



Department
of Health

Closing the Gap: Priorities for essential change in mental health

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Closing the gap: priorities for essential change in mental health

Prepared by the Department of Health

Foreword

In our mental health strategy, *No Health Without Mental Health*, we set ourselves – and society as a whole – some big challenges. We stated that mental health must have equal priority with physical health, that discrimination associated with mental health problems must end and that everyone who needs mental health care should get the right support, at the right time. We made it clear that tackling premature mortality of people with mental health problems is a priority. And we recognised that more must be done to prevent mental ill health and promote mental wellbeing.

We stand firmly behind that strategy, and the principles which underpin it – and two years on, the foundations have been laid. In many local areas, there have been real changes to the quality and availability of mental health services. Through the Time to Change campaign, led by Mind and Rethink Mental Illness, discrimination against people with mental health problems has decreased.

Mental health is moving up the policy agenda across government. Working together to improve outcomes for people with mental health problems is therefore a major policy priority for many government departments; from unemployment to policy on tackling gang culture.

All too often, for example, poor mental health precipitates premature job loss. This is a waste for individuals and for the economy. In addition, we know that not having a job is too often associated with the onset or recurrence of mental health problems and being out of or away from work can sustain the symptoms of mental ill health. Effective support requires a joined-up approach between health and employment services and supportive action by employers.

Mental health was at the heart of the first Mandates to NHS England and Health Education England which set out the Government's objectives for these organisations. It is also at the heart of the new public health system: mental health is firmly included within local government responsibilities for improving public health. Work led by Public Health England to promote good mental health, prevent mental ill health and improve wellbeing will help make a reality of these ambitions.

These are all hugely positive changes. But many people would, we are sure, agree with our view that things are not changing fast enough. We are not yet making enough of a difference to enough people.

People who use mental health services, and those that care for them, continue to report gaps in provision and long waits for services. There is still insufficient support within communities for people with mental health problems. In some areas there have been stories of people of all ages being transferred sometimes hundreds of miles to access a bed. We are not yet making an impact on the enormous gap in physical health outcomes for those with mental health problems. And so much more could be done to promote good mental health and prevent mental ill health.

We know that in tough financial times, funding for mental health at a local level can get squeezed. We are determined that it does not. We need to see funding channelled in the right direction to bring benefits across a number of areas, from education and employment to criminal justice and beyond.

That's why we are challenging the health and social care community to go further and faster to transform the support and care available to people with mental health problems – both children and adults. And we are challenging the public health community, with local government in the lead, to help give mental health and wellbeing promotion and prevention the long overdue attention it needs and deserves.

This document sets out that challenge. It identifies 25 aspects of mental health care and support where government – along with health and social care leaders, academics and a range of representative organisations – expect to see tangible changes *in the next couple of years*: changes that will directly affect millions of lives for the better.

The 25 areas we have highlighted here are in no way the full extent of our ambition for change; that can be found in the strategy. They are, however, all priorities for action and progress in the next couple of years.

Achieving that progress is something we cannot do alone. It requires not only the commitment of those working within the system, but also support and engagement across all of society. From the way that mental health is covered in the media, to how it is addressed in schools, to the response of families and friends, we can all do more to improve the lives of people with mental health problems and to promote wider mental wellbeing.

We know there is a real hunger for change – not only amongst those who suffer from mental health problems, but also amongst those who work to support them.

Together, we can accelerate the pace of change in both services and attitudes – transforming the lives of people with mental health conditions, and our communities, for the better.



A handwritten signature in black ink that reads "Nick Clegg".

The Rt Hon Nick Clegg MP
Deputy Prime Minister



A handwritten signature in black ink that reads "Norman Lamb".

