood but can also have an impact on the next generation. For example, emotional disorders in childhood are associated with depression and anxiety in adult years and contribute to increased risk of postnatal depression and persistent maternal depression. This in turn is associated with a five-fold increased risk of emotional or conduct disorders in children of mothers with poor mental health.[42]

Children in families living on the lowest incomes and their parents and carers have a higher risk of mental health problems than those living in more affluent circumstances.[43]

Poor mental health in children and young people is associated with risk behaviours such as smoking and substance abuse, and with adverse health outcomes, for example, teenage pregnancy, bullying and violent behaviour. It is also associated with lower educational achievement and reduced employment opportunities. Poor emotional adjustment in children is associated with subsequent criminal behaviour, misuse of drugs and higher suicide rates.[44]

Conduct disorder is the most common mental disorder in childhood[42, 45] and persists into adulthood in about 40 per cent of cases, with an increased risk of offending.[46] Half of children with conduct disorder receive a diagnosis of antisocial personality disorder as adults, and other problems such as schizophrenia, major depressive disorder and panic disorder are also more common.[47] Conduct disorders are associated with an increased risk of perpetrating (and experiencing) violence and abuse,[48] and increased risk of school dropout and alcohol and drug misuse.

The long-term social and financial costs of untreated mental health problems in young people are therefore significant for individuals, their families and for society.

Between a quarter and a half of mental health problems in adults are potentially preventable through treatment during childhood and adolescence, and much can be done.[40] A number of interventions have been developed to promote better mental health in the early years of life through empowering parents and strengthening resilience and competence in both children and parents. Such interventions have been found to be especially effective for families at higher risk and those living in disadvantaged communities.[49, 50, 51]

There is therefore a huge opportunity to reduce the overall social and economic burden of mental health problems by intervening early, when problems first emerge.[52, 53, 54, 55]

Policy context

Policy on children's mental health and well-being has been driven by two documents published in 2004: *Every Child Matters*[56] and the *National Service Framework for Children, Young People and Maternity Services*.[57] Standard 9 of the National Service Framework states that:

'All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.'

This has been reflected in the requirement under the most recent round of Public Service Agreements that primary care trusts (PCTs) and local authorities must together provide comprehensive CAMHS for their area. This includes 24-hour access, a full range of CAMHS for children and young people with learning disabilities, age-appropriate service provision for all 16- and 17-year-olds, and joint commissioning of early intervention support.

Every Child Matters[56] specifies five outcomes for children towards which local authorities and their partners are expected to work:

• being healthy

• staying safe

• enjoying and achieving

• making a positive contribution

• achieving economic well-being.

Every Child Matters is underpinned by the Children Act 2004,[58] which imposes a duty on statutory agencies providing services to children and young people to work with other local partners within children's trusts. There is also a requirement on local authorities to work with other agencies to produce a single strategic plan for all services affecting children and young people locally. All organisations are required to respond to the needs of children, young people, their families and communities, and to recognise that safeguarding children and young people from harm is a common and shared responsibility.

New tools have been introduced to help commissioners and providers improve the quality and continuity of care provided to children and young people. These include the Common Assessment Framework, a standardised approach to assessing and communicating children's and young people's needs for services, the Commissioning Framework for Health and Well-being, and joint area reviews, which assess the quality of council services and judge how well services work together (see section 7: How we will get there).

While CAMHs are not covered by the New Horizons programme or in this report, the recent review of CAMHS, *Children and Young People in Mind,*[21] highlighted a number of areas for improvement that would support the mental health and well-being of children who have or are at risk of mental health problems. It concluded:

'What children, young people and their families and carers want is often quite simple. They told us they want consistent relationships with people who can help and to be treated with dignity and respect.'

The review's main recommendations for improvements include:

• teach parents and families about how to support and build their child's emotional resilience

• address inequalities in access to treatments and the range of treatments on offer

• increase support for sustainable services and increase consistency

• improve support, preparation and continuity of care for young people approaching their 18th birthday, including the transition to adult services

• train and raise awareness among the children's workforce about mental health and well-being and how to protect and promote it

• engage with children and families locally to understand the needs of all local children

• address the stigma of many children and young people with mental health problems, for example through national media activity, to promote a positive understanding of mental health.

The policy framework is in place to encourage universal services to promote children's and young people's mental health and well-being, for example a Sure Start Children's Centre for every community by 2010; a duty on PCTs and local government to co-operate to promote children's well-being (including mental well-being); and embedding health promotion through the National Healthy Schools Programme and forthcoming Healthy Further Education Programme.

Laying the foundations

Interventions to improve mental health and prevent or treat mental disorders can be universal or targeted. Key areas for intervention include pregnancy and the perinatal period, parenting and the development of emotional and social skills.

Pregnancy and the perinatal period

Good physical and mental health in pregnancy is associated with better outcomes for children.[42] Anxiety, depression and maternal stress during pregnancy, especially the experience of domestic abuse, have been linked to impaired emotional, cognitive and language development in infants.[59, 60]

Maternal smoking, use of alcohol and poor diet are associated with lower birth weight and poor mental health in children. Providing information about physical and mental health at the earliest possible stage of pregnancy can promote awareness of these risks and reduce the danger of poor outcomes for women and their babies.

One in seven women will experience mental health problems during pregnancy or in the postnatal period and one in 10 new mothers is likely to experience postnatal depression. Smaller but significant numbers of new mothers (approximately two per thousand) will be admitted to hospital for specialist treatment for post-partum psychosis.

Interventions for promoting maternal mental health include routine antenatal screening for depression and experience of violence from a partner. Guidance issued by the National Institute for Health and Clinical Excellence (NICE)[61] has outlined evidence-based approaches to treating postnatal depression. These include health visitors trained to deliver brief psychological therapies with the support of GPs and specialist perinatal mental health services for women with more severe mental illness.

Good parenting skills

Good parenting enables children to develop good social and emotional skills. Early neglect and trauma are associated with problems in later life, including anxiety, impulsivity and hyperactivity, as well as poor problem-solving and empathy.

Parenting interventions are effective in reducing behavioural problems in children. They can also improve the mental health of families with children with conduct disorders[50] and improve maternal psychological health and social functioning. Home visiting programmes lead to improved parenting skills, improved child development, reduced behavioural problems and improved maternal mental health and social functioning.[49, 50]

Relationship conflict between adults can have an impact on the mental health of children in the household. The Government is supporting the Kids in the Middle campaign to improve support services. www.kidsinthemiddle.org

Universal parenting skills training, such as the Triple P programme, can reduce disruptive behaviour in children. Targeted interventions for high-risk families have been shown to pay for themselves after four years, for example the Family Nurse Partnerships and Sure Start interventions have resulted in improved parenting skills and social skills in children.[62]

There has been a significant investment in early years over the last decade. Sure Start Children's Centres are a universal service for 0–5-year-olds, established to help provide health and education services in the early years of a child's life. There are currently just over 3,000 Sure Start Children's Centres, with plans for 3,500 to be operational by 2010. They promote integrated health and related services, delivered by well-trained professionals, whose work in their local communities will include mental health and well-being.

Developing social and emotional skills

Preschool programmes in social skills training improve outcomes significantly for young children, including those at higher risk.[63] Programmes that address preschool development have been shown to improve language, cognitive and social skills.[51] Comprehensive preschool programmes that combine elements of home visits with

day care, high-quality education programmes and parent support appear to be the most effective.[64, 65] Long-term benefits for at-risk children include multiple health gains, a 28 per cent reduction in conduct disorder and a 17-fold return on investment.[66]

Social and emotional learning programmes have been found to improve schoolchildren's social and emotional skills, attitudes about self and others, connection to school, positive social behaviour and academic performance.[67] Such programmes are also effective in reducing conduct problems and emotional distress, and have been found to work equally well in school and outside school settings, for young people from black and minority ethnic groups, and for young people with behavioural and emotional problems.

The Targeted Mental Health in Schools programme is being developed and evaluated. This programme enables participating schools to test innovative models of mental health support for children, young people and their families who need it most, and to make better links to specialist services.

Healthy Lives, Brighter Futures,[31] the Government's strategy for children and young people's health, also stresses the importance of good quality personal, social, health and economic (PSHE) education. The strategy describes several school-based programmes and outlines the importance of access to educational, occupational, physical and social opportunities for young people in their local communities, such as sports, leadership and volunteering, drama and music.

Interventions in schools to promote mental health can influence positive mental health, reduce risk factors and behavioural and emotional problems,[68] and reduce rates of mental health problems such as depression.[69]

There are three main approaches to promoting mental health in the school setting:

- curriculum-based skills training – the teaching of life skills and social competencies as part of the school curriculum

- a whole-school approach – interventions aimed at changing the school environment and ethos, including involving parents and the community

- selective and targeted interventions – interventions for students at higher risk, aimed at strengthening their coping skills and reducing the risk of mental health problems, including suicide.

Benefits include improvement in educational outcomes, prevention of conduct disorder and reduced alcohol and drug use, smoking and bullying. Programmes that take a whole-school approach and encourage parental participation have been found to be more effective.[50]

The 21st-century school is increasingly seen as the hub of the community. By 2010 all schools will be providing access to a core of extended services, including swift and easy access to specialist services and parenting support. This means that schools and clusters of schools are working closely with other services to identify and support children and young people with emotional, behavioural, health or other difficulties as early as possible.

The Marlborough Family Education Service

The Marlborough Family Education Service organises and supervises multi-family therapy groups in schools. The aim is to identify vulnerable children, young people and families in need of mental health support to prevent more serious mental health problems from occurring. By operating in schools, the service reaches children, young people and families who do not traditionally engage with statutory clinic-based services. The service reduces the risk of children's behaviour leading to educational and social exclusion, and it works with the school to improve educational attainment for vulnerable children.

Overall, the service aims to deliver an innovative model of mental health support through schools, collaborating with teachers to raise awareness of mental health and the long-term developmental needs of children. It also builds supportive communities of parents to counter problems associated with social isolation and stigma.

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Connexions

The Connexions service was established in 2001 with the aim of providing a comprehensive service to meet young people's needs for information, advice and support.

Connexions provides high-quality, impartial information, advice and guidance (including careers advice and guidance), together with access to personal development opportunities. The idea is to help remove barriers to learning and progression and ensure that young people make a smooth transition to adulthood and working life. A dedicated website, Connexions Direct, is available for young people aged 13 to 19.

The service is provided through local Connexions services that bring together all the key youth support services.

www.connexions-direct.com

At-risk children and young people

Some children and young people are at greater risk of developing mental health problems because of their life experiences and therefore need specific, targeted interventions. Lord Lamming's review highlighted that child protection must be given higher priority to protect young people from abuse and the Department for Children, Schools and Families is taking extensive action with partners to improve services. Examples of such groups are listed on the following two pages.

Children and young people experiencing violence and abuse

Rates of mental health problems are significantly higher in adults who have been abused in childhood.[70, 71] Some 20 per cent of children in the UK experience some form of physical, emotional or sexual abuse.[72]

Children in households where there is domestic violence are at increased risk of behavioural problems, emotional trauma and mental health problems in adulthood.[73, 74]

Multi-agency risk assessment conferences (MARAC) combine risk assessment with a multi-agency approach to supporting and monitoring families where there are concerns about violence and abuse. Mental health services are among the agencies that can make an important contribution to this collaboration.

Young offenders

Young offenders have higher rates of mental health problems and are 18 times more likely to attempt suicide.[75] Some interventions, such as those that address conduct disorder, have been shown to reduce offending behaviour.[76, 77] Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system[78] recommended improved early identification and treatment of mental health problems in offenders.

Multi-systemic therapy

Multi-systemic therapy is an evidence-based community programme that is being piloted with young people and their families where the young people are at risk of being placed in care or custody. Eight pilot sites were launched in 2008 with two further sites in 2009. A further programme focusing on child abuse and neglect is being developed.

Looked-after children

Looked-after children are at five to six times increased risk of developing mental health problems, four to five times higher risk of self-harm, and six to eight times increased risk of conduct disorder.[42] They have much poorer educational outcomes and are much more likely to end up in custody. The majority of children in care are not there because they have poor behaviour but because they have been the victims of abuse, neglect and family dysfunction. Approaches such as multi-systemic therapy (see above) have been developed to reduce the number of children taken into care.

Young carers of parents with health problems

A number of projects are under way to support the needs of young carers of adults with health problems, including mental ill health. The Department for Children, Schools and Families (DCSF) is leading on this work, which includes setting up six extended Family Pathfinder pilot projects to test and inform the development of the Think Family approach.[37] This supports young carers by improving co-ordination between adult and children's services.

Children of parents with mental health problems

This important issue is addressed in section 5: Better mental health care for adults.

Disabled children

These children live with long-term disabilities, including learning disabilities, that impact on their mental health. Early identification and effective intervention will reduce mental health problems and long-term consequences for both the child or adolescent and their carers.

Talk to FRANK

Talk to FRANK is the Government's national drugs advice service for young people aged 13 to 19 years, and for concerned parents, friends and carers. It offers free, confidential drugs information and advice 24 hours a day via a helpline, website and email. Advice covers a wide range of topics – education, careers, housing, money, health and relationships.

www.talktofrank.com

Children and young people with substance misuse problems

An association has been found between regular use of cannabis and a doubling of the risk of developing schizophrenia.[79]

The importance of intervening early to prevent children and young people using drugs and alcohol is recognised in the 10-year cross-government Drug Strategy and the *Youth Alcohol Action Plan*. Initiatives such as the Talk to FRANK website (see opposite) provide information about the risks of using drugs.

Early detection and treatment of childhood mental disorder

Early intervention to treat childhood mental health problems will reduce the risk in adulthood. Access to timely, high-quality services will improve outcomes for children at risk and their families in both the short and long term. An estimated 60 to 70 per cent of children and young people who experience mental health problems have not had appropriate interventions at a sufficiently early age.[53]

NICE has issued guidelines for the treatment for depression (2005), conduct disorder (2006) and attention deficit/hyperactivity disorder (ADHD) (2008) in children and young people,[80] and effective treatments for childhood anxiety also exist.[81] Early intervention teams in psychosis are proven to be effective in reducing the impact of psychosis in young people (see section 5 Better mental health care for adults).

It is important that continued efforts are made to tackle the stigma associated with mental health problems, so that children and adolescents who, for example, self harm, feel able and are encouraged to seek assistance at an early stage.

Resilient communities

The role of resilient communities is covered in more detail in section 4. Safe, cohesive and resilient communities provide a positive environment for children to grow up in. Access to green spaces, and taking part in outdoor activities in green spaces in particular, may reduce stress in children and promote mental well-being.[82, 83, 84]

Early detection and treatment

The P-CAMHS service in Oxford is primary-care-based and takes referrals from all agencies, including health visitors, schools and GPs. It offers time-limited individual and family sessions, and advises other professionals.

Bury Pathfinder is a Children and Young People's IAPT pilot in Bury promoting primary prevention of mental health problems in children and young people. It adopts an early intervention ethos and promotes resilience in children and their families.

Transition from adolescence to adulthood

Aim

To improve transition and to ensure that young people receive age-appropriate care and support from adolescence through into adulthood.

Key messages

Local agreement between child and adolescent mental health services (CAMHS) and adult mental health services on how to manage transitions is vital.

A range of different approaches exist to support young people in the transition from CAMHS to adult services.

Any such approach needs to be accessible, non-stigmatising, age-appropriate, multi-disciplinary and multi-agency, and have good links to educational, employment and social outcomes.

'You need something in-between rather than just jumping from child to adult services … you need one specific person who will stick with you and not lots of different people who just pass you on the whole time.' [Quote from Pushed into the Shadows: young people's experience of adult mental health facilities. (2007) Office of the Children's Commissioner]

The transition from youth to adulthood is a time when continuity of care is particularly important; however, it frequently breaks down. This is critical not only for the young person, but also for their parents and family. The TRACK study found that less than 5 per cent of adolescents who made the transition received optimal care at the time.[85, 86] The recent independent review of CAMHS highlighted the weakness of services for young people at this crucial time in their development.[67]

Difficulties with the transition between services include:

- poor communication between agencies

- different eligibility criteria for adult services – adult services tend to focus more on acute and severe mental health problems rather than on the problems of developing adolescents

- young people may be deterred by conventional clinical settings

- differences in style of working in children's services, which tend to work more with families and partner agencies such as education services

- separate commissioning arrangements.

A variety of models of service provision could strengthen transition arrangements. These include specialist transition workers, flexibility in eligibility criteria and jointly agreed protocols between CAMHS and adult mental health services. There is also increasing interest in this country and elsewhere in the development of youth mental health services that span the period from teens to early adulthood.

A youth mental health service (Figure 4) can provide:

- an accessible and appropriate environment acceptable to young people

- simple referral routes from education, primary care, substance misuse services, probation and offender teams

- comprehensive multi-disciplinary assessment for young people and their families

- a range of interventions tailored to individual needs and delivered in non-clinical settings such as schools and colleges

- multi-agency care plans linking interventions to educational, employment and social outcomes

- support for vulnerable young people, including young carers, young people with learning disabilities and teenage parents

- referral for appropriate specialist assessment.

Figure 4: A youth mental health service
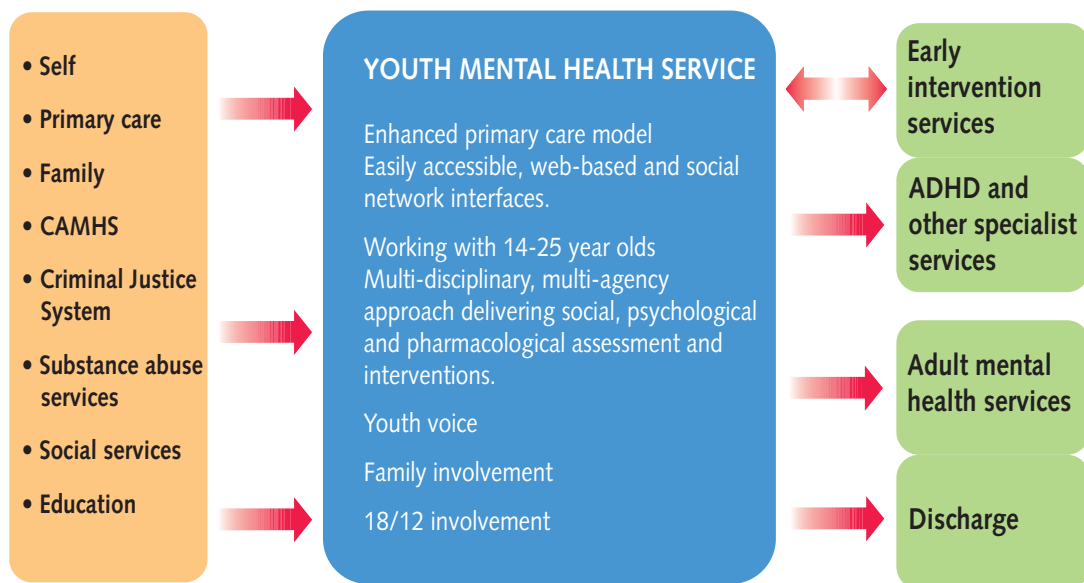
YouthSpace

Building on the model of its pioneering early intervention in psychosis service, Birmingham and Solihull Mental Health Trust has developed a youth mental health programme, in collaboration with the third sector and city council, to deliver a population-based public health intervention across the city.

YouthSpace is a multi-agency partnership including Fairbridge, Future Health and Social Care, Connexions and Unity FM radio, among others. Its vision is to encourage all young people in Birmingham to become members and to learn and be at ease with the language of mental health and well-being, to identify problems early, thus preventing longer-term difficulties.

The programme links with a number of streams of evidence-based interventions to prevent or reduce the impact of mental health problems on young people into their mid-twenties. These streams include psychosis, eating disorders, attention deficit/hyperactivity disorder (ADHD), depression and self-harm and emerging personality disorder.

The early detection team (ED:IT) undertakes specialised screening of 'at risk' groups, including young people leaving local authority care and those showing signs of school disengagement or who are in trouble with the police. School-based work includes mental health awareness and building resilience.

The YouthSpace youth board has developed a website, a cinema advert and a bus stop poster to encourage young people to seek help.

Of particular importance is the collaboration with CAMHS in providing early intervention in psychosis for young people from the age of 14, and a specialist team that manages the process of transition to adult services.

The programme links with the Collaborations for Leadership in Applied Health Research and Care pathways project, which is working with key 'pathway players' (for example, mosques, gurudwaras, Hindu temples, black churches and primary care services) to overcome stigma and other obstacles to accessing services and support.

www.wheres-your-head-at.com

Orygen Youth Health

Orygen Youth Health, based in Melbourne, Australia, provides mental health assessment and treatment services for young people aged 15 to 24 years with emerging mental health problems, including drug and alcohol issues. Treatment is focused on early intervention and includes working with family members and significant others wherever possible. The programme is time-limited to 18 months.

Services and interventions include community, inpatient and crisis care; preventive intervention in psychosis; intensive case management; an intensive outreach service for young people who find it hard to engage; individual, family and group therapies; and a range of group programmes, including vocational, exercise, social, leisure, life skills and self-management of mental health problems.

UThink

UThink is a training programme developed by Rethink (a national mental health charity) for young people at risk of developing a psychosis, and delivered in venues where they feel comfortable. UThink works at three sites – Bournemouth, Southampton and Derby – with two age groups: 14–18 and 19–25 years.

UThink programmes are developed with young people, families and carers and are delivered in eight sessions. The programmes cover personal awareness and assessment, resilience, prevention and recovery, and include a residential session for the older age group. Participants have the option of joining a leadership programme and developing mentoring skills. The programme is linked to qualifications.