Norman Lamb MP
Minister of State for Care and Support

Contents

Introduction	9
Increasing access to mental health services	10
1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need	10
2. We will lead an information revolution around mental health and wellbeing	11
3. We will, for the first time, establish clear waiting time limits for mental health services	12
4. We will tackle inequalities around access to mental health services	13
5. Over 900,000 people will benefit from psychological therapies every year.....	14
6. There will be improved access to psychological therapies for children and young people across the whole of England.....	15
7. The most effective services will get the most funding.....	16
8. Adults will be given the right to make choices about the mental health care they receive.....	16
9. We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor	17
10. We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children’s mental health services	17
11. Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients	18
12. Carers will be better supported and more closely involved in decisions about mental health service provision.....	19
Integrating physical and mental health care	20
13. Mental health care and physical health care will be better integrated at every level	20
14. We will change the way frontline health services respond to self-harm	21
15. No-one experiencing a mental health crisis should ever be turned away from services ...	22
Starting early to promote mental wellbeing and prevent mental health problems	24
16. We will offer better support to new mothers to minimise the risks and impacts of postnatal depression.	24
17. Schools will be supported to identify mental health problems sooner	25
18. We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18	26
Improving the quality of life of people with mental health problems	27
19. People with mental health problems will live healthier lives and longer lives.	27

20. More people with mental health problems will live in homes that support recovery28

21. We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided29

22. Anyone with a mental health problem who is a victim of crime will be offered enhanced support.....30

23. We will support employers to help more people with mental health problems to remain in or move into work.....30

24. We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work.....32

25. We will stamp out discrimination around mental health.....33

Mental health is everybody’s business.....35

Further information.....36

Introduction

In 2011, the government published its mental health strategy, *No health without mental health*. This set out our long-term ambitions for the transformation of mental health care – and more importantly, for a broad change in the way people with mental health problems are supported in society as a whole. The strategy was built around six unambiguous objectives:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

This document supports all of those objectives – just as it supports the mental health strategy implementation framework and suicide prevention strategy, published in 2012. But the principles and many of the programmes described in those documents are about long-term change, at the population level.

The actions in the implementation framework, many of which are underway, focus on how local partners can work to achieve the long-term objectives, and how national organisations can support and enable them. They are about organisational change, working together, using the resources available. They remain central to our direction and ambition.

How this document fits in

This document aims to bridge the gap between our long-term ambition and shorter-term action. It seeks to show how changes in local service planning and delivery will make a difference, in the next two or three years, to the lives of people with mental health problems.

It therefore sets out 25 areas where people can expect to see, and experience, the fastest changes. These are our priorities for action: issues that current programmes are beginning to address and where our strategy is coming to life.

Many are about mental health care and treatment, but others reflect the work done across the entire health and care sector, and indeed across government as a whole, to reduce the damaging impact of mental illness and improve mental wellbeing. In addressing these priorities, we will also continue to rely on the involvement of many partners across the voluntary sector – from national charities to local community groups.

More information

There is much more detailed information and evidence-based policy available about each of the 25 areas highlighted here, just as there is about our broader direction and long-term ambition.

Increasing access to mental health services

1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas, reflecting local need

We want to ensure that the right services are being commissioned in each local area, to reflect local need. That means not only making sure that there is a hospital bed available locally for every adult who needs one, but also offering high-quality, safe care in the community, that reflects what patients want and need and focuses on recovery.

So we are making sure commissioners – many of whom have less knowledge of mental health services than they do of physical health services – get the right information about what services are most effective at helping people recover, and what best looks like. The National Institute for Health and Care Excellence (NICE) has already published a wide range of quality standards around mental health, and is currently developing and reviewing several more. These will provide the core of the information available to commissioners. To give them further support, NHS England:

- has recently launched its mental health leadership programme for Clinical Commissioning Groups (CCGs);
- is working with relevant expert bodies to develop best practice specifications for commissioning specialist mental health services, for example for schizophrenia and bipolar disorder;
- is developing a range of clinical commissioning tools to support commissioners, including tools that will support integration of physical and mental health care.

Further guidance is provided by the Joint Commissioning Panel for Mental Health, a collaboration between seventeen leading organisations, co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners. It is focused on encouraging commissioners to use a values-based commissioning model, and is producing a wealth of practical guidance on what good services for mental illness, dementia and learning disabilities should look like.

To further build our understanding of psychosis and what best practice care is, in March 2014 we will hold a national summit on psychosis in partnership with Rethink Mental Illness. This will bring together a range of stakeholders to determine the best ways to support local commissioning of best practice care for psychosis and severe mental illness.

Integrated approaches to local commissioning also have an important role to play in promoting mental wellbeing and preventing mental illness, as part of the local Health and Wellbeing Strategy. Public Health England (PHE) is working to build up the evidence base around what kind of services and programmes are most effective.

Nationally PHE, NHS England and the Local Government Association will work together to develop resources that will support local authorities and CCGs in commissioning services to meet the needs of those in mental health crisis.

For example, PHE alcohol and drug teams will work with NHS England area teams, Local Authorities and CCGs to promote and support the commissioning of joined up mental health and substance misuse provision.

2. We will lead an information revolution around mental health and wellbeing

We need a truer, more up-to-date and more detailed picture of mental health and wellbeing nationally and in each area. This is essential to delivering measurable improvements in community and population mental health, service improvements, evidence-based commissioning and to changing attitudes to mental wellbeing. Until now, the quality and amount of information about mental health has lagged behind that about physical health.

We are therefore setting up a new national Mental Health Intelligence Network (MHIN), using a similar approach to the successful National Cancer Intelligence Network and Child and Maternal Health Intelligence Network. It will draw together comprehensive information about mental health and wellbeing to provide a greater insight into mental health problems, how they vary with age and in different parts of the country, and what the most pressing needs are in each area. It will also gather information about the services being provided – and how effective they are.

The information will be available to all, so that local people can see for themselves how their area is doing. But its main purpose will be to help local Health and Wellbeing Boards, CCGs and other partners to decide what types of health and social care services are needed in their area, and how they can improve the mix of services and support available.

We will also gather more information about mental health to let us know how we are doing on our promises in the NHS, Social Care and Public Health Outcomes Frameworks. These include a number of outcomes and measures around mental health and wellbeing. The information used to assess whether those outcomes have been achieved can be used in other ways too. And we will also measure our progress against the priority activities described in this document – reporting back next year.

Reviewing our outcomes frameworks is not just about checking on progress. It also gives us a good opportunity to check whether we are focusing on the right outcomes. The extra information we will gather will help us answer this question: where necessary we can add further outcomes. For example, we are currently investigating the development of an outcome indicator around recovery – working out what we can measure, and how.

The Department of Health has developed a Mental Health Dashboard which tracks the key measures that already exist and highlights the priority outcomes from the outcome

frameworks. This will be used to support overall strategy and policy development, as well as to make sure everyone can see what is happening.

All of these national level actions need to be backed by improvements in information sharing locally, between services. We know there is a lot of effort in many areas to address this: it is the essential foundation of a more personalised, joined-up response from public services to people with mental health problems.

With this new emphasis on information about mental health, we will have a clearer picture of how things are, how they can improve, and what services are available – which will, in turn – drive improvements in care.

Building information about mental wellbeing

Arguably the most ambitious part of our strategy is our determination to promote and sustain good mental health for all, and to prevent mental health problems developing. Alongside the MHIN, we are also launching a new programme of work, led by PHE, that will gather information around mental health and wellbeing and what affects them. This will help build our understanding of what can be done to promote and retain good mental health, prevent mental health problems and improve the health and wellbeing of those living with and recovering from mental illnesses.

In early 2014, PHE will publish a framework for action and a series of information briefings based on the existing evidence that set out what the new public health system can do to help improve the public's mental health as part of wider work on improving health and wellbeing.

3. We will, for the first time, establish clear waiting time limits for mental health services

Far too many people of all ages wait too long to get the mental health services they need. The longer they wait for support, the more likely it is their condition gets worse. This has to change. The Mandate to NHS England sets out our commitment to put mental health on a par with physical health, where there are already well-established standards for access to services. A commitment to access and/or waiting times standards for mental health services is critical to achieving parity of esteem for mental health services.

NHS England is currently gathering information about access to and waiting times for adult mental health services around the country, and whether any particular groups of people experience longer waits or poorer access than others.

Based on this information, we will then set new national standards that focus on improving access to adult mental health services. These will be introduced starting in 2015, and cover access to or waiting times for services. We will also work with a range of partners to identify the most effective ways to ensure those standards are met.

But we expect waiting times to be reduced long before the standards come into effect – and for children and young people’s mental health services, as well as for adult services. For example, in recent years we have invested in a dedicated transformation programme for children and young people’s services – enhancing access to evidence-based therapies. The 2013 Mandate to NHS England sets a new expectation that this should extend across the whole country, delivering a nationwide service transformation of children and young people’s mental health services. We expect this to further improve children and young people’s access to evidence-based, outcome-monitored therapies to a level comparable with the standards set for adult services.