Participants are able to:

• enjoy and achieve new skills and experiences that boost personal confidence and self-esteem

• believe that recovery is possible

• understand the personal effects of living with a mental health problem and how to stay safe

• understand how to improve mental, emotional and physical health

• develop self-help techniques to sustain good health and positive living

• make a positive contribution by speaking out and being heard by the people who influence their lives

• understand and manage the effects of mental health problems

• design their own recovery plans

• access the support and resources they need to recover

• engage with peer support opportunities

• work with a personal mentor who has similar life experiences

• develop skills and confidence in using a range of self-help/ condition management techniques

• access good school-, college- and community-based information and advice on mental health issues.

Better mental health and well-being for adults
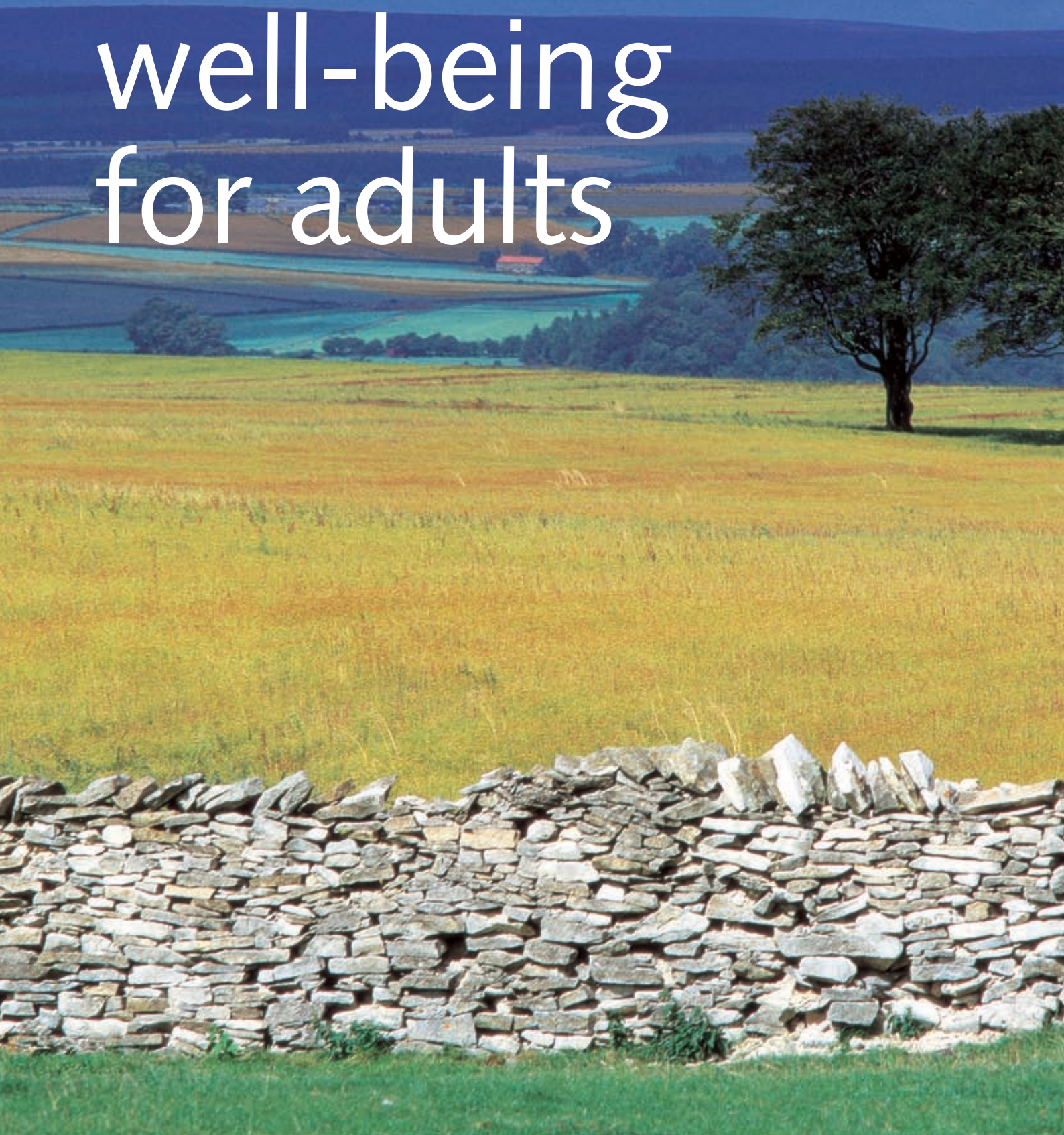
Aim

To improve the mental well-being of all individuals, families and communities.

Key messages

As individuals we can do a great deal to protect and promote our own mental health.
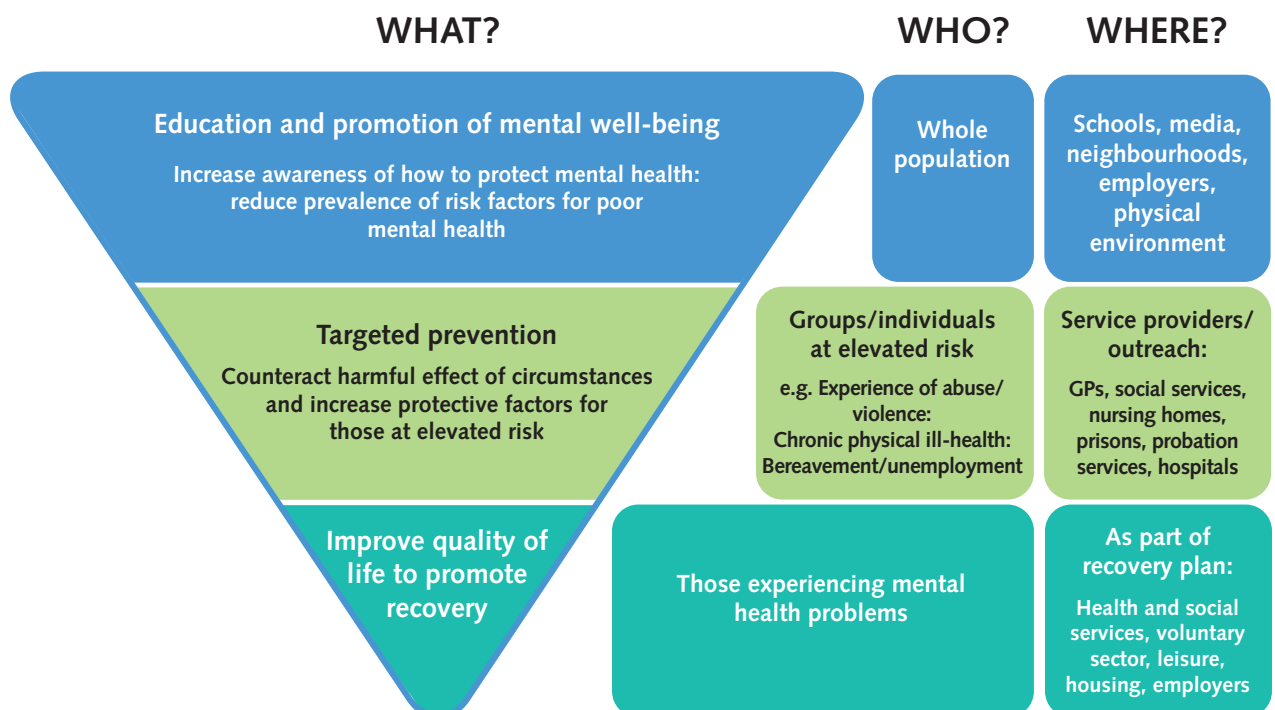
Multi-sector approaches can be taken at a wider population and community level to maintain and promote mental well-being.

The potential benefits to individuals and society of improving their mental well-being and resilience are far-reaching and long term.

Improving the mental well-being of the population requires action on three main levels:

- promoting mental well-being and reducing the risk factors for poor mental health

- targeting interventions towards those who are at risk of developing mental health problems

- promoting recovery and better outcomes for people who have mental health problems.

Figure 5: Approaches to improving mental well-being

WHAT?	WHO?	WHERE?
Education and promotion of mental well-being — Increase awareness of how to protect mental health: reduce prevalence of risk factors for poor mental health	**Whole population**	**Schools, media, neighbourhoods, employers, physical environment**
Targeted prevention — Counteract harmful effect of circumstances and increase protective factors for those at elevated risk	**Groups/individuals at elevated risk** — e.g. Experience of abuse/violence: Chronic physical ill-health: Bereavement/unemployment	**Service providers/outreach:** GPs, social services, nursing homes, prisons, probation services, hospitals
Improve quality of life to promote recovery	**Those experiencing mental health problems**	**As part of recovery plan:** Health and social services, voluntary sector, leisure, housing, employers

Promoting mental health and targeting at-risk groups

The key features of mental well-being concern our ability to live our lives to their full potential, enjoy mutually rewarding interpersonal relationships, maintain good physical health and stay resilient in the face of life's stresses and challenges. Someone with a severe mental health problem can still have good mental well-being; someone who does not have a diagnosed mental health problem may not have good mental well-being.

Interventions to promote mental health and well-being operate at three levels: individual, community, and structural/policy-making.

For some people, upbringing and daily circumstances make it harder to build and safeguard their mental health and to lead productive, healthy and rewarding lives. The factors – genetic, social and environmental – that affect mental health are increasingly well known and evidenced. We also know there are things we can do, individually, as communities and more widely as a society, to promote and safeguard our mental health.

This section outlines the key challenges and some approaches that are known to be effective, and others for which more evidence is emerging.

Tackling stigma and discrimination

The stigma associated with mental health problems is highly damaging to individuals and society. It discourages people from asking for help when they need it, it makes it harder for people to find or return to a job and harder to form and maintain relationships. For some people, the experience of stigma has a more negative effect on their well-being than the mental health problem itself.

The Department of Health has funded anti-stigma campaigns such as Mind Out for Mental Health and, currently, Shift (www.shift.org.uk). Shift focuses on employers and journalists and has produced guidance and training on the reporting of stories about mental health in the media, including stories about violence. The Department of Health's 2009 survey of attitudes to mental illness 2009[87] showed some improvements in attitudes in relation to employment and integration of people with mental health problems into the community. It also showed that the majority of the public think that people with mental health problems deserve sympathy and that society needs to be more tolerant towards them.

Legislation, such as the Disability Discrimination Act, helps to protect people with mental health problems from discrimination, for example in employment, and access to services.

Time to Change

Time to Change is a national three-year campaign launched in 2008 by Mind, Rethink and the Institute of Psychiatry with funding from the Big Lottery Fund and Comic Relief. It is developing a range of national and local social marketing campaigns, including community development and awareness-raising initiatives aimed at changing not just social attitudes but also people's behaviour towards people with mental health problems. This is supported by national media advertising, local anti-stigma campaigns and a national network of exercise and activity projects aimed at improving health and well-being and promoting social contact and inclusion. The planned evaluation will highlight the aspects of the programme that work best.

www.time-to-change.org.uk

The attitudes of staff in mental health services are particularly important, as negative views about people with mental health problems can lead to low expectations of what service users and their families and carers are capable of achieving.

Education Not Discrimination (END)

END (an element of Time to Change) offers training to professional groups to raise awareness of mental health issues, challenge prejudice and change behaviour. It targets medical students and trainee teachers: medical students because they are the doctors of tomorrow, and trainee teachers because they are a key influence on tomorrow's adults – children and young people.

The training is very short – a half-day session including a short lecture, a Q&A session and handouts, DVDs and slides on mental health. It shows the impact of different kinds of mental health problems, and the implications for people's lives. The programme uses direct contact between people experiencing mental health problems, carers and the target audience for breaking down prejudice, ignorance and fear. Research has shown that these short interventions and direct contact with users and carers are effective in changing attitudes in the short and medium term.

The END project is run by Rethink.

Self-care and personal responsibility

Individuals and families can do much to take responsibility for maintaining and improving their own mental well-being. Measures include recognising and reducing sources of stress and using self-help support. Mind is running a campaign called Get It Off Your Chest to encourage men to talk more about their feelings.[88] Other important messages include keeping physically fit and keeping alcohol consumption within safe limits, i.e. below 21 units per week for men and 14 units for women.[89]

Information on staying healthy and where to find help when needed is often available through primary care and third sector organisations. Useful websites include www.bbc.co.uk/headroom/wellbeing and NHS Choices www.selfhelpguide.nhs.uk/help.

The Foresight Project[14] has suggested a Five Ways to Well-being guide (see below) to taking care of your mental health, modelled on the 5 A DAY healthy eating campaign. Building on this work, the Department of Health is consulting on five healthy habits for mental well-being.

Five Ways to Well-being

1. Connect… With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

2. Be active… Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy; one that suits your level of mobility and fitness.

3. Take notice… Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are on a train, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

4. Keep learning… Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident, as well as being fun to do.

5. Give… Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and will create connections with the people around you.

Mental health and the workplace

Work is good for mental well-being. Having something meaningful to do, which can include voluntary work and supported employment, protects and promotes mental well-being. For employers, a mentally healthy workforce reduces sickness absences and maintains productivity. Addressing employees' health and well-being makes good business sense.[90]

The Government has initiated a number of measures aimed both at improving mental health in the workplace and at supporting people back into the labour market, especially if they have been unable to work for some time because of physical or mental health problems.[91] These include:

- for individuals – a range of early intervention initiatives to support people to return to work, including pilot Fit for Work services, improving advice from GPs about fitness for work, delivering an employment focus to its IAPT programme (Improving Access to Psychological Therapies) and a new 'fit note' to replace the traditional 'sick note' that will state what people can, rather than cannot, do

- for employers – support to address individual employee health issues (in particular for small and medium-sized enterprises), and funding to deliver innovative health and well-being measures in the workplace.

Regional employment teams promote better working across the business sector, volunteering opportunities, Mental Health First Aid Training in workplaces, and anti-stigma initiatives such as Mindful Employer and Shift's web resource for line managers.

The NHS aims to be a model employer by, for example, promoting healthy workplaces for professional staff. The Department of Health's report *Mental health and ill health in doctors* (2008) outlines some of the key issues and possible approaches.[92]

A National Mental Health and Employment Strategy is due to be published in 2009. The strategy will be the first cross-government opportunity to set out a vision for mental health and employment, outline government commitments and shape the future direction of policy. In so doing, it will cover the continuum of mental health from mental distress and mild to moderate anxiety or depression, to more severe forms of mental illness such as schizophrenia.

Shift

Shift, the Department of Health's anti-stigma initiative, has been working with employers to help them promote mental health in the workplace and to support employees with mental health problems. The Shift line manager web resource is a practical guide covering key topics such as promoting mental well-being in the workplace, recruitment, early intervention, keeping in touch during periods of sickness absence, returning to work and adjustments of work arrangements, and supporting staff with long-term mental health problems in work. Shift works in partnership with the Time for Change anti-stigma campaign.

www.shift.org.uk/employers/

Lifelong learning

Adult learning influences attitudes and behaviour; it can improve skills, confidence and employment and may prevent cognitive decline, thus having an impact on mental well-being. The National Institute of Adult Continuing Education (NIACE) aims to support and increase the number of adults participating in formal and informal learning.

Improving the social and physical environment

Developing positive social relationships is protective and people living in cohesive communities with high levels of trust and mutual support have better mental health and well-being.[93, 94, 95]

Local authorities, third sector and statutory organisations can do much to promote social cohesion through facilitating leisure and social activities. These can include sports clubs, lunch clubs and mother and toddler groups, as well as day care and learning environments such as children's centres, schools and further education colleges.

There is increasing evidence for the positive impact of the arts on health in general and on mental health in particular. Participation in arts activities has been shown to promote individual and community well-being and cohesion.[96, 97, 98]

Relationship difficulties and breakdown are common factors leading to poor mental health. Third sector organisations such as Relate offer relationship counselling. The IAPT programme is also exploring ways to extend psychological support to couples

Get Into Reading

Get Into Reading (GIR) is a unique shared reading project based in the North West. Groups meet weekly to enjoy books and poems together, guided by trained facilitators.

GIR now has more than 100 groups discovering the pleasures and benefits of reading in community centres, libraries, homeless shelters, schools, hospitals, doctors' surgeries, drug rehab centres and care homes throughout the region. Short stories, novels and poems are read aloud (members can choose to join in, but there's no pressure to). This provides immediate engagement with the text, which is enriched by the spontaneous sharing of participants' own life stories and experiences as

confidence builds over time. The groups meet weekly, providing valuable structure and support. Both of these elements are integral to the success of GIR.

Initially commissioned by Wirral Primary Care Trust in 2005, GIR was extended in September 2007 to provide reading groups across Mersey Care NHS Trust services. Readers-in-residence work with service users and staff to develop reading groups on wards and in specialist units. Mersey Care staff, including the chief executive and medical director, have been trained to facilitate the reading groups themselves, ensuring that these groups can continue for years to come.

and families. Cruse offers counselling for adults and children who have experienced bereavement. (www.relate.org.uk and www.crusebereavementcare.org.uk)

Features of the physical environment such as building layout, transport links, green spaces and lighting can improve safety and community cohesion. Social housing and housing-based services have potential as 'community anchors', promoting a sense of belonging.[99] Neighbourhood regeneration schemes can be innovative and do much to improve the environment.

The Department of Health is working with Natural England and the Department for Environment, Food and Rural Affairs (DEFRA) to explore the benefits to health and well-being of greater access to and engagement with safe green spaces.

Race inequality

Many black and minority ethnic (BME) communities experience greater social adversity than the majority population. Their experience of urban poverty, discrimination, racism and poor employment prospects can adversely affect their mental health.

Many of the root causes of this inequality are beyond the direct control of health and social care sectors, but local initiatives to promote better physical and mental health in BME groups can reduce the harm that inequalities can cause. Community development workers, who have been established as part of the Department of Health's Delivering Race Equality programme,[100] are one such measure.

Vacant Lot

Vacant Lot is a What if: project commissioned by Shoreditch Trust and funded by Arts Council England.

Working with the residents of an inner-city housing estate in Shoreditch, East London, What if: projects have transformed a formerly inaccessible and run-down plot of land earmarked for housing development into allotments by using giant growbags. Seventy half-tonne bags of soil were shipped in and arranged in neat rows, allowing residents to grow a spectacular array of vegetables, salads, fruit and flowers. A new sense of community has emerged.

The idea of Vacant Lot has also been used to forge partnerships between developers unable to develop land due to the recession, local authorities with long waiting lists for allotments and local communities lacking green space. Other disused spots in Hoxton Square, Store Street and Cheapside have also been colonised by What If: growbags.

www.what-if.info/VACANT_LOT.html

Anissa Hussain, community development worker, South Tyneside

'My job is so varied that no two days are the same but, on an average day, I might be organising sessions at the new youth project I run in conjunction with CREST (the Compact for Race Equality in South Tyneside). We run sessions on mental health, drugs, alcohol and sexual health for young people from across the BME and white communities in the area. They're already very successful, with 70 young men and 25 young women attending every week.

'I've also set up a link with Fighting Fit, a martial arts community group for young men run by BME youth workers. I've been supporting group members in making a DVD on what makes them anxious and stressed and I'm hoping to use this as a part of a toolkit for schools on mental health.

'Working to discuss mental health issues with young people isn't always easy. Many of them are suffering from a real identity crisis. They live westernised lives at school or work, but more traditional, community-based lives at home. On the plus side, the work I do with young people is becoming a tool to reach older members of the community.

'My biggest challenge is raising awareness of mental health issues among communities who don't even have a term for "mental health". In South Tyneside, there are virtually no BME service users in mental health services. Those that are only appear at real crisis points – when they've committed a serious crime, for example.

'So I do a lot of work to try and engage these people. Community events are always a good vehicle for raising awareness. One of the most successful events I worked on coincided with both World Mental Health Day and Ramadan last October. We held an evening party to celebrate the breaking of the daily fast and over 350 people attended – 80 per cent from BME communities.

'In order to engage people, you have to get them involved. People are more inclined to listen to contemporaries in their own communities. I recently ran a project where I liaised with a local art studio to allow five groups of young men and women to have access to their resources. They produced some leaflets on mental health issues which have been widely accepted by the BME community, who might have been more sceptical if presented with externally produced materials.'

Physical health

Good physical health and keeping physically fit are associated with mental well-being. This is the focus of Get Moving, a national project to promote the benefits to mental health of being active. This is co-ordinated by the Time to Change campaign (see 'Tackling stigma and discrimination').

Mental and physical health are interconnected. Having a mental health problem increases mortality from heart disease;[101] coronary heart disease can increase the risk of depression.[102] People with schizophrenia have a life expectancy that is significantly lower than that of the general population and have higher rates of serious long-term conditions.[29, 103]

People with mental health problems are also more prone to factors that are damaging to overall health, such as poor diet, heavy smoking and drug and alcohol misuse.[29] Equally, people who smoke or are obese, or take drugs or behave in other ways that put their health at risk are more likely to have mental health problems.[104]

Many people with long-term physical illnesses also suffer from depression and anxiety: depression is two to three times more common in people with diabetes or ischaemic heart disease, for example.[105] However, mental health problems are often left untreated,[102] despite being associated with early mortality and increased healthcare costs. Unnecessary hospital admissions and longer lengths of stay, for older people in particular, lead to an increased risk of institutionalisation.[106]

A significant number of people in both primary and secondary care are described as having 'medically unexplained symptoms', that is, they have persistent physical symptoms for which no medical explanation can be found. Some of these people will have underlying depression or anxiety, which are amenable to psychological interventions. Appropriate management in primary care and in acute hospitals has the potential to prevent unnecessary referrals, admission and interventions. IAPT,[11] which is outlined in more detail in the next section, is exploring ways to extend psychological interventions to groups with long-term and unexplained health conditions.

Achieving a fully integrated approach that supports both mental and physical health depends on effective partnership between general and public health and mental health services at local, regional and national levels. Where this is achieved, an understanding of the links between mental and physical health will be reflected in service planning and delivery. Ensuring that there is adequate provision of both psychiatry and psychology services in acute hospitals is important. Their input can both enhance quality of life and reduce healthcare costs.

Debt

Debt is a major cause and consequence of mental health problems and it can also hinder a person's recovery from mental ill health.

People in debt are between 2.5 and four times more likely to have a mental health problem.[107] In 2007, four per cent of the UK population was identified as in debt (three months in arrears with debt repayments) and this is likely to increase significantly in the current recession.

The Money Advice Liaison Group has developed good practice guidelines on debt management and debt collection in relation to people with mental health problems.[108] The Royal College of Psychiatrists has also produced guidance on how agencies can help people to escape the debt and mental ill health cycle.[109]

Including financial issues and debt in routine assessments of people with mental health problems and providing them with expert advice may help to address the problem. So too may greater awareness among health, social care, finance and other advice-giving agencies of the circular relationship between mental health and debt and how to identify problems and intervene. IAPT is currently working with NHS Direct on ways to improve access to debt advice services. The Citizens Advice Bureau is exploring ways in which it can be more accessible to those experiencing mental health problems.

Figure 6: Inter-relationship between debt and mental health problems
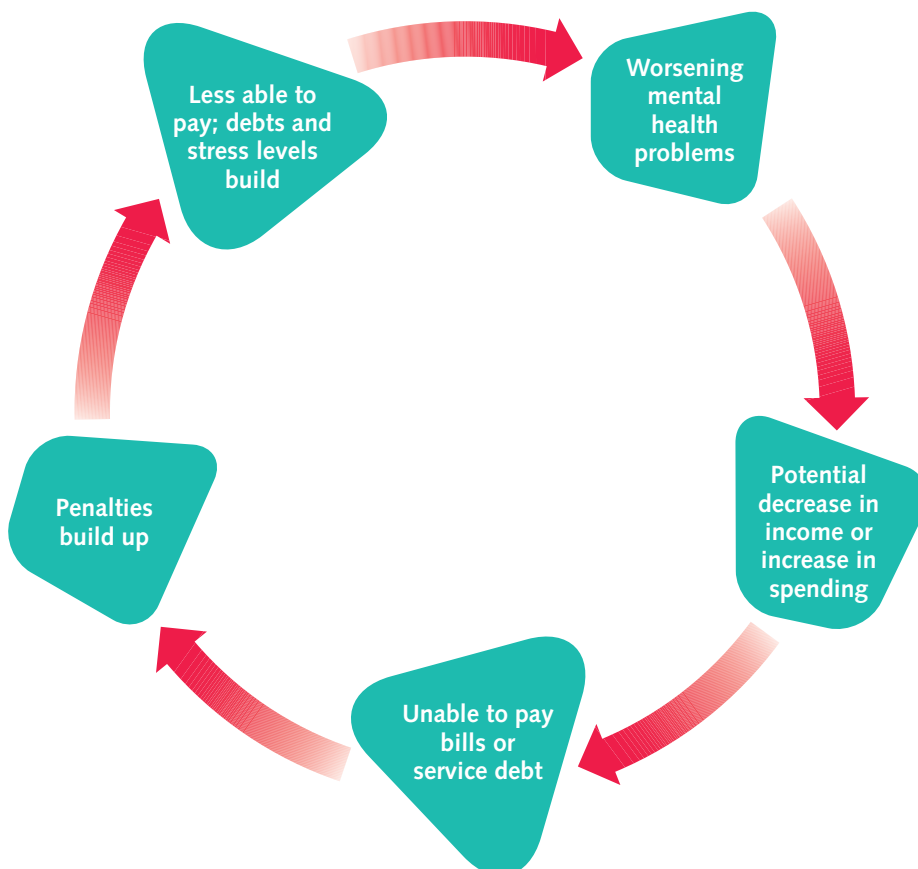
Suicide prevention

The likelihood of a person taking their own life depends on several factors. These include mental health problems, alcohol and drug misuse, physically disabling or painful illness and isolation. Stressful life events such as the loss of a job, imprisonment, a death or divorce can also play a part. For many people, it is a combination of factors.

The national suicide prevention strategy for England, launched in 2002,[110] sets out a comprehensive approach involving the many agencies that have a part to play in tackling the causes of suicide and preventing deaths. Around 75 per cent of the 4,000 people who take their own life each year in England are not in contact with mental health services.[6] This means that

emergency departments, primary care, probation, the third sector and many others have a key role to play. The strategy is built around a set of goals including the care and support of high-risk groups, the broader promotion of mental health and well-being, and sensitive media reporting.

The target for England is to reduce the suicide rate to 7.3 deaths per 100,000 population in 2009–11 – a 20 per cent reduction from the baseline rate in 1995–97. The most recent statistics show that the rate in 2005–07 reached 7.9, a fall of around 14 per cent.[111] There has been a sustained decrease in suicide among young men, the population group who were previously at highest risk. Suicides among mental health patients, particularly inpatients, and among prisoners, have also fallen.

c.a.l.m.

The Campaign Against Living Miserably (c.a.l.m.) is a help, information and advice telephone and web service for young men aged 15–35 who are experiencing emotional and mental distress. The helpline is operational between 5pm and midnight from Saturday to Tuesday and is staffed by trained advisers.

There are many reasons why young men need a campaign like c.a.l.m. Everyone has their own life, with different interests, circumstances, pressures and problems. But men aren't supposed to talk about stuff, so it can be hard to know where or who to go to for help when life gets on top of them.

The campaign was launched as a pilot by the Department of Health in Manchester in 1997, and has since been rolled out to Merseyside, Cumbria and Luton and Bedfordshire. In 2006 the pilot was relaunched as an independent charity.

Working with people from the music, sport and club scenes, c.a.l.m. encourages young men to 'open up' and sort out their problems. c.a.l.m. has a strong and very real presence through club flyers, posters, beer mats, gigs and in the media.

www.thecalmzone.net/

The current target runs to 2011, but suicide prevention will remain a vital aim for public health and mental health services in the years ahead. Suicide tends to rise at times of unemployment and economic problems, and the current recession will require the vigilance of many frontline agencies to advise and support people who are facing debts or who are in emotional crisis.

Violence and abuse

Living with violence or the fear of violence is a significant risk factor for poor mental health. This includes domestic violence, child abuse and community violence. Poor, socially disorganised neighbourhoods have higher rates of violence and strong norms of violence.[112, 113]

Child sexual abuse, domestic violence and sexual violence are common, occur in men and women, are often undisclosed and have a significant impact on mental and physical health.[114, 115]

In mental health services, studies indicate that 48 per cent of female service users have been subjected to sexual abuse and 48 per cent to physical abuse in childhood; 28 per cent of male service users report sexual abuse and 50 per cent physical abuse in childhood.[70] The figures are even higher when adult abuse is taken into account. It has been suggested that the much higher rates of depression and anxiety disorders in women can, in part, be explained by the higher rates of domestic abuse and child sexual abuse experienced by them.[116] Women victims of abuse are also at greater risk of self-harm and suicide,[117, 118] and risk is even higher in some ethnic minority groups.

A number of government policy and service development initiatives are in progress to address violence and abuse and to guide health service responses. They include *Saving Lives. Reducing Harm. Protecting the Public*,[119] the Youth Crime Action Plan[120, 121] and the setting up of local sexual assault referral centres (SARCs).

Multi-agency risk assessment conferences, see page 35, provide a forum in which mental health services can contribute to multi-agency collaboration on violence and abuse.

Veterans and people who have experienced trauma

People who have experienced other kinds of trauma may also be at risk of mental health problems. Veterans and people who have experienced major disasters, for example, may need psychological and social support. Some may also need treatment for depression or post-traumatic stress disorder (PTSD). NICE has issued guidance on evidence-based, effective approaches to treating PTSD.[122]

Other potential 'trigger' events for the onset of mental health problems exist. While not necessarily traumatic, they are still points when we want individuals and services to recognise that people are vulnerable to a worsening of mental health. They may include birth (triggering postnatal depression), relationship breakdown, bereavement, flooding and losing a job.

Better mental health care for adults

Aim

To build on the achievements of the National Service Framework towards high-quality, inclusive mental health care that respects the autonomy and dignity of individuals, families and carers and supports recovery.

Key messages

Mental health problems are common and place a considerable burden on individuals, families and society.

Early recognition and early intervention are vital – people are more likely to recover more quickly and stay well if they receive timely, effective and accessible treatment.

People with mental health problems should receive high-quality, personalised care based on recovery principles, whether in hospital or in the community.

The foundations for mental health care services include:

- equal access to services and equal opportunity to benefit from treatment

- a comprehensive single assessment followed by sharing of information with other agencies as appropriate

- high-quality clinical services providing evidence-based interventions along a care pathway tailored to individual needs, choices and preferences

- a recovery philosophy focusing on building on individual strengths and improving quality of life as defined by the service user

- consistency and continuity of care, including full implementation of the Care Programme Approach where appropriate.
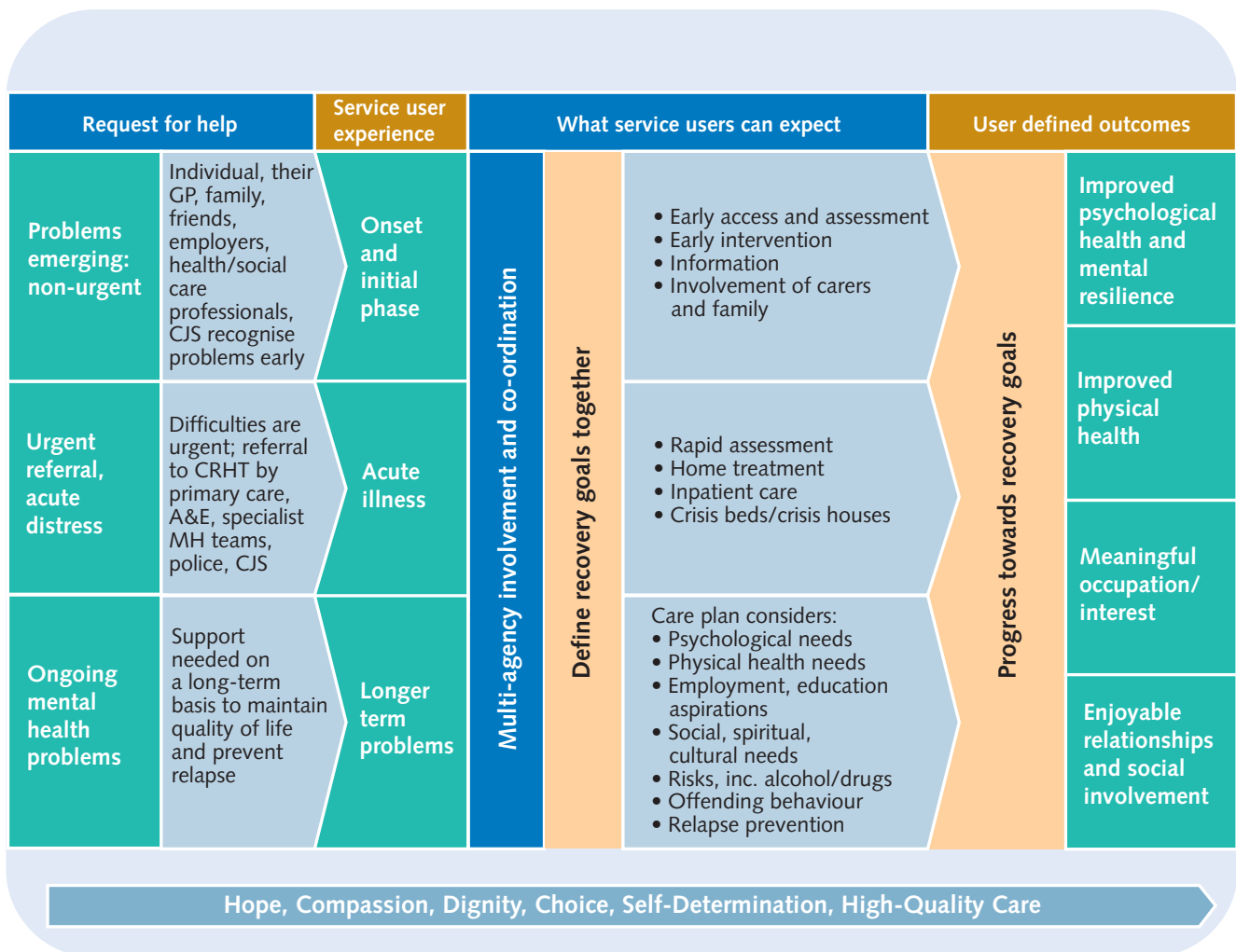
A recovery philosophy

Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms and problems. Hope is central to recovery and can be enhanced by a person having more active control over their life.

In practice this means:

- needs are identified by the service user, with professional support built around these

- setting optimistic, realistic goals in care planning, identifying barriers and devising achievable plans to overcome these

- better quality of life as the central aim of clinical care

- a broad range of interventions, reflecting the psychological, social and physical needs of the service user

- a care pathway that encourages collaboration and shared responsibility between provider agencies and commissioners of services.

Figure 7: Pathway towards recovery for emerging and ongoing mental health problems

Request for help		Service user experience		What service users can expect		User defined outcomes	
Problems emerging: non-urgent	Individual, their GP, family, friends, employers, health/social care professionals, CJS recognise problems early	Onset and initial phase	**Multi-agency involvement and co-ordination** / **Define recovery goals together**	• Early access and assessment • Early intervention • Information • Involvement of carers and family	**Progress towards recovery goals**	Improved psychological health and mental resilience	
Urgent referral, acute distress	Difficulties are urgent; referral to CRHT by primary care, A&E, specialist MH teams, police, CJS	Acute illness		• Rapid assessment • Home treatment • Inpatient care • Crisis beds/crisis houses		Improved physical health	
Ongoing mental health problems	Support needed on a long-term basis to maintain quality of life and prevent relapse	Longer term problems		Care plan considers: • Psychological needs • Physical health needs • Employment, education aspirations • Social, spiritual, cultural needs • Risks, inc. alcohol/drugs • Offending behaviour • Relapse prevention		Meaningful occupation/ interest	
						Enjoyable relationships and social involvement	

**Hope, Compassion, Dignity, Choice, Self-Determination, High-Quality Care**

Recovery Star

The Recovery Star is a tool that enables care to be planned around user-defined goals and quality of life outcomes. With professional support, service users are able to use the star to self-assess their recovery journey and identify where they need the most support. The service user rates 10 domains (including work, social networks, living skills and managing mental health) with a score of 1–10, according to where they feel they are in their journey towards recovery. Not only is this a useful tool for self-assessment and identification of needs; its use over time can demonstrate to commissioners that they are getting the right outcomes from the services they fund.

Figure 8: The Recovery Star
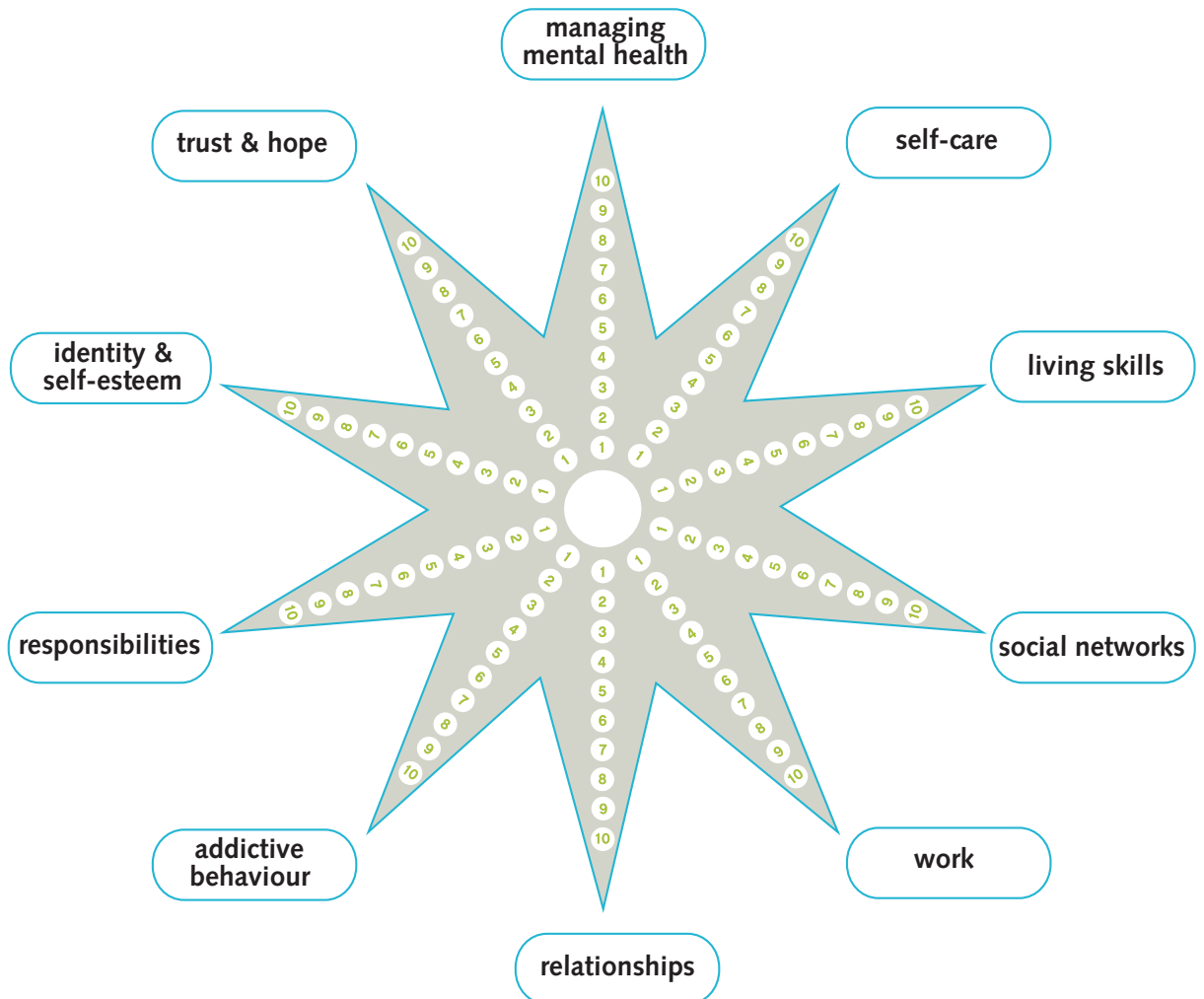
Mental Health Recovery Star, Mental Health Providers Forum and Triangle Consulting. Based on the Outcomes Star, Triangle Consulting and the London Housing Foundation.

Onset and initial phase

Early intervention

Early intervention (EI) teams for young people at the onset of severe mental health problems have been a cornerstone of community care reform over the past 10 years. They are built on the principle that early, effective care will improve outcomes for individuals and their families.

EI services:

- aim to reduce the time from onset of symptoms to first treatment (the duration of untreated psychosis, or DUP)

- are closely linked to primary care and other agencies to improve access to care

- work in non-clinical settings to improve their acceptability to young people

- support families

- offer psychosocial and drug treatments

- aim to help young people to return to education, training or work.

Evidence from research and the evaluation of individual services suggests that EI leads to:[103, 123, 124, 125]

- better engagement and patient and carer satisfaction

- better clinical outcomes, for example hospital admissions and relapse rates

- better social outcomes, for example employment and continuing education

- better value for money in comparison to standard care.

EI services are now likely to develop further. There is evidence that even earlier detection and intervention for people with an 'at-risk mental state' and a high likelihood of mental health problems may lead to greater benefits. The early intervention approach may be extended to other groups, such as young offenders with severe mental health problems and young people at the transition from child and adolescent mental health services (CAMHS) to adult services (see Figure 9).

Figure 9: The early intervention pathway
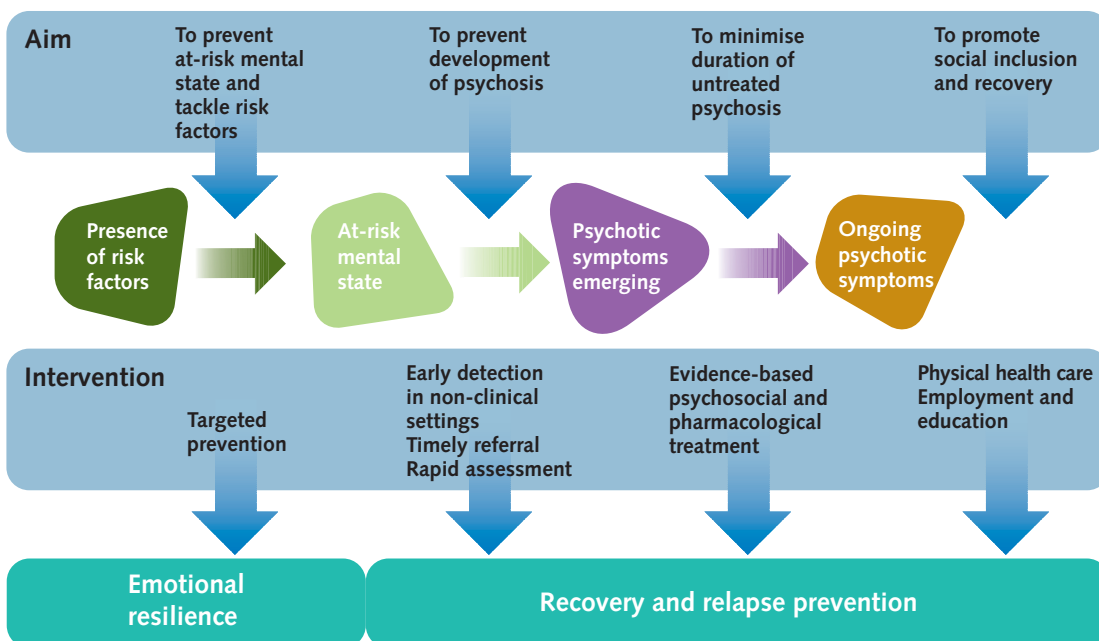
Assessment

Timely, comprehensive assessment that considers the needs of both the individual and their family or carers is central to care planning and to the delivery of multi-disciplinary care. One such approach is the '3 Keys' method.[126] This outlines three 'keys' to a multi-disciplinary assessment that supports recovery and the development of self-management skills:

- active participation of the service user and where appropriate their carer in a shared understanding with service providers

- input from different provider perspectives within a multi-disciplinary approach

- a person-centred ethos that builds on the strengths, resilience and aspirations of the individual service user as well as identifying his or her needs and challenges.