We will publish data gathered by NHS England so that everyone can see clearly the waiting times for different services and in different areas. This in itself should act as a catalyst for change.

4. We will tackle inequalities around access to mental health services

Simply making services available is not enough. We are also looking at ways to overcome inequalities around service usage – and around the outcomes those services achieve.

For example, evidence shows that people from black and minority ethnic (BME) communities have to date been less likely to use psychological therapies. We are working with the Race Equality Foundation and other stakeholders to try and understand why this is the case and to understand inequalities around access to other services. NHS England are also working with BME community leaders to encourage more people to use psychological therapies.

We also know that older people typically access mental health services less frequently than their working age counterparts. Again, we are seeking to understand why, so we can address this. For instance, only 6% of people who used psychological therapies were over 65: in response, we supported an advertising campaign delivered through Age UK and Carers UK that aimed to raise awareness amongst older people that they could use psychological therapies. We have also developed a new curriculum for psychological therapists that train them to work better with older people.

Work is already underway to address the stigma of mental health problems in different communities – particularly those who experience disproportionately high levels of mental illness, or those where the stigma of mental illness remains most significant. For example, the Time to Change campaign is launching a pilot project to support young African and Caribbean men, with the aim of reducing the stigma and discrimination experienced in statutory services. We will monitor the impact of this and apply the lessons learned in other areas.

In addition, we know that offenders and ex-offenders are disproportionately affected by mental health problems. Whilst liaison and diversion schemes will go some way to ensuring that offenders access mental health services, we need to ensure that services are in place for any section of the population that are affected by mental health issues, including ex-offenders.

Ensuring veterans have access to the services and support they need

The Armed Forces Covenant requires, "... that those injured in service, whether mentally or physically, should be cared for in a way which reflects the Nation's moral obligations to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving service, they should be able to access services with health professionals who have an understanding of armed forces culture."

The Government's mandate to NHS England requires the NHS and its public sector partners to help one another to achieve their objectives. This includes, in particular, demonstrating progress against the Armed Forces Covenant.

Dr Andrew Murrison's report on access to mental health services to the Armed Forces and Veterans '*Fighting Fit*' made a number of recommendations to meet the needs of the Armed Forces community. The Department of Health, MoD, NHS England, together with service charities such as Combat Stress, Royal British Legion, Help for Heroes and others have worked in partnership to deliver services against the recommendations made by Dr Murrison. The priority over the coming 18 months is to ensure that the services put in place are evaluated, so further services can be commissioned beyond the end of the current spending review. Subject to the evaluation, these will include:

- commissioning of veterans' mental health teams across the country;
- provision of an online mental health counselling service;
- provision of a National Veteran's Mental Health Network, Veteran's Information;
- a service and e-learning package for GPs.

The Department of Health will work with NHS England and others to help achieve this.

5. Over 900,000 people will benefit from psychological therapies every year

Psychological therapies work. In the last three years alone, they have helped more than 45,000 people to recover from and cope with mental health problems so that they can come off benefits and return to work. They help many people manage long-term mental health problems day-to-day; they are also a key means of early intervention. Many GPs want to be able to direct patients – including children and young people – to relevant psychological therapies at an early stage, as a way of preventing the deterioration of mental health.

We have already committed over £450 million to improve access to NICE-approved psychological therapies. We have asked Health Education England (HEE) to make sure that enough therapists are trained. We have shared best practice for delivering these therapies to children and young people. We are also exploring how psychological therapies can be used to help with severe mental illness and personality disorders – as part of a wider programme of care – and looking at how they can be integrated into care for people who have depression or anxiety that is related to a long-term physical condition.

Now we are actively incentivising CCGs to increase access to psychological therapies through the Quality Premium scheme, which provides additional funding to those that meet key goals.

Already, some 600,000 adults are benefiting from psychological therapies every year. We want this number to increase so more people get the help they need, when they need it, to support and accelerate recovery and manage long-term conditions. Our investment will mean 300,000 more adults will be able to access psychological therapies.

What are psychological therapies?