Assessment needs to be carried out by someone with relevant skills and in a setting that encourages open discussion. These features are particularly challenging, but no less important, in emergency departments, courts and prisons. Similarly, assessments under section 136 of the Mental Health Act (in 'places of safety') should whenever possible be conducted in suitable health settings; police stations should only be used in exceptional circumstances.

Assessment is a continuous process requiring regular review – needs and risk may change. At the same time, it ought not to be necessary for service users and their families to repeat an assessment process with different agencies – the Common Assessment Framework[127] and the Care Programme Approach[128] are intended to combine the assessment and care planning needs of different agencies. The Recovery Star can be used to monitor progress.

Information

Providing information to service users and their families is an essential element of a care plan. This includes information about their mental health problem, the staff who will be providing care, the choices they have, treatments and possible side-effects, available services and, where relevant, the person's rights under the Mental Health Act. This can be provided as an 'information prescription'.

Information prescriptions

Oxleas NHS Foundation Trust provides mental health services in the London Boroughs of Bromley, Bexley and Greenwich. The information prescription project started in the Bromley Complex Needs service, which provides intensive residential and community outreach services to people with severe mental health problems and complex needs.

A grant was received to develop information prescriptions as part of the NHS Choices and Expert Patient long-term condition management programme. Users and carers were asked what they wanted in terms of both the content and the format of information, and what staff working in the service would find helpful to better meet the needs of the users and carers.

Users and carers wanted factual information about their diagnosis, how to live with and manage long-term mental health problems, and services available in the community. They wanted this both in easy-to-read written information to take away, especially when first diagnosed, and as downloadable podcasts. They particularly wanted video clips of service users talking about their condition, what had helped, what had supported them in overcoming their difficulties and how they got back into work and regained a quality life. The trust has now produced a range of leaflets and video diaries covering the various diagnoses, and has also redesigned its intranet to include a user and carer information section with leaflets, podcasts, video diaries, reading lists and self-help sources such as useful websites, details of local self-help groups and a range of self-help tools.

Under the Care Programme Approach, service users and their carers should be given a copy of the care plan, including crisis plans and contact numbers. Recent National Patient Surveys have shown that this does not always happen in practice.

Acute care

Crisis resolution/home treatment (CR/HT) teams

The expansion of home treatment through crisis resolution teams has been the largest single change to the configuration of community mental health services over the past 10 years, providing a direct alternative to hospital admission for people with acute mental health problems.

Evaluation has shown that crisis resolution can both prevent admissions and reduce the length of admissions that are still needed, reducing pressure on beds and improving service user and carer satisfaction.[129]

The impact of crisis resolution teams is greater when they act as gatekeepers to acute beds, creating an integrated acute care service. Good assessment is crucial to their effectiveness and evaluation of effective services supports the inclusion of dedicated time from a senior psychiatrist.

Home treatment is likely to continue its integration with other parts of the acute care pathway, such as crisis beds and mental health teams working in emergency departments.

Acute inpatient care

Admission to a hospital inpatient unit continues to be part of the experience of care for many people. In 2007 there were around 130,000 admissions into acute care.[130] Inpatient care has become a sub-specialty in its own right, requiring skilled staff and strong links to other parts of the care pathway.

Many modern inpatient units have been built or redesigned with the help of service users and staff to offer privacy and dignity and a sense of personal safety. Most inpatient care is now provided in single rooms with separate facilities for women, and many wards display service users' art and have access to landscaped outdoor space.

In a high quality service, wards provide a genuinely therapeutic environment. Many units participate in Star Wards, a service user-led initiative that helps staff improve the recreational and therapeutic support they offer, reducing isolation and improving ward relationships.[131] Some wards have also introduced Protected Engagement Time (PET) – a set period each day when nurses devote their time to face-to-face contact with patients and visitors, with paperwork and other interruptions banned. This has been found to improve relationships with patients and reduce levels of frustration, violence and aggression on wards.

Enhancing the Healing Environment

The Enhancing the Healing Environment (EHE) programme was launched by The King's Fund in 2000 to encourage and enable nurse-led teams to work with patients to improve the environments in which they deliver care.

A wide range of different mental health environments have benefited from the programme, which has enabled staff and service users to create (among many schemes) truly family-friendly family rooms, renovate abandoned and overgrown outdoor spaces to provide relaxing, quiet, green spaces, upgrade day rooms into vibrant activity centres, decorate corridors and community areas with artworks, and provide spiritual spaces within acute and intensive care units.

Star Wards

Star Wards is a national charity that works with mental health trusts to promote provision of therapeutic activities for inpatients on acute hospital wards. Star Wards was launched in response to complaints from inpatient service users that admissions to hospital provided little or nothing in the way of therapeutic activities. Star Wards aims to help ward staff to devise and introduce a wide range of activities for patients, and promotes the sharing of good practice through publications, its website and conferences. More than 300 wards have now joined the campaign and are providing a vast range of different activities for patients throughout the day, from trampolining and comedy evenings to music projects and poetry reading, pamper the patient and exercise sessions, and much more. Staff have been energised and ward environments have been transformed into lively, engaging places, with reported reductions in violence and increased therapeutic patient contact: 'It's what I came into nursing to do.'

www.starwards.org.uk

These inpatient initiatives are based on the link between a more positive therapeutic setting, better staff skills and morale, and improved patient experience. Future developments in ward care are likely to build on these connections, with the emphasis on improving quality and value for money rather than reducing bed numbers or admissions as outcomes in themselves.

A continuing focus on patient safety as a key component of quality will aim to reduce absconding – people leaving the ward without staff agreement – and promote sexual safety. Further sub-specialty development is likely, building on the success of psychiatric intensive care units.

The Department of Health, working with partner stakeholders, will continue to support local services in building on initiatives such as the Royal College of Psychiatrists' AIMS accreditation scheme[132] and the Star Wards project.

Crisis beds and crisis houses

Some mental health services offer brief admissions for people who need short-term sanctuary and support. Admissions of this kind can be built into a longer-term care plan for people who do not feel comfortable in the more conventional ward setting.

The third sector has a good record of supporting people in these circumstances. One such crisis house is Maytree in North London, which offers short admissions to people at risk of self-harm or suicide.

Maytree

Maytree is a short-stay crisis and respite house in North London for people who are in extreme suicidal distress. It is open to referrals and self-referrals and guests can stay for a maximum of four nights, with a room of their own, meals, and access to a shared kitchen, sitting room and garden. Guests are offered time to talk, one-to-one, and support to regain hope. Maytree's philosophy is that listening, exploring and understanding a person's suicidal thoughts and feelings are the first steps to helping them come through a suicidal crisis. 'Four nights is not long but can make the difference between wanting to die and wanting to live.'

www.maytree.org.uk

Long-term care

The Care Programme Approach and risk management

The Care Programme Approach (CPA)[128] is the process by which treatment, care and support for people with serious mental health problems are agreed, co-ordinated and understood by all involved. It is needs based, encourages self-determination and provides support for families and carers. CPA applies to all parts of the care pathway, but in particular forms the basis of care in the community.

The essential components of CPA are multi-disciplinary care planning and review, a care co-ordinator and crisis plans. Guidance on CPA has recently been updated to align care planning and risk management. The guidance also emphasises that CPA is intended for people with complex health and social needs – in particular people with severe mental health problems and:

• who have parenting responsibilities

• who have significant caring responsibilities

• with a 'dual diagnosis' (drug or alcohol misuse)

• with a history of violence or self-harm

• who are in unsettled accommodation.

The management of risk is a key role of mental health services. The National Suicide Prevention Strategy specifies mental health patients as a high-risk group requiring specific measures, as set out in '12 points to a safer service'.[133]

Department of Health guidance on risk management highlights the importance of balancing patient autonomy with the safety of patients, their families and the public.

The views of the service user and carer may also differ and staff have a responsibility to consider both. The Mental Health Act 2007 introduces a new power, supervised community treatment, which can be used to require patients at high risk to accept treatment intended to reduce that risk.

Mental health teams in the community

Assertive outreach (AO) teams have been developed in most areas to bring treatment and support to people who find it hard to engage with mental health services. These teams work with people who have severe mental health problems and often additional needs relating to drug or alcohol misuse, offending and social relationships. The remit of AO approaches also includes people who traditionally have not accessed statutory services, such as homeless people, migrants and refugees, and some black and minority ethnic (BME) groups.

Evaluation of AO teams has shown that they achieve better engagement with these groups. However, the evidence that they reduce admissions is unclear,[103] although individual services have reported fewer admissions.

Future development of AO is likely to enhance the teams' role in working with dual diagnosis patients. They are also likely to provide care and support to many people receiving supervised community treatment, with team leaders taking on the new role of Responsible Clinician under the Mental Health Act 2007.

Community mental health teams (CMHTs) continue to provide the backbone of care for many people who need mental health services. They work alongside specialist community teams (CR, AO and EI) and are particularly valuable in providing continuity of care and long-term support. Many CMHTs are developing their own specialist roles. In particular, they can provide:

• community-based care and rehabilitation for people with severe and enduring mental health problems, addressing employment and housing needs

• assessment and treatment for people who do not need referral to CR or AO teams, working closely with primary care as part of a stepped care model.

Social inclusion

People with long-term and severe mental health problems face particular difficulties in finding employment – only around 13 per cent of those with very severe mental health problems are working.[134] At a time when unemployment is rising, this problem may become worse.

Mental health services aim to improve not only a person's clinical condition but their quality of life as well – better opportunities for employment and training, satisfactory housing and improved relationships. In doing so, they contribute to the cross-government aim of promoting social inclusion and the related Public Service Agreement (PSA) target of increasing rates of employment and settled housing for people with mental health problems.

Mental health services are able to improve service users' chances of finding (or keeping) employment by:

• including a person's employment needs in care planning under CPA

- recognising the positive contribution that good work can make towards a person's recovery from a mental health problem

- introducing dedicated employment support within care teams for those with severe and enduring mental health problems – research evidence supports the Individual Placement and Support (IPS) model[135]

- linking to employment and support services, often in the third sector, who can:
  - help the person improve the skills they need to apply for and retain work
  - provide advice and support to an employer

- directly employ people with mental health problems

- collect outcome data on employment and housing.

User Employment Programme

The User Employment Programme at South West London and St George's Mental Health NHS Trust was established in 1995 to help people with mental health problems to retain or gain paid employment and voluntary work or enter into mainstream education and training. The key objectives of the programme are:

- to provide support for people who have experienced mental health problems to gain/retain open employment

- to provide short-term work preparation for people looking for employment within or outside the trust

- to increase the number of people with direct experience of mental health problems employed within the trust

- to support people with mental health problems employed by the trust to keep their jobs.

A small specialist team helps trust service users with job searches, writing CVs and interview skills. They also offer benefits advice and information. Ongoing one-to-one support is also provided once clients have been successful in finding work, for as long as the person wants it.

Individualised budgets

People who use mental health services may also need and be eligible for social care. In the future, this will be increasingly made available through individualised budgets. These allow the person or their representative to make their own decisions about the services that will help them most. A recent evaluation, The IBSEN Project,[136] found that people using this approach generally reported a higher level of control, and that people with mental health problems reported a higher quality of life. It is easy to see how well this fits in with a recovery focus.

Delivering race equality

The factors underlying high rates of severe mental illness in some BME groups are complex, but

there is much that mental health services and commissioners can do to respond. Some have developed dedicated BME services or work with third sector organisations to promote engagement and social inclusion. To support local services and inform New Horizons, the Department of Health is collecting and analysing data for a new 'dashboard' of indicators covering:

• BME access to early intervention

• access to CR/HT

• use of AO services

• access to, and outcomes from, psychological therapies

• implementation of supervised community treatment (under the Mental Health Act 2007).

New Horizons will also be informed by an assessment of the Delivering Race Equality programme[100] to be completed in the early autumn, but future developments in promoting race equality are likely to be built on:

• assessments of local needs based on a better understanding of the ethnic composition of the local population

• consultation with local community leaders on the development of appropriate services

• measures to ensure equality of access and outcomes, particularly to services such as early intervention teams and psychological therapies

• identifying and addressing any inequalities in patient experience between ethnic groups

• ensuring that staff receive training in cultural competence.

Enhancing Pathways into Care

When Rashna Hackett was the consultant nurse for acute care at Sheffield Care Trust, she spearheaded an initiative to help health professionals to engage with the local Pakistani community.

With a lack of home treatment and third sector options, members of the community had been reluctant to approach clinicians and too often accessed mental health services at points of crisis. Says Hackett: 'There was a lot of stigma attached to mental health issues and language barriers that made it difficult to promote an understanding of the services available to help.'

A community-based initiative looked at ways to address the situation and, under the leadership of the crisis assessment and home treatment team, the Enhanced Pathways into Care project was launched in 2005. 'We wanted to explore diverse routes to recovery for BME patients,' says Hackett, 'so we looked to develop the services that were available within the community, to promote home treatment and to reduce the length of hospital admission. We wanted people to be able to access statutory care via trusted community organisations so that they felt secure.'

Alcohol and drug misuse

For many people with severe mental health problems, harmful alcohol or drug use contributes to a pattern of relapse and risk. Dual diagnosis is one of the most challenging problems in mental health care. It is particularly associated with the work of AO and offender mental health teams but is sufficiently common for dual diagnosis skills to be essential in all frontline services.

Future service developments and approaches are likely to be characterised by:

- joint working, including referral pathways and specialist advice, between mental health and community alcohol and drug teams

- training in the care of substance misuse for mental health staff

- priority for dual diagnosis under CPA

- clinical leadership (for example, nurse consultants).

Children of parents with mental health problems

People with mental health problems who are also parents or carers should have access to additional services to support them in these roles if necessary. These can be accessed by professionals completing the Common Assessment Framework and using locally agreed systems within children's trusts.

The vast majority of parents who have a history of mental health problems present no risk to their children. However, some parents with mental health, alcohol or drug, personality or behavioural problems can present a risk of harm or neglect, and their children may

need protection, due to the direct or indirect impact of the mental health problem.

The recently updated guidance on CPA includes adults with mental health problems who are parents as a priority group in need of specific help, and states that their parenting role and responsibilities should be taken into account in their assessment and care planning.

The risks need to be addressed sensitively and honestly through multi-agency collaboration and sharing of information. Close links between mental health services and child protection agencies are essential through membership of local safeguarding children boards (LSCBs) and using the LSCB policies and procedures.

Access to support services, improved identification and management of risks, and more collaborative working between adult and children's mental health services and child protection services will give those families that do experience problems a better chance to manage the difficulties they face. The National Patient Safety Agency has issued guidance on preventing harm to children from parents with mental health needs.[137]

Physical health

As described earlier in this document (see section 4, Better mental health and well-being for adults), people with mental health problems have higher rates of preventable physical health problems and shorter life expectancy than the general population. Their physical health needs are also frequently overlooked. The updated CPA guidance and recent review of

mental health nursing[138] have highlighted the importance of including physical health in care planning for people with mental health problems. Increasingly, mental health services, working with primary care, offer smoking cessation support, health checks and advice on diet and exercise.

Personality disorder

Personality disorders are common conditions. Estimates of prevalence rate vary between 5 and 13 per cent of adults in the community.[139] Among community mental health patients this rises to between 30 and 40 per cent, and 40 to 50 per cent of mental health inpatients.[140] Personality disorders are also common among people in the criminal justice system, affecting 50 to 70 per cent of prisoners.[141] It is also a major factor in suicide: 47 to 77 per cent of people who take their own life have a personality disorder.[142]

Personality disorder has in the past been considered untreatable, and people with the diagnosis have been excluded from mental health services. However, policy guidance published by the Department of Health in 1999 and 2003 identified approaches that were helpful and this led to a national work programme and investment by the Department of Health in new services, via the National Personality Disorder Programme.

National Institute for Health and Clinical Excellence (NICE) guidelines for borderline personality disorder and anti-social personality disorder were published in February 2009.[143] The commissioning guidance *Recognising complexity*

has also recently been published by the Department of Health to complement and support the NICE guidelines. *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system* outlines further ways to improve services for people with a personality disorder.

People with complex problems make frequent and often chaotic use of inpatient mental health, primary care, A&E, social care, and criminal justice and other services. Emerging evidence from the new personality disorder services demonstrates that this can be reduced, and people with this diagnosis can engage in training and work if they receive appropriate support to address their problems. Outcomes from the new services demonstrate the benefits of multi-agency, cross-sector commissioning and collaborative working.

The following issues are central to the continued development of services for people with a personality disorder:

• co-ordinated policy-making

• prevention and early intervention with children, young people and families

• appropriate levels of service provision for personality disordered adults

• innovative collaboration between agencies

• regional and local leadership that is able to support cross-governmental initiatives

• competent, capable and confident workforces

• empowered service users and support for carers.

Thames Valley Initiative

The Thames Valley Initiative is one of 11 national pilot projects supported by the National Personality Disorder Programme. The service covers Berkshire, Buckinghamshire and Oxfordshire and offers a range of outreach and inreach services. Former service users (experts by experience) are employed to help ensure that the services are acceptable and accessible to users.

The service is based on a non-residential clinical model with four tiers, and numerous possible care pathways: assertive assessment, therapy programmes offered in a range of community settings, an intensive treatment programme based on a modified therapeutic community approach, and a follow-up support service provided by former users to help clients find training and work. A training programme for staff has also been developed alongside the treatment service.

www.tva2i.net/

Offender mental health care

Following the report of Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, Ministers in the Government have recognised the need for reform and better connected services.[78] The Bradley report makes a number of recommendations for improvements in the pathway of care for people with mental health problems or a learning disability, with a focus on links between criminal justice settings, forensic mental health and general mental health services. The Government has accepted the responsibility of making Lord Bradley's vision a reality – although, as the Government's response made clear, there is a need for further work to establish the full potential impact of the recommendations, including the impact on resources and deliverability. Lord Bradley's report recognises that many recommendations will need further work to ensure that all implications are considered. The recommendations include:

- greater diversion of offenders into mental health care from courts and police custody

- the health and criminal justice workforces to have greater understanding and awareness of the needs of people with mental health problems or a learning disability

- better understanding of the specific needs of women and people from BME groups

- better communication and flow of information between partner organisations

- joined-up health and criminal justice commissioning

- offender mental health teams to provide specialised care

- shorter time for transfer to secure care of prisoners with severe mental health problems

- improved care for offenders with dual diagnosis (mental health and drug and/or alcohol problems).

Secure care

Mental health secure services provide treatment for people whose mental health problems 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. High-quality secure services help patients to recover from or alleviate their condition, and help to protect the public. Patients are referred to secure hospitals via the courts, prisons, other secure environments and mental health service providers, and the NHS is working with other agencies, such as the Prison Service, to ensure improved pathways of care for patients in secure services.

Specialist services

A number of specialist services have been developed in mental health care. These services range from low-volume, high-cost care for people whose condition is severe, often provided at regional level and requiring specialised commissioning, to less intensive care for problems of lesser severity, often provided

by a local service. Several of these services are supported by NICE clinical guidelines.

Examples are services for:

- eating disorders[144] – specialist services offer inpatient care for people with severe anorexia nervosa, and family and individual psychotherapy

- perinatal mental disorders[61] – specialist services provide joint mother and baby admissions, assessment during pregnancy for women at risk of severe postnatal mental illness and assessment of parenting skills. Less severe depression is treated in primary care, often by trained health visitors

- autistic spectrum disorders and attention deficit hyperactivity disorder (ADHD) – specialists offer assessment and advice to local services. There are few services at present but a National Autism Strategy is soon to be published.[145]

Figure 10: NICE stepped model of care

Step I: Identification in primary care and general hospital settings
Step 2: Treatment of mild symptoms in primary care
Step 3: Treatment of moderate to severe symptoms in primary care
Step 4: Treatment by mental health specialists
Step 5: Inpatient treatment

Common mental health problems

Common mental health problems can occur in a wide spectrum of severity and include depression and anxiety. They affect some 16 per cent of people at any one time.[18] Some of these problems resolve quickly, but without intervention others can persist, leading to long-term distress, adverse social consequences including unemployment, and increased risk of dying early from physical ill health.

The approach recommended by NICE for the treatment of common mental disorders is the so-called stepped approach. This requires effective working across primary and secondary care so that individuals receive timely and appropriate psychological, social and physical care at each level.[146, 147]

Improving Access to Psychological Therapies

The Improving Access to Psychological Therapies (IAPT)[11] programme is a major development in mental health services and an important advance in treating common mental health problems.

New psychological therapy services are being rolled out throughout England, supported by an investment rising over three years to £173 million by 2010/11. Based on NICE guidance, the services offer evidence-based treatment for depression and anxiety disorders. So far, the investment has focused on training a new workforce in cognitive behavioural therapy. Evidence suggests that this approach can help up to 50 per cent of people who complete treatment.

The programme has been welcomed by key stakeholders representing service users and psychological therapy disciplines, as well as the NHS, which is implementing it through a common framework tailored to local needs. It has established strong links with employment services to ensure that it has a positive effect on economic circumstances at individual, regional and national levels. Patients' progress towards recovery is rigorously monitored.