Often known as “talking therapies”, psychological therapies involve a person talking to a trained therapist, either one-to-one, in a group or with their wife, husband or partner. Types of psychological therapy that are approved for use within the NHS – based on extensive reviews of evidence about what works – include:

- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Brief Dynamic Interpersonal Therapy (DIT)
- Couple Therapy for Depression
- Counselling for Depression
- Behavioural Family Therapy & Cognitive Behavioural Family Interventions
- Eye Movement Desensitisation and Reprocessing (EMDR) Therapy

6. There will be improved access to psychological therapies for children and young people across the whole of England

We want to do more to promote mental wellbeing amongst children and young people, and prevent them from developing mental health problems. Half of those with lifetime mental health problems first experience symptoms by the age of 14; early identification and where necessary intervention can make a massive difference. Good mental health can help achievement in school and avoid poor health outcomes in the future: in short, it is vital to helping children to fulfil their potential.

We know that psychological therapies work for many people. But we also know that they need to be delivered in different ways to children and young people, compared to adults. Younger children in particular may not be able to talk about their feelings or problems in the way adults can. So we have invested in providing psychological therapies in a way that we know works for children and young people too.

Already, over half the country is involved in our transformational programme. NHS England is planning for a country-wide extension of the programme, and the Government’s aim is that all of England is involved by 2018.

7. The most effective services will get the most funding

In 2012 we started to introduce a new payment system for adult mental health services. Many adults receiving care are allocated to a mental health 'cluster' based on their need; services are then tailored according to the needs of the people they treat. In some local health economies, these 'clusters' are also used as the basis of payment replacing a system of block payment arrangements, generally based on what the service historically received rather than how many patients it is currently supporting.

We are working alongside Monitor and NHS England to develop the payment system further, in a way which enables commissioners to use payment systems increasingly to reflect quality and outcomes as well as volumes of activity. From April 2014, the Health and Social Care Information Centre will produce monthly reports for commissioners and providers which show how providers are doing against a number of quality and outcome measures. This will make it easier for commissioners of mental health services to hold providers to account. In the future this could mean that the best services – i.e. those that deliver the most successful outcomes, such as highest recovery rates – get more funding.

8. Adults will be given the right to make choices about the mental health care they receive

Just like people with long-term physical conditions, we want adults with mental health problems to be able to exercise choice about the care they receive and how they receive it. This is a general principle that should apply to all aspects of care. But we are establishing new legal rights around mental health care.

The NHS Constitution Handbook sets out legal rights for physical health patients in England to choose the organisation that provides their NHS care when they are referred for their first outpatient appointment with a service led by a consultant. From April 2014, the scope of the legal right will be extended to adults with mental health problems. They will be given the opportunity to choose which provider and consultant or mental health professional will be in charge of their care when they attend their first outpatient appointment. Some exemptions will apply, including when people need urgent or emergency treatment, or are detained under the Mental Health Act 1983. Patients should speak to their GP first about their choices.

Anyone eligible to receive social care services will be able to choose to receive a personal budget, and the NHS is working with local areas on applying personal health budgets to mental health – giving people even more control over their care. Through the way choice and personal budgets are used, the best care and services will be recognised and rewarded – empowering individuals and improving the quality of services.

9. We will radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor

The Serious Case Review into the events at Winterbourne View made it clear that restraint and restrictive practices – such as medication and seclusion – have been over-used in the care of people with challenging behaviour in health settings, and not always as a last resort. This is not acceptable.

We also recognise that dealing with patients who are aggressive or threatening, or who refuse treatment, is difficult. To help care providers adopt a positive alternative, we have asked the Royal College of Nursing, working with other relevant organisations and authorities, to develop new guidance on different models for reducing the use of restraint. This will include the use of positive behaviour support to minimise the use of restrictive interventions. It will also provide clear guidance on the use of restrictive practices as a demonstrable last resort. By following this guidance, providers will be able to ensure that they are using restraint in a transparent and ethical manner, and that they are acting within the law. We will expect all commissioners and providers to adopt this guidance. Subject to consultation on the guidance, we will make clear that the practices of deliberately holding people on the floor or restraining people in a way that impacts on their airway, breathing or circulation are high risk approaches and we want to see an end to their use as an accepted part of normal health and care. We will be looking at other levers alongside this guidance to effect change and to make sure that all the actions that will reduce the use of restrictive practices are being considered - including training, information and regulation.