The programme has focused initially on people of working age but 11 Pathfinder primary care trusts have explored the particular needs of children and adolescents, new mothers, BME groups, older people, people with long-term conditions and disabilities, and offenders. Future development of IAPT is likely to extend the availability of therapy to these and other groups. There are links also to services offering psychological therapies to veterans.

The programme has recently been accelerated and expanded to offer help to people suffering distress related to the impact of the recession, with additional one-off funding of £13 million in 2009/10.

Improving Access to Psychological Therapies for black and minority ethnic communities

Newham was one of the first IAPT pilot sites, set up in 2006. The London Borough of Newham has a large BME population, but uptake of the IAPT programme was slow among these communities.

The service was initially available only to patients referred from 13 GP surgeries. The decision was made to open up the service to self-referrals in early 2007. This resulted in a rise in numbers of patients from BME communities to levels that more accurately reflected the local population's ethnic profile. People from BME communities accounted for 22 per cent of self-referrals but just 16 per cent of GP referrals.

Dr Ben Wright leads the Newham IAPT team: 'There are three key elements to our work – access, engagement and treatment. Enabling self-referral has been critical to making sure BME patients are walking through our doors. We telephone all patients to speak to them about any concerns before treatment begins. This is of real importance as BME patients in particular may be wary of treatment procedures. Our access materials are also translated into the main languages spoken in the area and we use interpreters in Punjabi, Hindi, Bengali and Urdu. This is significant given that 13 per cent of our referrals in 2006 and 2007 did not speak English. All members of our team have significant experience of transcultural work.'

The IAPT approach incorporates a number of features that could be applied to other areas, such as the treatment of medically unexplained symptoms:

- early access to assessment and therapy, including self-referral

- choice of treatments

- stepped care, working across the traditional primary–secondary care boundary

- care pathway to include self-help

- clinical intervention linked to quality of life outcomes such as employment, supported by joint working with social care and the third sector

- skilled staff with dedicated training.

Symptom management clinic

Devon Partnership NHS Trust hosts a Mental Well-Being and Access Professional Expert Group that includes people with expert lived experience, GP mental health experts, the Devon Primary Care Trust mental health commissioner, the IAPT manager and a service development manager. The group has been commissioned to design new service models to meet emerging needs in primary care and the community.

One current project is testing out taking health psychology and liaison psychiatry into the less stigmatised setting of primary care. The initial focus is people who experience medically unexplained symptoms. Many of the people who 'do the rounds' of general hospital departments become more and more socially isolated and less able to work, and have high levels of depression and/ or anxiety. Significant proportions have more complex mental health presentations. They describe their lives as blighted by their symptoms. GPs report high levels of frustration and feelings of helplessness about these patients, who make heavy demands on GP and diagnostic services.

The pilot offers a 'symptom management clinic' – a one-off, detailed bio- and psychosocial assessment – followed by a feedback session to the person and their GP together. They then explore and agree strategies for treatment, which may include referral to IAPT services, recovery coaching or non-mental health options. Follow-up includes using recovery-based outcome measures.

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Older
adults

Aims

To improve the mental well-being of all older adults.

To build on the achievements of the *National Service Framework for Older People* and the *National Service Framework for Mental Health* towards high-quality, non-discriminatory mental health care that respects the autonomy and dignity of the individual, families and carers, and supports recovery.

Key messages

Improving the mental well-being and mental health care of older adults requires:

- *action to challenge ageist attitudes in society and to promote positive mental health in older age*

- *well informed commissioning to ensure that the complexity of needs of older adults is met by all sectors working together*

- *tailored, specialist approaches and a workforce with specialist skills. One size does not fit all*

- *action to eliminate discrimination and inequalities in service provision and quality of care for older adults.*

Everything in the last two sections about adults applies equally to older adults. This section describes additional approaches to support high-quality, non-discriminatory mental well-being and mental health care services for older adults.

There are 9.7 million people aged over 65 in the UK. By 2020 one in five people in the UK will be aged 65 or older. Between 2006 and 2072 the number of people over 65 will double and those over 80 treble to nearly 21.3 million and 9.5 million respectively.[148] In recognition of this, a cross-government Ageing Strategy is to be published in 2009.

Better mental health for older people has enormous benefits not only for individuals but for the whole of society as well, with the potential to reduce the demand on health and social care services. Many of the problems experienced by older people are to do with social attitudes and values; social exclusion can be a cause of as well as result of mental health problems in older age.

Poor mental well-being is not an inevitable feature of older age. Neither depression nor dementia, or any other mental health problem, is a natural or normal part of ageing – as with younger adults, there are effective treatments and preventive interventions. Improvements to the physical environment, opportunities for social involvement and activity, good peer and neighbourhood relationships, and a sense of being valued and making a meaningful contribution to society all have a role in maintaining good mental health in old age.

The *National Service Framework for Mental Health* was explicitly

targeted at working age adults, and specialist older people's mental health services by the *National Service Framework for Older People*.[149] There is evidence that the investment in quality improvement of inpatient and community mental health services for working age adults during the period of the National Service Framework may not have been matched consistently by similar development or investment in older people's mental health services.[26]

Roughly one third of all mental health service activity in England is concerned with the care and treatment of people over the age of 65.[150] While the majority of the mental health problems found in older people, other than dementia, are no different from those experienced by working age adults, older people often have different care and treatment needs. Depression can be complicated by coexisting dementia, and vice versa. Both can be made more complex because of high levels of co-morbid physical illness and disability. Meeting these complex needs requires specific professional skills. In addition, services have to be structured in such a way that they can respond to this complex mix of social, psychological, physical and biological factors.

Better mental health and well-being for older adults

'Suddenly here I am, a shadow of the person I used to be and sometimes not even feeling that person… and this awful feeling, as I say, once you are old you are on the scrap heap really, nobody wants you.'

The quotes in this section come from *Improving services and support for older people with mental health problems: The second report from the UK Inquiry into Mental Health and Well-Being in Later Life*. Age Concern England, 2007.[151]

The foundations for good physical and mental health in older people are laid down in childhood and throughout adulthood. However, much can be done to promote and maintain good mental health and well-being in older age. Five factors have been identified as being important to the mental health of older people, whether they are living in the community or in residential care:

- stigma and discrimination

- participation in meaningful activity

- relationships

- physical health, including the ability to carry out everyday tasks

- poverty.

Addressing these requires multi-agency interventions at multiple levels. Local authorities, health services, third sector agencies and communities all have a role to play in tackling the barriers to continued mental health and well-being into older age. Primary care may have an important signposting role in ensuring that older people are able to access mental health promoting services and activities, as well as treatments for mental health problems.

Stigma and discrimination

'[When] they know you have Alzheimer's, they just kind of ignore you. You can go to a family affair and everybody is kind of gabbing, gabbing. But they leave you alone because they figure you don't know what is going on… They are frightened, they think you have lost your mind… You are just there and that's it.'

Older people with mental health problems can be among the most socially excluded in society. The stigma of old age is amplified by the stigma of having a mental health problem, and may be further compounded by physical health problems and disabilities. The Department of Health is already encouraging staff training to raise awareness of age discrimination and abuse through its ongoing Dignity[152] campaign, and more work is planned. Other key strategies include the Dementia Strategy, published in February 2009,[153] and the cross-government Ageing Strategy, due to be published in 2009.

Unfair or unjustifiable discrimination in the provision of mental health services or care is unethical. The Equality Bill, currently before Parliament, will, if passed, also make it unlawful. Yet there is evidence of inequity in the resources allocated to mental health care for younger and older adults with apparently similar needs. More research is necessary to explain why this is so, and to identify any differences in outcomes from services between age groups.

A national review of age discrimination in health and social care is due to report to the Department of Health in October 2009. The outcome will inform the future development of New Horizons.

Public awareness campaigns and information that challenges ageist attitudes and promotes positive images of older people can help to tackle social exclusion, as may intergenerational projects (in schools, for example) to encourage greater contact between young and old.[14]

Information and engagement

Older adults need accessible information about how to care for their own mental health, including the benefits of maintaining cognitive functioning, exercise and a healthy diet, and where and how to access the broad range of health and social care services.

Service user involvement and consultation is widely recognised in services for working age adults as important for improving service provision. User consultation and involvement structures for older people's services tend to be less well developed, but may bring benefits for commissioners and providers, as well as for older people themselves. Recovery principles of self-determination and a say in policies and decisions affecting them, individually and globally, are as relevant to older people's well-being as they are to younger age groups.

Partnerships for Older People Projects

Partnerships for Older People Projects (POPP), a Department of Health initiative, deliver a range of interventions aimed at promoting independence for older people in line with local needs. For example, they provide better access to information and peer support for older people, health promotion activities to support healthy living, and low-level or simple services for older people such as help with shopping and household repairs. Early findings from POPP pilot sites have shown improved access for excluded groups and greater involvement of older people in service planning and delivery (NICE, 2008).

Social involvement

'When my husband died, I was lost… I had no structure to my life. I felt as though I was short of a goal in life…. Volunteering saved my life. Having a purpose in life dragged me out of the swamp and onto the road again. And I've met some lovely people. It makes me shudder to think of the waste of my life if I hadn't got anything like this to do.'

Fear of violence, loss of independence, lack of transport and lack of community support can all impact on quality of life and increase the risk of depression in older people in the community. Prevention of depression can itself prevent social isolation. Environments and public sector services and amenities that promote social cohesion, reduce social isolation and enable physical activity will all support mental well-being in older people.[154, 155]

'It helps me to be able to talk to someone… even having someone that I could get hold of on the phone would be good…I feel I should get help to keep things going rather than waiting for things to go wrong before I get support. I feel isolated.'

Loneliness and social isolation are risk factors for depression in older people.[156] Older people have many skills and untapped social capital to contribute to communities, for example in schools and the third sector. Access to adult learning courses promotes social contact. Work is known to be good for mental health: flexible retirement schemes and employment opportunities for older people may contribute to continuing mental well-being and social engagement.

In rural areas, the proportion of people over 75 is already at the level that we expect to see in the rest of the country in 20 years or more. This creates extra challenges for rural communities and those planning health and social care.

Hackney Silver Surfers

Hackney Silver Surfers is an Age Concern Hackney project providing free computer training and free internet access to anyone aged over 50 in Hackney, East London. The project offers a range of activities to match the needs of users, including a 'drop-in' where older people can use the computers as they wish and one-to-one learning with volunteers. It also offers short optional courses leading to a City & Guilds StartIT certificate and half-day workshops on topics such as digital photography, mobile phones, email, computer graphics, internet radio, spreadsheets and more – most of the workshops are arranged when somebody requests a particular topic.

Since the project opened five years ago, more than 1,000 people have used its services. 'They find the internet enables them to shrink the planet so they can keep in touch with all their friends and relatives in a way they never could before. And that is important to our community because more than half of their family roots are in the Caribbean or Africa… just the fact that we are a social centre where people can come and be part of the group and the community is important because they are isolated if they don't come. And if they can share their knowledge with the person next to them, they love to be helpful. I think that's one of the most worthwhile services we can provide – that they can contribute and be valuable. It helps to keep people going.' (Age Concern Development Officer)

http://lawns.org.uk

Contact the Elderly

Contact the Elderly is a third sector organisation offering social contact to older people aged 75 and over who are living alone, without family or friends living nearby. Volunteer drivers who each collect one or two elderly people from their homes and take them to the home of a volunteer host where the volunteers and older people spend a few hours together with afternoon tea, usually on a Sunday. Each group normally meets once a month, in the homes of different hosts. 'I felt that I had come out of a dark tunnel into the light. Before I joined Contact, I thought that my life had ended – and now it's started again.' (Contact the Elderly guest)

Poverty and debt

Retirement brings a reduction in income for the majority of older people, and some older people are more disadvantaged than others. Older women in particular are at greatest risk of extreme poverty in older age.[157]

Debt may become a more significant problem among older people as use of credit cards becomes more common in this age group. Debt is strongly associated with mental health problems, and access to good financial and benefits advice and opportunities for flexible employment will help.

Warm homes

Cold weather and the stress of not being able to afford fuel bills contribute to poor mental health, and have been linked with a fourfold increased risk of depression. People in fuel poverty are also 2.5 times more likely to report high or moderate stress than people who are able to afford their fuel bills.

Interventions such as the government-funded Warm Front scheme (see next page) and help with claiming benefits entitlements have been shown to lessen the impact of cold weather on physical and mental health. The Warm Front scheme has resulted in overall improvements of up to 50 per cent in self-reported health, 27 per cent reductions in use of GP services and a 50 per cent reduction in risk of depression and anxiety compared with people not receiving this help.[158]

Keep Warm Keep Well

The Department of Health's Keep Warm Keep Well campaign offers older people, people with disabilities and those on low incomes advice on keeping warm and staying healthy during the colder months. A free guide gives practical tips and information on financial support such as grants for home improvements to help make homes warmer or help to meet the cost of heating bills.

A guide for health and social care professionals, *Supporting vulnerable people during cold weather*, gives advice to people working in primary care and social services and to home care providers about ways to reduce chronic and acute health risks associated with cold weather.

The Warm Front scheme

The Warm Front scheme is a government-funded fuel poverty programme. It has an annual budget of some £350 million and funds a range of insulation and heating improvements to eligible households. The scheme is designed to assist the most vulnerable owner occupiers and people who rent from private landlords.

www.warmfront.co.uk

Improving physical health

Keeping physically healthy and active is good for all aspects of mental health. Physically fit older people are less likely to be isolated and depressed and have a lower rate of dementia. Up to half of all people with dementia may have a vascular component (ie vascular dementia or mixed dementia). Current health promotion messages on diet and lifestyle and regular health checks are therefore likely to reduce this risk. Raising public awareness of this link may also encourage people to take steps to reduce risk.[159]

Maintaining and maximising mobility, vision and hearing are vital to sustaining an active life and social contact. Podiatry, chiropody, audiology, optical and related services all have a key role in supporting and promoting good mental health.

Silver Deal Active

Silver Deal Active (SDA) was launched in Glasgow in November 2005 to provide a structured and tailored physical activity programme for Glasgow Housing Association (GHA) tenants in local community venues (including GHA's sheltered and very sheltered housing complexes). The aim of SDA is to offer opportunities for older people who are too frail to take part in more traditional exercise programmes to build physical activity into their lifestyles. SDA has since expanded to other parts of the city. SDA East, for example, offers a programme of free activity sessions for people aged over 60 living in the east end of Glasgow. Run in partnership by East Glasgow Community Health and Care Partnership GHA and Culture and Sport Glasgow, the activity sessions are led by a qualified coach and tailored around the needs of local residents, ensuring that they are appropriate for their mobility and activity levels. The weekly one-hour sessions offer a variety of physical activities, including chair aerobics, t'ai chi and Pilates. A programme of health talks and active arts sessions is also available.

A range of benefits have been reported by those taking part in Silver Deal, including increased strength, stability and mobility, increased confidence and a more active social life – with many people making friends and enjoying the opportunity to get out of their homes on a regular basis.

Interventions for high-risk groups

Supporting families and carers

Families and carers are not only vital in providing care for older people with mental health problems; they are also at risk themselves of developing mental health problems. Carers of older people may themselves be elderly and frail. Most older people want to remain independent and living at home as long as possible, and most carers want to help them to do so; timely and appropriate support will help them to achieve this.

Over 500,000 family members care for people with dementia, contributing the equivalent of some £6 billion a year in unpaid care. The Department of Health Carers' Strategy[36] and the National Dementia Strategy,[160] which includes a significant component on carers' needs, outline how carers can be supported so they can have a life outside caring. Joint working will facilitate implementation of the dementia and carers' strategies at a local, regional and national level.

Early identification and treatment of depression

'I think a sympathetic and understanding GP and somebody who knows you well is very important. Because it's that first contact that is vital really. If [the GP] says, 'Oh pull yourself together, get on with it, live your life'… If you get that sort of reaction I can imagine being very much put off.'

Depression is the most common mental disorder in later life. Between 13 and 16 per cent of older people will have depression that is sufficiently severe to require treatment.[161, 162] Older people with physical health problems have higher rates of depression.[163] Older people in residential care are at particularly high risk.[164] Yet depression in older people often goes undiagnosed and untreated by primary care services, in care homes and in acute general hospital services.[165, 166]

Depression is not an inevitable feature of growing old; rather, it is often a predictable response to the range of known factors commonly experienced by older people, not least of which are increased social isolation, increasing disability and physical ill health, lack of opportunities for meaningful activity and reduced independence.

Sandwell Third Age Arts

Sandwell Third Age Arts (STAA) is a charity providing creative activities for older people with mental health problems and dementia and their carers living in Sandwell in the West Midlands. It offers a range of creative activities – new hobbies and old interests – to enhance well-being and enrich quality of life for older people with mental health needs and their carers. STAA offers a one-to-one, personalised service with the client and one of STAA's artists working together in the client's own home, and themed creative sessions for small groups at day centres and hospitals and in residential homes. STAA won the National Institute for Mental Health in England Positive Practice Award for Older People's Mental Health in 2005.

The Treasure Chest Banner project was devised for patients on the short-stay assessment and rehabilitation wards at Edward Street Hospital, West Bromwich.

The patients, staff and carers worked with an STAA artist to create a banner for display in the hospital. Activities included painting, drawing, collage, hand and machine embroidery, appliqué, rag rugging, knitting, crochet, batik and metal work. Some people continued to attend the group after discharge as outpatients or day hospital patients. The banner was completed over 21 weekly afternoon sessions and 22 patients took part in total. The banner was unveiled at a ceremony and many of the participants brought relatives and friends to show off their work and celebrate their achievements. The banner is on permanent display at Edward Street Hospital.

'I've done such a lot... I've done all these things, the podging, the knitting, the project... I've forgotten how interesting it was... It made me feel better and lifted my spirits... it was something different, you know.' (Amy, project participant)

www.staa.org.uk

Greater awareness of these risk factors among primary care staff and availability of a range of treatment options in addition to medication can help to improve detection and intervention. Primary care may have an important signposting role here, working with local social care and third sector organisations. Social prescribing offers one model to connect older people with local support networks and opportunities for learning, volunteering, mentoring, peer support and leisure activities that are known to be of benefit to people with depression.

Older people with chronic physical health problems

Older people with chronic physical health problems are at twice the risk of developing mental health problems, and vice versa. Very few of them are diagnosed or receive treatment for their mental health problem – an estimated 10 to 15 per cent – whether they are in hospital or the community.[167] Training for all health service staff in mental health awareness and treatment options across all age groups may help to increase identification of mental health problems and early intervention.

Older people in residential care

Many thousands of older people live in residential and nursing care homes.[168] They are in many ways society's most excluded group. Up to 50 per cent of older people in residential care have clinically severe depression, yet only between 10 and 15 per cent receive any active treatment.[169] Much of the distress and disability resulting from this depression could be relieved by early identification, intervention and treatment.

Live Music Now

Live Music Now (LMN) is a national charity dedicated to using live music to bring a range of benefits to the welfare, educational, justice and health sectors, using the talents of young musicians. One recent project, Musical Memories, worked with residents aged 60–100 in three residential care homes in Northern Ireland. Three LMN musicians visited the homes with a professional storyteller to collect the songs and stories the residents remembered from their pasts. The musicians used these as the inspiration and focus for a Singspiel – a new piece of music-drama, which they performed back to the residents and an invited audience of families and friends. An evaluation of the project found that it promoted communication, stimulated the older people mentally and emotionally, increased confidence and self-esteem, and encouraged social contact. It also ensured that these older people's stories were kept alive and passed down to younger generations.

'I thought it was magnificent, really great, for people to go to so much trouble to entertain us is brilliant. It was good the way they made the play at the end, about us and what we talked about beforehand. It was good craic! I enjoyed it, I loved the singing and the dancing too!' (Lily, nursing home resident)

www.livemusicnow.org.uk

A little goes a long way

The psychology service of North Yorkshire and York Primary Care Trust conducted a controlled research study to explore the benefits of personalised, one-to-one activity sessions for the mental health of nursing home residents. Depressed older people in 14 care homes in Yorkshire were given some regular extra quality time with their main care worker for two to three months to arrange three or four individual activities that the residents said were important to them. They included arranging transport to visit friends, going to church, revisiting old hobbies, getting hold of large print books, help to sit outside in warm weather, organising better hearing aids, physical health check-ups, and just time to talk about their feelings. The care workers had previously attended four training sessions in care planning with the psychology service and were supervised by mental health professionals. The 87 residents who received the extra time and help showed clear improvements in their mental health, as rated on a depression scale, with the greatest improvements among the most depressed. A comparison group of fellow residents in the same care homes, who continued to receive only ordinary care, did not improve. Many of the care staff were also very enthusiastic about the approach, even though they were having to make the time to do it within their normal hours. Some thought the holistic care planning approach should be used for all residents, not just for those who were already depressed.

An issue of particular concern is the over-use of antipsychotic medication in care homes for the management of behavioural and psychological symptoms in people with dementia. Antipsychotic medications are known to cause increased risk of mortality and stroke in people with dementia. Behavioural and psychological problems in older people can be managed by changes to their environment and psychosocial interventions.[170]

The high rates of mental health problems among care home residents may be addressed by better liaison between homes and their local older people's mental health services. One approach might be to commission the specialist older people's mental health services to conduct mental health assessments and regular follow-up reviews when residents are newly admitted to care homes. This would also provide a regular forum for discussion between nursing staff, GPs and specialist older people's mental health teams to identify and manage the mental health problems of care home residents. Joint commissioning of inreach services from other professionals, such as community pharmacists, community dentists, arts therapists and geriatricians, could also improve support to care homes and enhance their environment.

Better mental healthcare for older adults

'The thing was, I went to this service for several years, on and off, and then to my horror I discovered that at 65, they no longer take people because 'it's not for pensioners'.'