Clearly, new training will be necessary to support this, and we will also look at other ways to help embed the change we want to see into everyday practice.

To ensure that there is the right legal framework around mental health services, we are also reviewing how the Mental Health Act and Mental Capacity Act have been implemented and how their provisions and requirements are being followed in practice.

10. We will use the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children’s mental health services

The most important measure of quality is what people who use mental health services think. The Francis Report highlighted the Friends and Family Test as a means of identifying poor quality services early. The Friends and Family Test asks patients and staff how likely they are to recommend a health or care provider’s services to their friends and family if they needed similar care or treatment.

We have already piloted using the Friends and Family Test in some mental health care settings. From the end of December 2014, it will be routinely used in all mental health care settings. We would encourage providers to start using it sooner.

We will publish the results so that providers are open to scrutiny – helping us increase transparency around mental health services. By ensuring that the voices and views of patients, families and carers are heard, we can also learn about potential service improvements of all kinds.

11. Poor quality services will be identified sooner and action taken to improve care and where necessary protect patients

We want people to have confidence that mental health services meet the standards we expect. So the Care Quality Commission (CQC) is currently developing a new model for monitoring, inspecting and regulating mental health providers that will ensure poor quality services or gaps in provision are identified sooner. This will mean we can respond faster and so improve quality of care overall.

For example, in response to concerns about access to places of safety, where people can be taken for an assessment of their mental health needs rather than being taken into police custody, the CQC has launched a thematic review of emergency mental health care.

By October 2014, there will be a new set of measures about care quality, new rating systems for mental health services and a new inspection process for mental health NHS trusts, which puts patient opinions and experiences at its heart. The CQC will carry out more visits to service providers, and talk to people who use those services, as well as their families and carers. It will also ensure it speaks to people detained under the Mental Health Act.

This will be backed up by greater use of experts during inspections, as well as use of external sources of information, including:

- providers' own reviews,
- advocacy services,
- national surveys,
- Healthwatch information,
- information held by local community groups, and
- social media

to gather a fuller picture of what people's experience of care is really like. The CQC will also directly take into account the priorities in this document, where they apply to the provider.

Where problems are identified, the CQC will use its powers to ensure action is taken to improve care. If services are putting patients at risk in any way, it can use enforcement powers to stop further admissions, suspend services or even prosecute service providers.

The new regulatory model will apply to all mental health service providers registered with CQC. This includes inpatient and community services for children and young people, adults of all ages and inpatient assessment/treatment services for people with a learning disability. The CQC has appointed a Deputy Chief Inspector for mental health services to oversee the process.

12. Carers will be better supported and more closely involved in decisions about mental health service provision

We know that caring for someone with a mental health problem can be hugely draining, both emotionally and financially, and we are determined to improve the support available to carers. The changes to carers' assessments, which will be introduced when the Care Bill becomes law, will ensure many more carers can get support – whether caring for those with mental or physical health problems, or both. The Children and Families Bill will ensure that young carers' assessments are simplified – for the first time, all young carers will have the right to an assessment of their needs for support as part of a whole family approach to assessment.

Local commissioners will also be expected to consider specific support for carers – such as respite care – in the services that are available locally.

The Standing Commission on Carers, which advises government, is focussing its fact-finding visits during 2013/14 on how carers of those with mental health problems are supported.

As we said in our strategy, we also want to ensure that carers are involved more closely in decisions about service provision. This is something that the Carers Trust is focusing on with its Triangle of Care project, funded by the Department of Health. The project has produced best practice guidance on how carers can be better involved in both the planning and delivery of mental health services. A self-assessment tool for providers has also been developed, which aims to ensure that providers are following best practice.

Addressing the mental health needs of carers

The mental health needs of carers themselves are often overlooked. A carer looking after someone with a severe mental health condition can often feel isolated and frustrated, which in turn can lead to carers themselves becoming depressed.

One way we are looking to address this is through working with the Alzheimer's Society to develop an online tool for carers of people with dementia. The tool will provide cognitive behaviour therapy for carers, aiming to help them understand their feelings of depression, frustration and anxiety and develop coping mechanisms. It reflects the fact that their caring responsibilities make it more difficult for this group to visit services. The tool will be clinically trialled in 2014.