Mental health services for older people, like those for younger adults, are governed by the same principles of high-quality treatment and care outlined in section 5, Better mental health care for adults. However, older people are likely to have additional needs that services for younger adults do not address.

Non-discriminatory care

There is evidence that older people can experience discrimination and inequity in access to and availability of mental health services, and can experience poorer quality of care than working age adults. Older people also typically present with more complex needs.

They are more likely to have:

- multiple care needs for a range of co-existing problems
- physical and mental health and social care needs
- different patterns of social care and family support
- specific problems such as dementia.

The 2005 Department of Health good practice guide *Everybody's Business: Integrated mental health services for older adults*[160] states that:

- mental health and care services should be available on the basis of need, not age
- older people's health and care services should address mental as well as physical health needs.

Following this, age equality guidance published by the Department of Health recommends: 'An ageing population has particular needs… The mental health needs of older

people are often multi-factorial and frequently complicated by failing physical health. This complexity requires the skills of specialist practitioners… Specialist mental health services for this group should be the bedrock on which other services can rely for clinical advice, support and practical help.'[171]

The aim of the age equality agenda is for services to be of equivalent good quality for people of all ages.

The 2009 Healthcare Commission report *Equality in later life: A national study of older people's mental health services*[26] highlighted likely age discrimination within services. It found: older people's services were falling behind those for working age adults; clear evidence of age discrimination in access to services; and a lack of age appropriateness. The report concluded that equality of access could not simply be provided through providing access to services designed for younger adults.

Undoubtedly some older people with severe mental illness have needs that are indistinguishable from those of adults of working age and these older people may well be best served by specialist working age adult services. However, adult mental health services have mostly been designed and developed to meet the needs of working age adults with severe mental health problems. This can result in indirect age discrimination, whereby 'apparently neutral practice… disadvantages people of a certain age'.[172]

Specialist older people services should be available to people who would benefit from them. Services should be designed around the needs of older adults with mental illness, with appropriately skilled staff and run in appropriate safe and therapeutic environments.

Many mental health trusts have developed formal agreements between working age adult and older adult mental health services. These make it clear that age should be used as a guide, not an absolute marker, when decisions are made about which service would be most appropriate. Older people have particular needs and older people's mental health teams, staffed by professionals with training and expertise in the care of older people, are needed.

Common features in these agreements include:

- people who grow old with enduring mental health problems remain under the care of the working age adult service with which they are familiar unless their needs would be better met by the older people's service, in which case good transition becomes important

- people who experience their first episode of mental health problems after the age of 65 will be seen in the first instance by the older people's service

- people of any age with dementia will be seen by the older people's service

- older people whose primary need is for specialist services such as substance misuse services or forensic mental health care will not be denied access and care from these services on the basis of age

- joint working between services where patients would benefit from collaboration.

Community mental health services for older adults

Older adults, like younger adults, are likely to benefit from specialist community mental health approaches, such as assertive outreach, out-of-hours support, crisis care and home treatment, and access to psychological therapies. Achieving equity of access and a range of services tailored to the needs of older people may require the development of different approaches and not simple duplication of services. More evaluation of different approaches would be helpful.

Reconnect

Rethink's Reconnect Floating Support Service provides housing-related floating support to older people with dementia or memory problems living in Bournemouth, Poole and Somerset to help them regain and maintain their independence and quality of life in the community. Trained support workers typically provide 5–10 hours of support per person per week, usually in the person's own home. The service is available seven days a week. Support is tailored to the needs of the individual and may include:

- helping service users to manage their money and avoid or sort out debt problems

- helping service users to claim state benefits and maximise their income

- advice on home maintenance

- guidance on the safe use and maintenance of domestic equipment

- advice on maintaining personal and home security

- advice on diet.

The support workers will also provide information about community facilities and services locally, as well as help with self-care issues, such as reminding clients to take medication and helping them and their carers to develop coping strategies and crisis management plans for their mental health.

Liaison services in general hospitals

Up to 70 per cent of acute hospital beds are currently occupied by older people[173] and up to half of these may be people with cognitive impairment, including dementia and delirium. Levels of depression in general hospital wards are also high (around 30 per cent).[174] Both depression and dementia may hinder recovery and rehabilitation. The majority of these patients are not known to specialist mental health services, and their problems are not diagnosed. General hospitals are particularly challenging environments for people with memory and communication problems.

People with dementia and depression in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.[175] This impact creates a strong incentive for clinicians, managers and commissioners to improve liaison psychiatry services.

General hospital staff have few skills and little training in working with people with mental health problems. The National Dementia Strategy[160] recommends three ways to improve the care of older people with mental health problems in general hospitals:

• a senior clinician in the general hospital to take the lead for quality improvement in dementia care in the hospital

• the development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician

• commissioning specialist liaison older people's mental health teams to work in general hospitals.

These principles would apply equally to the other mental health problems commonly exhibited by older adults in hospital.

The commissioning of such teams would be of benefit to those older people with mental health problems other than dementia as well as to those with dementia.

Let's Respect

Let's Respect is a campaign aimed at better meeting the mental health needs of older people, focusing initially on generic secondary care settings and the three most common mental health problems – depression, delirium and dementia. Let's Respect has produced a range of support and training materials for nurses working in acute hospitals including a good practice guide and PowerPoint presentations. It has also devised a Resource Box toolkit with photographs and case studies to provide practical suggestions for ways to better meet the mental health needs of older people in acute care settings. Information is presented in a variety of formats, including booklets, guide books and bookmarks.

www.mentalhealthequalities.org.uk/our-work/later-life/lets-respect.html

Early and effective diagnosis and treatment of dementia

Currently only about one third of people with dementia receive a formal diagnosis at any time in their illness. When diagnoses are made, it is often too late for those suffering from the illness to make choices. Further, diagnoses are often made at a time of crisis; a crisis that could potentially have been avoided if diagnosis had been made earlier. A core aim of the National Dementia Strategy is therefore to ensure that effective services for early diagnosis and intervention are available for all on a nationwide basis.[160]

Analyses completed for the Department of Health set out clearly that a 'spend to save' approach as advocated by the National Audit Office in their value for money report can both increase the quality of care and save hundreds of millions of pounds of expenditure over a 10-year period. These analyses suggest that such services are clinically and cost effective using accepted measures.[176]

Such early diagnosis and treatment services are a new introduction into our health and social care system. They are designed to carry out work that is simply not done at present. One effective way for them to be provided would be as a newly commissioned, stand-alone service with a single focus on mild to moderate dementia, its diagnosis and its management. Such teams are designed to be complementary to existing services and cannot duplicate the work of specialist community mental health teams with those with severe and complex illnesses.

The National Dementia Strategy states that specialist older people's mental health services are a vital component of service provision for people with dementia. Strong, well resourced and effective specialist older people's community mental health teams are needed with a role that extends beyond dementia, to include responsibility for older adults with functional illness so that they have the capacity and skills to provide the range of care needed for people with dementia whose needs cannot be met by the memory services described above.

How we will get there

The vision for 2020

We started with a vision of how things could be when we properly value our own mental health and know how to preserve it; when we look on mental health problems as common, and as something for which good-quality care and treatment exist; when we know how to access these for ourselves, and can support others when they need to do so; when we understand that work and life can and should continue with a mental health problem, as with a physical illness; and that recovery, on our terms, is the shared aim of all involved.

Mental health is everyone's business. In 2020 mental health will be seen as an important asset for our society, as 'capital' in which we all have an investment and to which we all – individuals, employers, the third and statutory sectors, local authorities, the health services and all government departments – have an important contribution to make. This section looks at how our current systems of organisation and delivery could align to bring this vision to life.

That was then...

The *National Service Framework for Mental Health* engaged commissioners and providers of adult mental health services in a 10-year programme of reform that introduced radical and widespread changes. The vision was supported by specific national targets set out in the NHS Plan, and significant new funding.

The National Service Framework (NSF) was successful because key elements in the system were led by the same agreed vision. There was a clear strategy, local and national leadership, and evidence-based service models; commissioning was supported by resources, more and better information was available and progress was monitored against agreed outcomes.

Progress has been slower where these elements are not aligned – for example, mental health services for older people were covered in

the *National Service Framework for Older People*, but investment and reform in these services have not kept pace with those in adult services. Some elements within the NSF for adults, such as the wider issues of mental health promotion and prevention, received less attention. Delivering race equality has been a slower process.

However, in the wider context, healthy life expectancy and health inequalities have become a priority for the Department of Health, as reflected in the Public Service Agreements (PSA). Increasingly, as our understanding of the social determinants of mental health problems and health and social inequalities has grown, the importance of involving other sectors, such as local government, third sector employers and education, has become inescapably apparent.

This is now...

New Horizons has two main aims:

- improving the mental health and well-being of the population
- improving the quality and accessibility of services for people with poor mental health.

In practice, this means maintaining the momentum of the reform of mental health services and improving access to and the quality of services for all who need them, while broadening the agenda to promoting mental health, preventing mental health problems and building mental resilience and well-being. This in

turn requires the same alignment of key elements for change, but broadened beyond the NHS and the Department of Health. The key elements are:

- a clear strategy supported by a broad consensus
- prioritisation of mental health nationally and locally across government and all sectors
- local and national leadership
- evidence-based service models and approaches
- effective and resourced commissioning, both multi-agency and specialist
- information, monitoring and regulation and high-quality outcome measures
- a skilled workforce.

We also need the key partners to work together. Success in achieving this much broader agenda will depend on co-ordinated action across government departments at national level, and effective working at local level between commissioners and providers, including primary care and the statutory, private and third sectors. Tackling attitudes and stigma, opening up employment and educational opportunities, building resilient individuals and communities and making progress on social justice for people with mental health problems require sustained change across all sectors. An example is the cross-government target PSA 21: to build cohesive, empowered and active communities, measured in part by the levels of volunteering and employment in the third sector.

The past 10 years have seen major reforms across the public sector, and particularly within the NHS and local authorities. Decisions about what local communities need are best made at the most local level possible. The best decisions will also come from the active involvement of the people, of all ages, whom the decisions directly affect. These two principles, 'subsidiarity' and 'co-production', are fundamental. Alongside 'alignment', the subject of this section, and 'leadership', they form the four key change principles currently active in public services.

There is a strong tradition of involving users of mental health services in designing services. Many changes have been driven by and with the backing of local communities. For example, in the last 10 years increasing numbers of third sector organisations, many of them employing former service users, have begun to provide services designed to meet what service users say helps and matters to them, with funding from local investment streams.

Personalisation and the development of individual budgets are good examples of how joined-up approaches at all levels are required to support individuals to make the best choices for themselves to improve their own mental health and well-being. Individuals, with the help of friends and family and professionals, consider their own needs and goals and how they want them to be met. To do this successfully, they need funding, support to make decisions, and
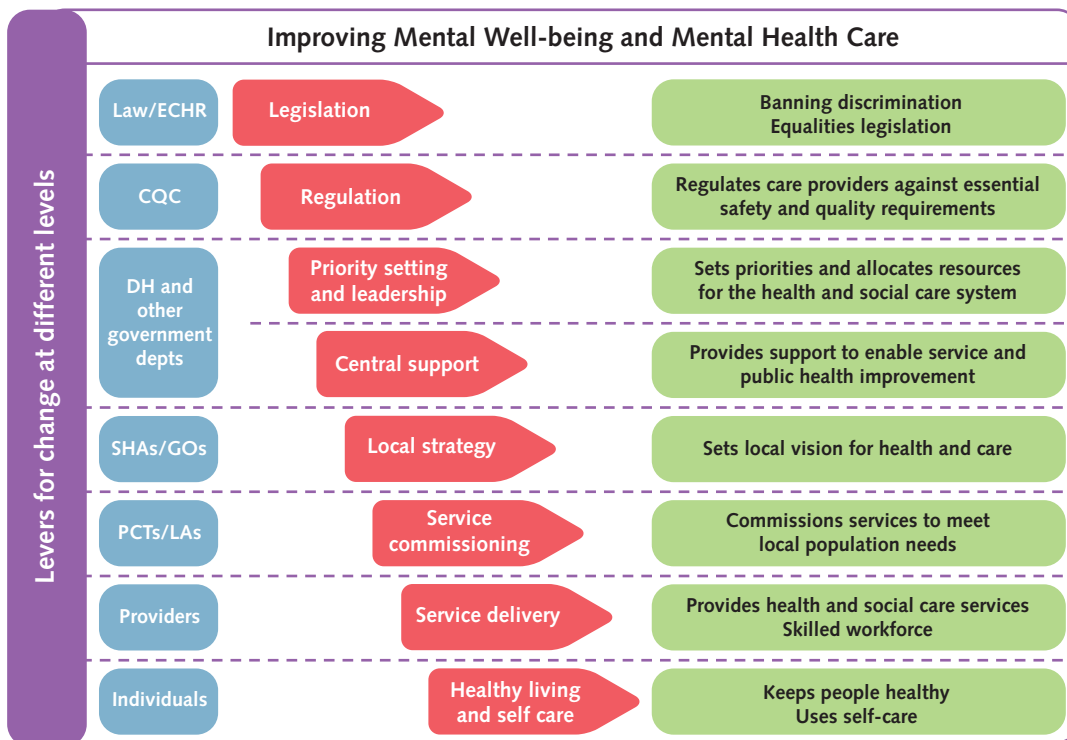
a range of local resources from which to choose to meet those needs. Getting that right requires and drives attitudinal and structural change at all levels. Indeed, personalisation will become an increasingly important lever for improving the quality and range of local services.

There are many examples of good practice. The task now is to ensure that there are consistently high-quality services and sustainable, effective approaches across all communities, across the whole country. Making the vision a reality will require action by people at individual, family and community levels, supported and informed by action at local authority and national government levels.

Because of the economic situation, we are also entering a period of much slower growth and problems with personal income; unemployment – and, indeed, mental health problems – may increase. Building and nurturing the resilience of individuals and communities are particularly important at this time. An example is the growth in voluntary self-help community projects that can foster people's sense of purpose and promote community cohesion. However, financial constraints also mean that service improvements will need to be self-financing, soundly evidence-based, and clearly related to local commissioning intentions, as informed by Joint Strategic Needs Assessments (JSNAs).

Figure 11: Aligning the key levers for improving mental well-being and health care

The diagram below shows responsibilities for action at different levels.

	Improving Mental Well-being and Mental Health Care	
Law/ECHR	**Legislation**	Banning discrimination. Equalities legislation
CQC	**Regulation**	Regulates care providers against essential safety and quality requirements
DH and other government depts	**Priority setting and leadership**	Sets priorities and allocates resources for the health and social care system
	Central support	Provides support to enable service and public health improvement
SHAs/GOs	**Local strategy**	Sets local vision for health and care
PCTs/LAs	**Service commissioning**	Commissions services to meet local population needs
Providers	**Service delivery**	Provides health and social care services. Skilled workforce
Individuals	**Healthy living and self care**	Keeps people healthy. Uses self-care

(Left vertical label: Levers for change at different levels)

A strategy

We need a national strategy that builds on the Strategic Health Authority Clinical Pathway Groups' 'Visions' for mental health and local area agreements (LAAs); one that is agreed by local commissioners and providers and is supported by the public and service users. New Horizons will form the foundation stone of the Government's vision for driving improvement in mental health services, and developing programmes and initiatives to support mental well-being.

The New Horizons programme will support and drive change at local and national levels. It will build on a number of other workstreams and strategies, including the Foresight Report on *Mental Capital and Well-being*,[14] the Marmot Review (Strategic Review of Health Inequalities in England post-2010),[178] the National Dementia Strategy, *Healthy lives, brighter futures* (the child health strategy), the mental health and employment strategy (in development), Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system and more.

Progress will continue to be underpinned by appropriate legislation consistent with international human rights law and equalities legislation. Better health and well-being will remain a key government priority, uniting the aims of many government departments, and operating in close harmony with other priorities that promote cohesive communities, thriving families, better employment, less crime and greener environments.

Nationally, the Public Service Agreements (PSAs), which set the current Government priorities, increasingly require cross-government working – for example, PSA 16 on prioritising employment and accommodation opportunities for people with mental health problems – and this will continue into the future.
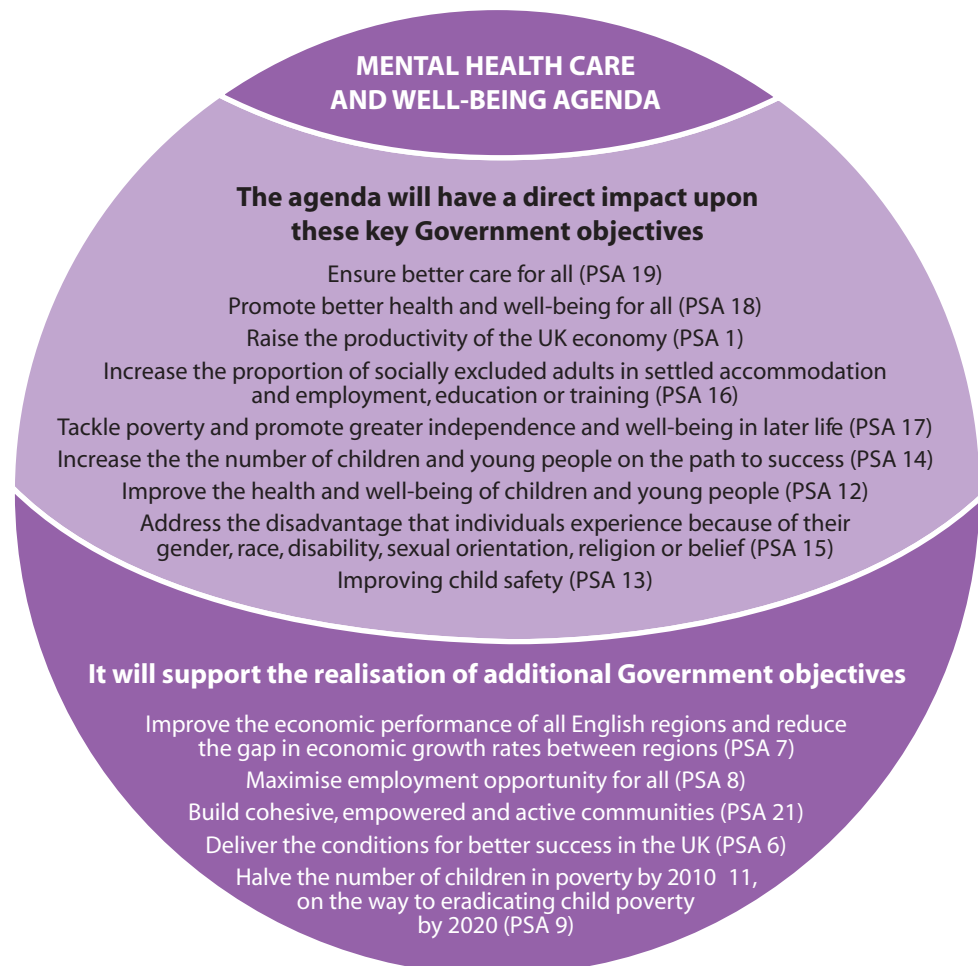
Leadership

Good cross-sector local leadership that develops and delivers effective local strategies requires active engagement with all stakeholders, including users, families and carers and the public and frontline staff.

Local authority and health commissioners, working in their local strategic partnerships (LSPs), need to map and understand variances in mental health outcomes across communities and ensure that investment goes where it is needed most. LAAs, drawn from a national indicator set and tailored to match local priorities, are a public expression of these plans.

Local democratic and public involvement processes, including council elections, community membership of NHS foundation trusts, attitude surveys and consultations, ensure that there is real community ownership of local plans. As *Communities in control: real people, real power* states:[177]

Figure 12: The links between improving mental well-being, mental health care and other key government objectives

MENTAL HEALTH CARE AND WELL-BEING AGENDA

The agenda will have a direct impact upon these key Government objectives

Ensure better care for all (PSA 19)
Promote better health and well-being for all (PSA 18)
Raise the productivity of the UK economy (PSA 1)
Increase the proportion of socially excluded adults in settled accommodation and employment, education or training (PSA 16)
Tackle poverty and promote greater independence and well-being in later life (PSA 17)
Increase the the number of children and young people on the path to success (PSA 14)
Improve the health and well-being of children and young people (PSA 12)
Address the disadvantage that individuals experience because of their gender, race, disability, sexual orientation, religion or belief (PSA 15)
Improving child safety (PSA 13)

It will support the realisation of additional Government objectives

Improve the economic performance of all English regions and reduce the gap in economic growth rates between regions (PSA 7)
Maximise employment opportunity for all (PSA 8)
Build cohesive, empowered and active communities (PSA 21)
Deliver the conditions for better success in the UK (PSA 6)
Halve the number of children in poverty by 2010 11, on the way to eradicating child poverty by 2020 (PSA 9)

'The key themes are power, influence and control: who has power, on whose behalf is it exercised, how is it held to account, and how can it be diffused throughout the communities in which we live. It is about democracy, and how democratic practices and ideals can be applied to our complex, modern society.'

Regional development agencies are now charged with creating regional strategies that include social, economic and environmental benefits as key objectives. An understanding of the importance of well-being is emerging within that work.

Local leadership and multi-agency action will be supported by visible national leadership and cross-government working to embed recognition of the importance of mental health across all sectors.

Clinical/professional leadership is seen as fundamental to driving quality across the pathways and to empowering frontline staff to improve the quality of services.

Agreed service models and high-quality services

The National Institute for Health and Clinical Excellence (NICE) will continue to review and publish evidence-based clinical guidelines and appraisals, and will extend its role to agree quality standards with the National Quality Board for selected care pathways. This work will eventually form a library of clinical standards. Many of the clinical guidelines produced by NICE include broader public health approaches to prevention and early identification and treatment. For example, the NICE schizophrenia guidance examines the evidence base for different approaches to promoting access to employment for people with severe mental health problems.