Integrating physical and mental health care

13. Mental health care and physical health care will be better integrated at every level

As much as 80% of all mental health care takes place in GP surgeries and hospitals. So it is essential that staff working in these settings understand the symptoms of mental illness and the physical health needs of people with mental health problems. This will help guide treatment decisions, as well as lead to better day-to-day care. Physical illnesses can be diagnosed sooner; treatment plans adapted to reflect mental health needs; recovery accelerated.

We are working across the whole system to improve integration between physical and mental health care.

- As set out in our Mandate, NHS England is expected to make rapid progress, working with CCGs and other commissioners, to help deliver our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services. This includes ensuring there are adequate liaison psychiatry services.
- We have tasked HEE to develop training programmes that will enable all healthcare employers to ensure that their staff have a greater awareness of mental health problems and how they may affect their patients. This should include understanding the links between patients' mental and physical health, so that staff know what actions they can take to ensure that patients receive appropriate support for both their mental and physical health care needs.
- NHS England is launching a new programme dedicated to ensuring that, across the entire health system, mental health has equal priority with physical health.
- We are making sure that best practice approaches to caring for patients with many common conditions include potential psychological care needs.
- PHE has embarked on work to improve the understanding of mental health issues within the public health workforce.
- The Royal College of GPs (RCGP) will work to support, develop and improve GPs' knowledge and experience of the management of severe mental illness, including physical health and crisis care. It is adapting its Curriculum Statement for Mental Health and will appoint a Mental Health Clinical Lead. It is also developing proposals to enhance and extend GP training so that all future GPs will receive specialist-led training in the care of young people and adults with mental health problems.
- We are also looking at improving the standards of physical health care within mental health in-patient facilities to support earlier diagnosis and treatment of common illnesses. This is vital to our on-going goal of reducing premature mortality.

To support the integration of physical and mental health care, and social care, we have allocated £3.8 billion to help every Health and Wellbeing Board in the country to develop its own plan for joined up health and care locally. On 1 November 2013, we announced that 14 Integrated Care pioneer sites will be leading the way in joining up care services. Most of these sites include a focus on mental health, and plan to offer joined up care across the whole spectrum of services.

14. We will change the way frontline health services respond to self-harm

Self-harming can be one of the first outward signs of mental illness. It can be, though is not always, the sign of a mental health crisis – particularly when it is severe enough that the person ends up in an Emergency Department. And it is a habit that, once started, is hard to break: it is estimated that 1 in 6 people who require treatment in Emergency Departments due to self-harm will be back again within a year.

NICE guidelines already make it clear that anyone who attends an Emergency Department for self-harm should be offered a comprehensive assessment of their physical, psychological and social needs. However, we know that too often this does not happen: in fact, people who self-harm are often treated as low priority in Emergency Departments. Many report too that GPs can be dismissive of self-harm.

We now know more about self-harm than ever before. We understand better why people self-harm, and – thanks to the research undertaken as part of our suicide prevention strategy – have a greater insight into the links between self-harm and suicide. We want to put that knowledge to work, to improve the care and support offered to those who self-harm, recognising that the mental health needs might be far greater than the physical ones. By understanding those needs earlier, we can do more to prevent long-term mental health conditions developing. We can also reduce repeat admissions to Emergency Departments, and in some cases, help prevent suicide. Emergency Departments should aim to refer all those who present with self-harm for a psychosocial assessment, as set out in the NICE guidelines. We expect GPs to refer people who disclose self-harm to psychological therapies as appropriate.

In the revised Public Health Outcomes Framework, we have therefore introduced a new indicator that is specifically about self-harm. Under this indicator, we will measure:

- attendances at Emergency Departments for self-harm per 100,000 population
- percentage of attendances at Emergency Departments for self-harm that received a psychosocial assessment.

This two-part indicator helps us not only understand the prevalence of self-harm but also how Emergency Departments are responding. This information can then inform future commissioning.