The Foresight Report on *Mental Capital and Well-being* and the Marmot Review (*Strategic Review of Health Inequalities in England post-2010*)[178] of health inequalities, with other initiatives, have explored and will continue to explore and present the evidence on effective interventions to address health inequalities and build resilience. An evidence-based public mental health framework is being developed to support strategic and systemic approaches to improving mental well-being (see Figure 1, page 13).

There is a wealth of community development experience in local authority and third sector projects that can be drawn on, and an increasing amount of work being carried out by regional development agencies. Figure 13 shows a framework for ensuring quality care for all within the NHS. The principles are applicable across all services and in all sectors, not just the NHS.

Figure 13: High Quality Care for All – a vision for quality improvement

- NHS Leadership Council
- Leadership training embedded in undergraduate curricula
- Accredited leadership standards for clinicians and managers

Leadership for quality

Quality as the organising principle

and the public

quality

- Help to stay healthy
- Empowering patients
- Most effective treatments for all
- Keeping patients as safe as possible

- Empowering frontline staff to lead change that improves quality for patients
- Valuing the work of NHS staff

Effective multi-agency and specialist commissioning

Primary care trusts (PCTs) and local authorities are responsible for commissioning health and social services to deliver the best possible outcomes (including reduced health inequalities) and the best possible care for their local populations, within the resources available. Local authorities in addition have a duty to promote the well-being of their population, to which PCTs are expected to contribute.

JSNAs bring local authorities and health commissioners, public health specialists and health and social care planners together to jointly review local needs, plan service provision, and prioritise investment. Many people at greatest risk of mental health problems are not known to local authorities. They may live on the margins of society or be in contact with the criminal justice system. It is therefore particularly important that JSNAs seek out the seldom heard and those who find it hardest to engage with and influence

the society in which they live. These include older people.

JSNAs will be informed by evidence on the determinants of well-being, including the interplay between physical and mental health. This means that the impact on health and well-being of, for example, closing a local shop, providing new social housing, improving transport links between communities or building on common or greenbelt land, is considered when these decisions are made.

LSPs are non-statutory multi-agency local partnerships based on local authority boundaries. They are responsible for ensuring all the relevant statutory partners (such as the NHS, local government and the police) are participating in the production of sustainable community strategies and co-operating to agree local targets to feed into local plans and LAAs. LAAs set out the priorities for a local area as agreed between central government and the local authority, the LSP and other key partners at the local level.

Within the health sector, World Class Commissioning provides a framework for improving the capacity and capability of those responsible for commissioning services on behalf of their populations. The aim is to ensure the planning, development and provision of sustainable and responsive services that offer the best value and highest quality standards.

The principles of WCC are equally relevant to all public sector multi-agency commissioning within LSPs. Integrated commissioning is the best way to deliver comprehensive, seamless pathways of care, tailored to the individual needs and aspirations of people with mental health problems.

Effective multi-agency commissioning will:

• be based on effective process and the content of the JSNA

• integrate approaches across the whole population

• include the needs of mentally ill offenders

• procure efficiently, including the use of World Class Commissioning, tariffs and the standard contract

• stimulate vigorous, competitive provider markets

• be based on an understanding of value for money, with agreed and appropriate means of measuring outputs and outcomes

• involve frontline staff, service users and carers.

Value for money in mental health services requires an understanding of the costs of services and of the implications of interventions for health and other services.

For example, the introduction of community teams has reduced admissions to and lengths of stay in hospital and therefore the cost of inpatient care. But very short admissions may be associated in the longer term with increased relapse and readmission rates. So, a simple outcome such as reduced length of stay is insufficient in isolation as a measure of success.

However, improving conduct disorder services may cost money in the short term, but in the longer term may reduce costs not only in health service provision, but also in the criminal justice system.

Effective commissioning will be the keystone for better quality services and better value for money. Currently commissioners are sometimes unclear exactly what care they are buying for their population. The work to develop mental health Payment by Results should provide some clarity, creating a nationally consistent 'language', allowing more meaningful contracting discussions between commissioners and providers.

As mental health services become more diverse, procurement will become more important. Done well, it could lead to some significant gains. But it is not an easy task. Guidance can be found in the Mental Health Procurement Roadmap published in conjunction with PASA and available on their website (www.pasa.nhs.uk/PASAWeb/PCTzone/Yourroadmap/mentalhealthservices).

The Quality and Outcomes Framework (QOF), used to monitor and reward activity in primary care, already incentivises GPs and their practice teams to improve the

identification, care and support of people with long-term severe mental health problems.

Frontline staff have direct knowledge of the needs of the people with mental health problems with whom they work and of the services and approaches that work well within their local communities. Involving frontline staff in the design and commissioning of services will improve the quality and appropriateness of services, and benefit the staff themselves by recognising their unique and expert contributions to improving care.

Outcome measures help providers, commissioners, service users and the public to assess their progress and overall success. In the longer term such measures could provide the trigger for 'Payment by Results'.

Information, metrics, monitoring and regulation

High-quality information continues to be important to the effective commissioning and development of mental health services and improvements in quality. To ensure this, the right data need to be collected reliably and this means involving mental health professionals in improving information systems. In 2008, the Information Centre recommended: 'Clinicians should be fully involved in development work on both information and on IT so that these resources meet their needs.' It also stressed that the primary purpose of local IT systems is to 'provide useful and clinically relevant data to clinicians', and that, when information is collected, 'the information loop should be closed by

returning information on individual patients and aggregate analyses to clinicians so that they have a direct interest in improving data coverage and data quality.'

Outcome measures

The practice of measuring individual, clinical outcomes will need to develop further, not just to ensure that services can better show their value and effectiveness, but also to enable practitioners and multi-disciplinary teams to reflect on quality and how it may be improved and how to build and sustain a recovery focus. To this end, Health of the Nation Outcome Scales (HoNOS) are an important component of the mental health minimum data set. The *Outcomes Compendium*, published in 2008, provides information to help teams choose the most appropriate measurement tools for their services.

Other options being explored are the development of a population mental well-being measure and a national specialist mental health observatory.

The Care Quality Commission will continue its regulatory role. The Commission will continue to use surveys and the National Patient Survey to provide information to the public. It will also use feedback from the patient and public forums being set up by foundation trusts.

Comprehensive area assessments

The Care Quality Commission has published the framework it uses to assess how well local councils and their partners are delivering better outcomes and improving the quality of life for local people.

This assessment is part of the local performance framework, which also includes LAAs and the National Indicator Set. The framework is available from www.audit-commission.gov.uk/localgov/audit/CAA/Pages/CAAframework.aspx, which also contains a prototype reporting tool.

A skilled and supported workforce

It is important that staff working across all sectors have the knowledge, skills and attitudes necessary to deliver interventions and approaches that challenge stigma and discrimination and improve quality of care, social outcomes and mental well-being across all ages and communities. Guided by recovery principles, staff need to be well supported and supervised and will work with users of services and carers to achieve their hopes and self-defined goals.

Good clinical and professional leadership is key to driving forward improvements in service quality at local level. Professional bodies, provider organisations and the Health Professions Council regulatory body have a lead role in ensuring that the workforce is appropriately trained and skilled to meet these new demands and challenges, and that it is supported by continuing professional development, appraisal and supervision.

In January 2009, the Social Work Task Force was set up to undertake a comprehensive review of frontline social work practice. It was asked to identify any barriers that social workers face in doing their jobs effectively and to make recommendations for improvements and long-term reform in social work. It is due to report in summer 2009.

In an equitable service, the training and specialist skills of the workforce working with older people across all sectors are given the same priority as those of any other staff group. Professional and vocational training are of major importance in maintaining knowledge and ensuring positive attitudes and behaviour towards older people. Improved cultural competence will also leave staff better able to respond to people from all backgrounds.

Public accountability will become a main driver of future reform. The public sector, including the NHS and social care organisations, has a responsibility to the public and users of its services that goes beyond how services are provided. The public and people who use services expect to play their part in decisions about how priorities are determined and how public money is spent. Mental Health Foundation Trusts are creating new ways of ensuring accountability through their governing bodies and membership arrangements and the public will increasingly look to commissioners of services and other decision-makers to provide them with genuine involvement.

Glossary

CQUIN
The new commissioning for higher quality and innovation scheme (CQUIN) will 'overlay' payment by results so that a proportion of provider income will be conditional on quality and innovation.

Foundation trusts
Increasing numbers of mental health trusts have become foundation trusts. They have begun to use their expanding membership as a key element in the fight against stigma and discrimination by directly involving the local community in the trust's business and operation.

HoNOS
Health of the Nation Outcome Scales are the most widely used routine clinical outcome measure in mental health services in England.

Mental health indicators
There have been several significant pieces of work over recent years to develop what are termed quality indicators, or metric or outcomes measures, depending on the context. While it is useful to draw on these separate sets of indicators, it is also important to recognise that they may:

• have been drawn up for quite different purposes

• have a different scope, for example may restrict focus to a particular group of people

• be available to varying extent by organisation or geographical region

• be a source of confusion to many when trying to select the most appropriate for a given purpose.

Mental health minimum data set
This data set brings together administrative and clinical information about people using specialist NHS mental health services for adults and older people.

National standard contract
The national standard contract, as an enabler, should free up commissioner time to focus on those parts of the commissioning cycle that will deliver the most gain. The contract, once revised in 2009, will spell out to all providers from all sectors the expected standards of services, and the penalties and incentives to deliver those standards. This will bring greater clarity about commissioner expectations for all provider organisations across the statutory, third and private sectors, and so improve fairness and competition.

Payment by results

Payment by results (PbR) is now established in general acute care, where it is a tariff-based 'payment for activity' transaction. PbR is a significant enabler of service change, as it allows commissioners, and in particular clinical commissioners, to understand the costs associated with different elements of the care pathway, and so make informed choices about appropriate care provision that offers best value and patient responsiveness. PbR therefore also facilitates patient choice and fairness and competition in management of the healthcare market.

PbR in mental health, and other enduring conditions, is not easily defined in discrete cost per activity terms. Mental health PbR seeks to bring transparency to the £8 billion spent on mental health annually by the NHS. It is being developed using a methodology first developed in the Yorkshire and Humber and North East strategic health authorities by the Care Pathways and Packages Project. It is now being refined across England, to develop a set of currencies (units of care for which a payment is made) whch will be available in 2010/11.

Mental health PbR must link to other parts of system reform. It has the potential to become a major tool to help commissioners identify what their spending is buying. It can support personalisation and choice by focusing on the needs of the individual service user and identifying resources to meet their needs. The mental health outcome measure HoNOS is central to how it operates, and further work is being done on how PbR can support quality.

QOF

The Quality and Outcomes Framework is used to monitor and reward activity in primary care, incentivising GPs and their practice teams to improve the identification, care and support of people with long-term severe mental health problems.

World Class Commissioning

World Class Commissioning (WCC) is the process whereby health service commissioners identify, procure and secure sustainable and responsive services that offer the best value and highest clinical standards.

The WCC assurance system assesses primary care trust competence in both process and capability, and identifies gaps and the development needs of the organisation to reach the highest standards in commissioning.

References

1   Department of Health (DH) (1999) *National Service Framework for Mental Health: Modern Standards and Service Models* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

2   DH (2004) *The National Service Framework for Mental Health – Five Years On* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4099120

3   DH (2007) *World Class Commissioning: Vision* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956

4   WHO Regional Office for Europe (2008) *Policies and Practices for Mental Health in Europe: Meeting the Challenges*

5   Office for National Statistics www.statistics.gov.uk

6   University of Manchester (2006) *Avoidable Deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/reports/avoidabledeathsfullreport.pdf

7   Mental Health Strategies www.mentalhealthstrategies.co.uk

8   The NHS Information Centre www.ic.nhs.uk

9   NHS Information Centre Hospital Estates and Facilities Statistics www.hefs.ic.nhs.uk/Home.asp

10   Prescription Pricing Division (2006) Prescription Cost Analysis 2006 www.ic.nhs.uk/statistics-and-data-collections/primary-care/prescriptions/prescriptions-cost-analysis-2006

11   Improving Access to Psychological Therapies www.iapt.nhs.uk

12   Healthcare Commission (2008) *National Survey of Users of Community Mental Health Services* www.cqc.org.uk

13   Mental Health Act 2007 www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1

14   Foresight for Government Office for Science (2008) *Mental Capital and Well-being: Making the Most of Ourselves in the 21st Century* www.foresight.gov.uk

15   Friedli L (2009) *Mental Health, Resilience and Inequalities*. Mental Health Foundation and World Health Organization (WHO) Europe www.euro.who.int/document/e92227.pdf

16   DH (2009) *The NHS Constitution: securing the NHS today for generations to come* www.dh.gov.uk/en/Healthcare/NHSConstitution/DH_093184

17   Darzi (Lord) (2008) *High Quality Care For All: NHS Next Stage Review Final Report*. DH www.dh.gov.uk/en/Publicationsandstatistics/ Publications/PublicationsPolicyAndGuidance/DH_085825

18   Office for National Statistics (2001) *Psychiatric Morbidity among Adults living in Private Households, 2000* www.statistics.gov.uk/ downloads/theme_health/psychmorb.pdf

19   Sainsbury Centre for Mental Health (2003) *The Economic and Social Costs of Mental Illness* www.scmh.org.uk/pdfs/costs_of_mental_ illness_policy_paper_3.pdf

20   DH (2009) *Departmental Report 2009: The Health and Personal Social Services Programmes* www.officialdocuments.gov.uk/ document/cm75/7593/7593.pdf

21   DH (2008) *Children and Young People in Mind: The Final Report of the National CAMHS Review* www.dh.gov.uk/en/ Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/ DH_090399

22   Marmot M, Friel S, Bell R et al. 'Closing the Gap in a Generation, Health Equity Through Actions on the Social Determinants of Health'. *The Lancet* 372(9650): 1161–1169

23   Green H, McGinnity A, Meltzer H et al. (2004) *Mental Health of Children and Young People in Great Britain 2004*. London: Office for National Statistics

24   NHS Information Centre (2007) *Adult Psychiatric Morbidity in England, 2007: results of a household survey*

25   Meads C, Pennant M, McManus J et al. (2009) *A Systematic Review Of Lesbian, Gay, Bisexual And Transgender Health in the West Midlands Region of the UK Compared to Published UK Research*. University of Birmingham, Department of Public Health and Epidemiology Report Number 71. West Midlands Health Technology Assessment Collaboration

26   Healthcare Commission (2009) *Equality in Later Life: A National Study of Older People's Mental Health Services*. www.cqc.org.uk/_db/ _documents/Equality_in_later_life.pdf

27   Pressman S and Cohen S (2005) 'Does positive affect influence health?' *Psychol Bull* 131(6):925–971

28   Royal College of Psychiatrists (2005) *Who Cares Wins: Improving the Outcome for Older People Admitted to the General Hospital*

29   Disability Rights Commission (2005) *Equal Treatment – Closing the Gap* report

30   The Future Vision Coalition (2008) *A Future Vision for Mental Health* www.newvisionformentalhealth.org.uk

31   DH (2009) *Healthy Lives, Brighter Futures: The Strategy for Children and Young People's Health* www.dh.gov.uk/en/ Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance_ DH_094400

32   AESOP (2006) Aetiology and Ethnicity in Schizophrenia and Other Psychoses. Institute of Psychiatry www.iop.kcl.ac.uk/departments/?locator=398&contest=997

33   Healthcare Commission (2007) Count Me In Censuswww.cqc.org.uk/_db/_documents/Count_me_in_2007.pdf

34   *Moving Forwards: Pathways to Better Mental Health and Well-Being* (2008), a report produced by the Chairs of the NHS Next Stage Review Mental Health Care Pathway Groups www.rcpsych.ac.uk/pdf/Moving%20Forwards%20Report.pdf

35   Shepherd G, Boardman J and Slade M (2008) *Making Recovery a Reality.* The Sainsbury Centre for Mental Health www.scmh.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf

36   DH (2008) *Carers at the Heart of 21st-century Families and Communities* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345

37   Cabinet Office (2009) *Reaching Out: Think Family.* Social Exclusion Task Force www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk_reaching_out_summary.aspx

38   DH (2007) *Mental Health: New Ways of Working for Everyone – Developing and sustaining a capable and flexible workforce* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490

39   Richards M and Abbott R (2009) *Childhood Mental Health and Life Chances in Post-War Britain. Insights from Three National Birth Cohort Studies.* The Smith Institute www.smith-institute.org.uk/pdfs/life_chances_report.pdf

40   Kim-Cohen J, Caspi A, Moffit T et al. (2003) 'Prior Juvenile Diagnoses in Adults with Mental Disorder'. *Arch Gen Psychiatry* 60:709–717

41   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'. *Arch Gen Psychiatry* 62:593–602

42   Meltzer H, Gatward R, Corbin T et al. (2003) *Persistence, Onset, Risk Factors and Outcomes of Childhood Mental Disorders.* Office for National Statistics www.statistics.gov.uk/downloads/theme_health/PMA-ChildPersist.pdf

43   Green H, McGinnity A, Meltzer H et al. (2005) *Mental Health of Children and Young People in Great Britain.* Office for National Statistics www.statistics.gov.uk/downloads/theme_health/GB2004.pdf

44   Fergusson D, Harwood L, Ridder E et al. (2005) 'Sub-threshold Depression in Adolescence and Mental Health Outcomes in Adulthood'. *Arch Gen Psychiatry* 62:66–72

45   Stewart-Brown S (2005) 'Mental Health Promotion: Childhood Holds the Key?' *Public Health Medicine* 5(3):96–104

46   Collishaw S, Maughan B, Goodman R et al. (2004) 'Time Trends in Adolescent Mental Health'. *J Child Psychol Psychiatry* 45(8):1350–1362

47   NICE (2006) Technology Appraisals: Conduct disorder in children – parent-training/education programmes in the management of children with conduct disorders and implementation advice www.nice.org.uk/TA102

48   Odgers C, Milne B, Caspi A et al. (2007) 'Predicting Prognosis for the Conduct-Problem Boy: Can Family History Help?' *J Am Acad Child Adolesc Psychiatry* 46(10):1240–1249

49   Kendrick D, Barlow J, Hampshire A et al. (2007) 'Parenting Interventions for the Prevention of Unintentional Injuries in Childhood'. *Cochrane Database Syst Rev* 2007(4):CD006020

50   Tennant R, Goens C, Barlow J et al. (2007) 'A Systematic Review of Reviews of Interventions to Promote Mental Health and Prevent Mental Health Problems in Children and Young People'. *Public Mental Health* 6(1):25-32

51   Barlow J and Coran E (2004) 'Parent-training Programmes for Improving Maternal Psychosocial Health'. *Cochrane Database Syst Rev* 2004(1):CD002020

52   Karoly L, Greenwood P, Everingham S et al. (1998) *Investing in our Children: What We Know and Don't Know about the Costs and Benefits of Early Childhood Interventions.* California: Rand Publications

53   Karoly L, Kilburn M and Cannon J (2005) *Early Childhood Interventions: Proven Results, Future Promises.* Retrieved 6 May 2009 from www.rand.org/pubs/monographs/MG341

54   Romeo R, Knapp M and Scott S (2006) 'Economic Cost of Severe Antisocial Behaviour in Children – and Who Pays It'. *Brit J Psychiat* 188:547–553

55   Friedli L and Parsonage M (2007) *Mental Health Promotion: Building an Economic Case.* Belfast: Northern Ireland Association for Mental Health

56   DH (2004) *Every Child Matters: Change for Children in Health Services* http://publications.everychildmatters.gov.uk/eOrderingDownload/DH-4153.pdf.pdf

57   DH (2004) National Service Framework for Childrenwww.dh.gov.uk/en/Healthcare/Children/DH_108

58   Children Act 2004www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1

59   O'Connor T, Heron J, Golding J et al. (2003) 'Maternal Antenatal Anxiety and Behavioral/Emotional Problems in Children: A Test of a Programming Hypothesis'. *J Child Psychol Psychiatry* 44(7):1025–1036

60   Bergman K, Sarkar P, O'Connor T et al. (2007) 'Maternal Stress During Pregnancy Predicts Cognitive Ability and Fearfulness in Infancy'. *J Am Acad Child Adolesc Psychiatry* 46(11):1454–1463

61   NICE Clinical Guideline 45 (2007) Antenatal and postnatal mental health: clinical management and service guidance http://guidance.nice.org.uk/CG45

62   NESS Research team (2008) *The Impact of Sure Start Local Programmes on Three Year Olds and their Families.* Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London

63   Nelson G, Westhuis A and Mcleod J (2003) 'A Meta-analysis of Longitudinal Research on Preschool Prevention Programmes for Children'. *Prevention and Treatment* 6:31

64   Barry M and Jenkins R (2006) *Implementing Mental Health Promotion.* London: Churchill Livingstone

65   Sylva K, Melhuish E, Sammons P et al. (2008) Final Report of the Effective Pre-School and Primary Education 3–11 Project (EPPE 3–11) www.dcfs.gov.uk/research/data/uploadfiles/DCFS-RB061.pdf

66   Schweinhart L, Montie J, Xiang Z et al. (2005) 'Lifetime effects: The HighScope Perry Preschool Study through Age 40'. Monographs of the HighScope Educational Research Foundation, 14. Ypsilanti, Michigan: HighScope Press www.highscope.org/file/Research/PerryProject/3_specialsummary%20col%202006%2007.pdf

67   Payton J, Weissburg B, Duslack J et al. (2008) *The Positive Impact of Social and Emotional Learning for Kindergarten to Eighth-grade Students.* Chicago, Illinois: Collaborative for Academic, Social and Emotional Learning

68   WHO (2007) *Mental Well-being in School-aged Children in Europe: Associations with Social Cohesion and Socioeconomic Circumstances* www.euro.who.int/document/sed/hbsc_forum_2007_mental_well-being.pdf

69   Jané-Llopis E, Barry M, Hosman C et al. (2005) 'Mental Health Promotion Works: A Review'. *Promotion and Education* 2:9–25

70   Read J, Hammersley P and Rudegeair T (2007) 'Why, When and How to Ask about Childhood Abuse'. *Adv Psychiatr Treat* 13:101–110

71   DH (2002) *Women's Mental Health: Into the Mainstream* www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4075478

72   Finkelhor D (1994) 'The International Epidemiology of Child Sexual Abuse'. *Child Abuse Neglect* 18(5):409–417

73   Morley R and Mullender A (1994) 'Domestic Violence and Children: What We Know from Research'

74   Mullender A and Morley R (1994) *Children Living with Domestic Violence: Putting Men's Abuse of Women on the Childcare Agenda.* London: Whiting and Birch Ltd

75   Fazel S, Benning R and Danesh J (2005) 'Suicides in Male Prisoners in England and Wales, 1978–2003'. *The Lancet* 366(9493):1301–1302

76   Scott S (2008) 'Conduct disorders in childhood and adolescence'. Chapter in Gelder M, Lopez-Ibor J, Andreason N et al. (eds) *New Oxford Textbook of Psychiatry* (2nd edition). Oxford: Oxford University Press

77   Woolfenden S, Williams K and Peat J (2001) 'Family and Parenting Interventions in Children and Adolescents with Conduct Disorder and Delinquency aged 10–17' *Cochrane Database Syst Rev* 2009(3):CD003015 www.cochrane.org/reviews/en/ab003015.html

78   DH (2009) *Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

79   Moore T, Zammit S, Lingford-Hughes A et al. (2007) 'Cannabis Use and Risk of Psychotic or Affective Mental Health Outcomes: A Systematic Review'. *The Lancet* 370(9584):319–328

80   NICE Clinical Guideline 28 (2005) Depression in children and young people: Identification and management in primary, community and secondary care. NICE Technology Appraisal 102 (2006) Parent-training/educational programmes in the management of children with conduct disorders. NICE Clinical Guideline 72 (2008) Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults

81   Storey P and Smith M (2008) *Methods and Approaches to Improving the Emotional Health and Well-being of Children: A Briefing Paper Concerning Inteventions to Prevent Internalising Disorders.* London: Institute of Education, University of London

82   Wells N and Evans G (2003) 'Nearby Nature: A Buffer of Life Stress among Rural Children'. *Environ Behav* 35(3):311–330

83   Mitchell R and Popham F (2008) 'Effect of Exposure to Natural Environment on Health Inequalities: An Observational Population Study'. *The Lancet* 372(9650):1655–1660

84   Greenspace (2008)www.green-space.org.uk

85   Singh S, Paul M, Ford T et al. (2008) 'Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK Study): A Study of Protocols in Greater London'. *BMC Health Serv Res* 8:135

86   Singh S (2009) Findings from the TRACK study, presentation at the symposium 'Bridging the Divide: Transition of Care from CAMHS to Adult Mental Health Services', 30 April 2009, Birmingham Botanical Gardens

87   DH (2009) *Attitudes to Mental Illness: 2009 Research Report* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_100345

88   Mind Campaign, Get it Off Your Chestwww.mind.org.uk/News+policy+and+campaigns/Campaigns/Men+and+mental+health/

89   Safe units for alcoholhttp://units.nhs.uk

90   Sainsbury Centre for Mental Health (2007) *Mental Health at Work: Developing the Business Case* www.scmh.org.uk/pdfs/mental_health_at_work.pdf

91   The Government's Response to Dame Carol Black's Review (2008) *Improving Health and Work: Changing Lives* www.workingforhealth.gov.uk/Government-Response/

92   DH (2008) *Mental Health and Ill Health in Doctors* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083066

93   Bartley M (2006) *Capability and Resilience: Beating the Odds* ESRC Human Capability and Resilience Research Network. London: UCL Department of Epidemiology and Public Health www.ucl.ac.uk/capabilityandresilience

94   Fagg J, Curtis S, Stansfeld S et al. (2006) 'Psychological Distress Among Adolescents, and its Relationship to Individual, Family and Area Characteristics in East London'. *Soc Sci Med* 63(3):636–648

95   Sacker A and Schoon I (2007) 'Educational Resilience in Later Life: Resources and Assets in Adolescence and Return to Education after Leaving School at Age 16'. *Soc Sci Res* 36(3):873–896

96   DH and Arts Council England (2007) *A Prospectus for Arts and Health* www.artscouncil.org.uk/publications/publication_detail.php?sid=27&id=581

97   Staricoff R (2004) *Arts in Health: A Review of the Medical Literature.* London: Arts Council England www.artscouncil.org.uk/documents/publications/php7FMawEdoc

98   DH (2007) *Report of the Review of Arts and Health Working Group* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073590

99   Housing Associations' Charitable Trust (2006) *An Opportunity Waiting to Happen: Housing Associations as 'Community Anchors'* www.hact.org.uk/uploads/BCAN_summary_final_A4_website.pdf

100   DH (2005) *Delivering Race Equality in Mental Health Care* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

101   Goff D, Sullivan L, McEvoy J et al. (2005) 'A Comparison of Ten-year Cardiac Risk Estimates in Schizophrenia Patients from the CATIE Study and Matched Controls'. *Schizophr Res* 80(1):45–53

102   DH (2006) *Long-term Conditions and Depression: Considerations for Best Practice in Practice Based Commissioning* http://icn.csip.org.uk/_library/Long-term_conditions_and_depression_PBC.pdf

103   NICE Clinical Guideline 82 (2009) Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update) www.nice.org.uk/guidance/index. jsp?action=byID&o=11786

104   Coulthard M, Farrell M, Singleton N et al. (2002) *Tobacco, Alcohol and Drug Use and Mental Health.* Office for National Statistics www.statistics.gov.uk/downloads/theme_health/tobacco_etc_v2.pdf

105   Simon G, Katon W, Lin E et al. (2005) 'Diabetes Complications and Depression as Predictors of Health Service Costs'. *Gen Hosp Psychiatry* 27(5):344–351

106   Prince M, Harwood R, Blizard R et al. (1997) 'Impairment, Disability and Handicap as Risk Factors for Depression in Old Age'. *Psychol Med* 27:311–321

107   Jenkins R, Bhugra D, Bebbington P et al. (2008) 'Debt, Income and Mental Disorder in the General Population'. *Psychol Med* 10:1–9

108   Money Advice Liaison Group (2007) *Mental Health Awareness Guidelines* Money Advice Trust www.moneyadvicetrust.org/images/ DMHEF_guidance_notes_(09_07_19c).pdf

109   Fitch C et al. (2009) *Final Demand: Debt and Mental Health* (2nd edition). Royal College of Psychiatrists www.rcpsych.ac.uk/pdf/ final%20demand%20-&20compact.pdf

110   DH (2002) *National Suicide Prevention Strategy for England* www.dh.gov.uk/en/Publicationsandstatistics/Publications/ PublicationsPolicyandGuidance/DH_4009474

111   National Institute for Mental Health in England (2008) *National Suicide Prevention Strategy Annual Report 2007* www.nmhdu.org.uk/ silo/files/national-suicide-prevention-strategy-for-england-annual-report-2007.pdf

112   Steptoe A and Feldman P (2001) 'Neighborhood Problems as Sources of Chronic Stress'. *Ann Behav Med* 23(3):177–185

113   Krueger P, Bond H, Rogers R et al. (2004) 'Neighbourhoods and Homicide Mortality: An Analysis of Race/Ethnic Differences' *J Epidemiol Community Health* 58(3)223–230

114   World Health Organization (1996) *Violence Against Women*. Geneva: WHO

115   World Bank (1993) *World Development Report 1993*: *Investing in Health*. Washington, DC: World Bank

116   Gold J (1998) 'Gender Differences in Psychiatric Illness and Treatments: A Critical Review'. *J Nerv Ment Dis* 186(12):769–775

117   Coll X, Law F, Tobas A et al. (2001) 'Abuse and Deliberate Self-Poisoning in Women: A Matched Case-control Study'. *Child Abuse Neglect* 25(10):1291–1302

118   Hawton K and Fagg J (1988) 'Suicide, and Other Causes of Death, Following Attempted Suicide'. *Brit J Psychiat* 152:359–366

119   Home Office (2008) *Saving Lives. Reducing Harm. Protecting the Public: An Action Plan for Tackling Violence 2008–11* www.homeoffice.gov.uk/documents/violent-crime-action-plan-08/

120   Home Office (2008) *Youth Crime Action Plan* www.homeoffice.gov.uk/documents/youth-crime-action-plan/

121   Home Office (2009) *Together We Can End Violence Against Women: A Consultation* www.homeoffice.gov.uk/documents/cons-2009-vaw/

122   NICE Clinical Guidance 26 (2005) The management of post-traumatic stress disorder (PTSD) in adults and children in primary and secondary care www.nice.org.uk/CG26

123   Peterson L, Jeppesen P, Thorup A et al. (2005) 'A Randomised Multicentre Trial of Integrated versus Standard Treatment for Patients with a First Episode of Psychotic Illness'. *Brit Med J* 331(7517):602

124   McCrone P, Dhanasiri S, Patel A et al. (2008) *Paying the Price: theCost of Mental Health Care in England to 2026.* London: The King's Fund

125   McGorry P (2009) 'Is Early Intervention in the Major Psychiatric Disorders Justified? Yes'. *Brit Med J*, 337:a695

126   CSIP/NIMHE (2008) *3 Keys to a Shared Approach in Mental Health Assessment* www.3keys.org.uk/downloads/3keys.pdf

127   DH Common Assessment Framework for Adults Consultation www.dh.gov.uk/caf

128   DH Care Programme Approach (2008)www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083650

129   National Audit Office (2007) *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services* www.nao.org.uk/publications/nao_reports/07-08/07085.pdf

130   DH Hospital Episode Statistics (National statistical data warehouse) www.dh.gov.uk/en/Publicationsandstatistics/Statistics/HospitalEpisodeStatistics/DH_576

131   Star Wards (service user led charity)http://starwards.org.uk/

132   Royal College of Psychiatry Accreditation for Inpatient Mental Health Services www.rcpsych.ac.uk/crtu/centreforequalityimprovement/aims.aspx

133   Checklist underpinning the National Suicide Strategy (seewww.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/about/keyfindings/saferservice/)

134   Department for Work and Pensions figures

135   Bond G (2004) 'Supported Employment: Evidence for an Evidence-based Practice'. *Psychiat Rehabil J* 27:345–359

136   The IBSEN Project (2009) Evaluation of the Individual Budgets Pilot Programme Final Report www.york.ac.uk/inst/spru/pubs/pdf/IBSEN.pdf

137   National Patient Safety Agency (2009) *Preventing Harm to Children from Parents with Mental Health Needs.* Rapid response report www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/preventing-harm-to-children-from-parents-with-mental-health-needs/

138   DH (2005) *Chief Nursing Officer's Review of Mental Health Nursing: Summary of Responses* www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4130976

139   Coid J and Yang M (2006) 'Prevalence and Correlates Of Personality Disorder in Great Britain'. *Brit J Psychiat* 188:423–431

140   Casey P (2000) 'The Epidemiology of Personality Disorders'. In Tyrer P (ed) *Personality Disorders: Diagnosis, Management and Course*. London: Wright

141   Singleton N, Meltzer H, Gatward R et al. (1998) *Psychiatric Morbidity Among Prisoners in England and Wales.* Office for National Statistics

142   Moran P (2002) 'The Epidemiology of Personality Disorders'. *Psychiatry* 1(1):8–11

143   NICE Clinical Guideline 78 (2009) Borderline Personality Disorder: Treatment and Management www.nice.org.uk/Guidance/CG78

144   NICE Clinical Guideline 9 (2004) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders http://guidance.nice.org.uk/CG9

145   NICE Clinical Guideline 72 (2008) Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults http://guidance.nice.org.uk/CG72

146   NICE Clinical Guideline 22 (2004) Anxiety: Management of anxiety in adults in primary, secondary and community care www.nice.org.uk/CG22

147   NICE Clinical Guideline 23 (2004) Depression: Management of depression in primary and secondary care www.nice.org.uk/CG23

148   Office for National Statistics figures (2006)

149   DH (2001) *National Service Framework for Older People* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

150   Philpot M and Banerjee S (1997) 'Mental Health Services for Older People in London'. In *London's Mental Health* (eds Johnson S, Ramsey R, Thornicroft G et al.), pp 46–62. London: King's Fund

151   Age Concern (2007) *Improving Services and Support for Older People with Mental Health Problems* www.ageconcern.org.uk/Age-Concern/EB83A4F3BC064055A82E5C4C7037EB0B.asp

152   DH Dignity in Care Campaign, wwwdhcarenetworks.org.uk

153   DH (2009) The National Dementia Strategywww.dh.gov.uk/en/ Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/ DH_094058

154   Cooper R (2008) *The Impacts of the Physical Environment on Mental Capital and Well-being: Ideas for the Physical Environment to Improve Mental Well-being in Older People*. Paper prepared for the Foresight report *Mental Capital and Well-being* www.foresightgov.uk

155   Aked J, Marks N, Cordon C et al. (2008) *Five Ways to Well-being: The Evidence*. Paper prepared for the Foresight project www.foresight.gov.uk

156   Prince M, Harwood R, Blizard R et al. (1997) 'Social Support Deficits, Loneliness and Life Events as Risk Factors of Depression In Old Age'. *Psychol Med* 27:323–332

157   Equal Opportunties Commission (2006)

158   Green G and Gilbertson J (2008) *Warm Front, Better Health: Health Impact Evaluation of the Warm Front Scheme.* Sheffield: Centre for Regional, Economic and Social Research, Sheffield Hallam University

159   Foresight for Government Office for Science (2008) *Mental Capital and Well-being: Making the Most of Ourselves in the 21st Century* Chapter 6 (Summary of evidence)

160   DH (2005) *Everybody's Business: Integrated Mental Health Services for Older Adults*: *A Service Development* Practice Guide www.mentalhealthequalities.org.uk/silo/files/six-key-messages.pdf

161   Livingston G, Hawkins A, Graham N et al. (1990) 'The Gospel Oak Study: Prevalence Rates of Dementia, Depression and Activity Limitation among Elderly Residents in Inner London'. *Psychol Med* 20(1):137–146

162   Copeland J, Dewey M, Wood N et al. (1987) 'Range of Mental Illness among the Elderly in the Community. Prevalence in Liverpool using the GMS–AGECAT Package'. *Brit J Psychiat* 150:815–823

163   Harwood R, Prince M, Mann A et al. (1998) 'Associations between Diagnoses, Impairments, Disability and Handicap in a Population of Elderly People'. *Int J Epidemiol* 27(2):261–268

164   Ames D (1990) 'Depression among Elderly Residents of Local-authority Residential Homes. Its Nature and the Efficacy of Intervention'. *Brit J Psychiat* 156:667–675

165   Conwell Y (2001) 'Suicide in Later Life: A Review and Recommendations for Prevention'. *Suicide Life Threat Behav* 31(Suppl):32–47

166   Banerjee S (1993) 'Prevalence and Recognition Rates of Psychiatric Disorder in the Elderly Clients of the Community Care Service'. *Int J Geriatr Psych* 8:125–131

167   Prince M, Harwood R, Blizard R et al. (1997) 'Impairment, Disability and Handicap as Risk Factors for Depression in Old Age'. *Psychol Med* 27:311–321

168   Bajekal M (2002) *Health Survey for England 2000: Characteristics of Care Homes and their Residents.* London: TSO

169   Ames D (1990) 'Depression among Elderly Residents of Local-authority Residential Homes. Its Nature and the Efficacy of Intervention'. *Brit J Psychiat* 156:667–675

170   Ballard C, Gauthier S, Cummings J et al. (2009) 'Management of Agitation and Aggression Associated with Alzheimer disease'. *Nat Rev Neurol* 5(5):245–255

171   DH/CSIP (2009) *Age Equality: What Does it Mean for Older People's Mental Health Services?* Guidance note on age equality www.mentalhelathequalities.org.uk/silo/files/everybodys-business-age-equality-guidance-.pdf

172   Age Concern (2006) *Promoting Mental Health and Well-being in Later Life: A First Report from the UK Inquiry into Mental Health and Well-being in Later Life* www.ageconcern.org.uk/AgeConcern/Documents/Inquiry_report_Promoting_mental_health_and_well-being_in_later_life_-_FINAL.pdf

173   DH (2001) *National Service Framework for Older People* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

174   Royal College of Psychiatrists (2005) *Who Cares Wins: Improving the Outcome for Older People Admitted to the General Hospital*

175   National Audit Office (2007) *Improving Services and Support for People with Dementia*. London: TSO

176   Banerjee S and Wittenberg R (2009) 'Clinical and Cost Effectiveness of Services for Early Diagnosis and Intervention in Dementia'. *Int J Geriatr Psych* 24(7):748–754

177   Communities and Local Government (2008) *Communities in Control: Real People, Real Power* www.communities.gov.uk/documents/communities/pdf/886045.pdf

178   DH (2009) *Post-2010 Strategic Review of Health Inequalities* (The Marmot Review) www.dh.gov.uk/en/Publichealth/healthinequalities/DH_094770

179   Parks J, Svendsen D, Singer P et al. (2006) *Morbidity and Mortality in People with Serious Mental Illness*. National Association of State Mental Health Program Directors (USA), 13th technical report www.nasmhpd.org

The consultation process

This consultation will begin on 23 July 2009 and will run until 15 October 2009, and we welcome all comments on the contents of the consultation document.

How to respond

There are different ways to comment. You can:

• use the online questionnaire at
  www.info.doh.gov.uk/questionnaire/newhorizons.nsf
  to give us your views, and/or

• post comments to:
  New Horizons Programme Administrator
  Mental Health Division
  Wellington House
  133–155 Waterloo Road
  London SE1 8UG

Your views will be fed into the process of preparing the final document.

Extra copies

Further paper copies of this consultation can be obtained from:

DH Publications Orderline
PO Box 777
London SE1 6XH
Email: dh@prolog.uk.com
Tel: 0300 123 1002
Fax: 01623 724 524
Textphone: 0300 123 1003 (8am to 6pm, Monday to Friday)

and it is also available online at:
www.dh.gov.uk/mentalhealth

Easy read and translated versions of this consultation document are available from the above address.

Summary of the response to the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at
www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter**.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Criteria for consultation

This consultation follows the Government Code of Practice. In particular we aim to:

- formally consult at a stage where there is scope to influence the policy outcome

- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible

- be clear about the consultation process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals

- ensure that the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach

- keep the burden of consultation to a minimum to ensure that consultations are effective and to obtain consultees' 'buy-in' to the process

- analyse responses carefully and give clear feedback to participants following the consultation

- ensure that officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice
www.berr.gov.uk/whatwedo/bre/consultation-guidance/page44420.html

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Co-ordinator
Department of Health
3E48 Quarry House
Leeds LS2 7UE

or email consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Consultation questions

Please reply to as many of these questions as possible. We encourage responses from anyone interested in the issues raised in this document.

We would find it particularly helpful for you to refer to any research or evaluation evidence that supports your views. We would also like to hear more about proven measures in place in your local area which bring measurable benefits to your own community.

If you need more room to answer any of the following questions, please continue on a separate sheet, clearly marking the question number.

1. What do you think are the three most important changes for mental health and mental health care in the next 10 years? And why?

2. Do you support the twin themes of public mental health/prevention and mental health service development? Please explain your views, giving examples if possible.

3. Are the guiding values described in section 1 the right ones? Please explain your view giving examples, if possible.

4. What should the Government do to promote more personalised services for people with mental health problems and their families? It would be helpful to hear about both what works in your area, and, if appropriate, what does not and what could be done in the future.

5. In your view, which are the most important areas in mental health services where value for money could be improved? And how should that be done? If possible, please indicate examples of the current costs of services and areas where the potential savings might exist.

6. Which areas can you identify where innovative technology can help people with mental health problems, and their families? It would be particularly helpful to hear about examples of what works well in your local area and what could be done in the future.

7. In your view, where are the current gaps in research evidence supporting the development of New Horizons?

8. How can we support local leadership in building mental well-being and mental health care services? Please explain your view giving examples, if possible.

9. How can we promote joint working between local authorities, the NHS and others to make New Horizons effective in your local area?

10. What do you think are the most important steps that the Government can take to reduce the inequalities that affect our mental health? And why?

11. How best can we improve a) the transition from child and adolescent mental health services to adult services, and b) the interface between services for younger and older adults? What works well in your local area? And what does not?

12. In your view, what more should the Government do to combat stigma?

You do not have to complete the sections about your personal background if you prefer not to. However the information is confidential and will only be used to assess whether the responses we receive represent a balanced cross-section of views from across society.

Name:

_____

If you are responding on behalf of an organisation or interest group, please indicate the name of the organisation:

_____

Respondent's role within the organisation:

_____

Gender

☐ Female ☐ Male ☐ Transgendered ☐ Rather not say

How old are you?

☐ Under 18 ☐ 18-24 ☐ 25-34 ☐ 35-54
☐ Over 55 ☐ Rather not say

Ethnicity:

☐ White – British   ☐ Asian/Asian British – Pakistani
☐ White – Irish   ☐ Asian/Asian British – Bangladeshi
☐ White – Other   ☐ Asian/Asian British – Other
☐ Mixed – White and Black Caribbean   ☐ Black/Black British – Caribbean
☐ Mixed – White and Black African   ☐ Black/Black British – African
☐ Mixed – White and Asian   ☐ Black/Black British – Other
☐ Mixed – Other   ☐ Chinese
☐ Asian/Asian British – Indian   ☐ Other

(other: please specify below)

_____

Do you consider yourself as a person with a disability?
☐ Yes ☐ No

(If yes, please specify)

_____

Would you say that you have experienced mental health problems, either recently or in the past?
☐ Yes ☐ No

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