We are also looking at how other frontline services respond to incidents of self-harm – including across the criminal justice system, whether in prison or where the police attend an incident involving self-harm. For example, self-harm is closely monitored within prisons. There is a well-established process for supporting prisoners at risk of, or who have, self-harmed, called Assessment, Care in Custody and Teamwork (ACCT). The process includes a requirement to consider mental health, and where appropriate refer prisoners on to mental health services. We will examine what other services can learn from this.

In addition, the survey recommended by the Chief Medical Officer into the prevalence of mental health problems amongst children and young people includes specifically investigating the prevalence of self-harm. It is widely acknowledged that teenagers – in particularly teenage girls – are amongst the most likely to self-harm, but we would like to gather more detailed data around this.

15. No-one experiencing a mental health crisis should ever be turned away from services

There are far too many examples of public services failing to respond effectively to people experiencing a mental health crisis. Children and adults alike have been turned away because health services are full, or made to wait until Monday morning because services are not available at the weekend. In some cases, they do not receive adequate treatment and support early enough, because information about their problem is not effectively shared between services. This is simply unacceptable and *must* change.

To tackle this, we will soon publish a new national Crisis Care Concordat. This will set out clearly what kind of support people in mental health crisis should receive, no matter where they are in the country or which public service they turn to – or which service those who care for them turn to. In particular, it focuses on better co-ordination between emergency services and mental health services, so that mental health support is available as soon as possible. This not only serves the individual concerned better, but also helps those emergency services perform their roles better.

So for example, when police take an individual to a “place of safety” under the Mental Health Act, the Concordat sets clear expectations as to how mental health services should respond. It also makes it clear that police custody should not be used as a place of safety and that emergency departments should be able to quickly get hold of a psychiatrist when a patient is or appears to be suffering from a mental health crisis. Wherever possible, the goal is through early intervention to avoid hospital admission for the mental health problem – and instead provide alternative care and support.

The Concordat emphasises the pivotal role of Approved Mental Health Professionals not only in arranging Mental Health Act assessments quickly, but also in ensuring that the least restrictive option is put in place and that the person’s rights are safeguarded.

The Concordat has been jointly developed by a range of services, as well as other stakeholders. It will mean that whether individuals themselves request help because they are in crisis, or any public service recognises that someone they are dealing with is experiencing a crisis, the response will be consistent, compassionate and comprehensive. Most importantly, no-one who needs urgent support during a mental health crisis should be turned away.

Street triage – a new approach to effective and co-ordinated crisis response

We are also piloting street triage as a way of helping people experiencing a mental health crisis get the help they need faster. This involves trained mental health professionals working with police officers, as a first-line response – either directly on the street or through a dedicated phone line. If the police are called to an incident where a person is suicidal or self-harming, creating a disturbance or upsetting others, but has not committed a crime, they can ask the mental health professional to conduct a rapid needs assessment and direct the individual to the most appropriate source of help. Street triage is being tested with nine police forces around England, and is a good example of how the principles of the Concordat can be turned into action.

Starting early to promote mental wellbeing and prevent mental health problems

16. We will offer better support to new mothers to minimise the risks and impacts of postnatal depression

Arguably the most ambitious part of our strategy is our determination to promote and sustain good mental health for all, and to prevent mental health problems developing.

We now know much more about the causes of some of the most common mental disorders such as depression and anxiety – and what can be done, in many cases, to prevent them. We will therefore focus on raising awareness of the interventions that we know work – like taking steps to reduce isolation in older people, working proactively with troubled families, and early interventions to prevent people struggling to find work from developing depression.

We are focusing in particular on maternal mental health during pregnancy and after birth including postnatal depression. This is important not only for mothers, but also their children. Mental health issues affect around 10% of women either when pregnant or after their baby is born, better support for parents can improve the mental health outcomes for them and their children. We are therefore determined to help children start well. Experiences in the early years can be hugely influential on lifetime wellbeing.

Whilst the majority of new mothers with mental health problems can be effectively managed within the extended primary care team, a minority with more serious problems will require specialist care. This should be provided by specialist community perinatal mental health teams and if necessary, admission to specialist mother and baby units. The NHS England Clinical Reference Group for perinatal mental health is working to improve the quality of care, promote equity of access to specialist care and reduce unwarranted variation in the quality of care that individuals receive.

Under new plans HEE, the national training body, will make sure there is enough training in perinatal mental health so there are specialist staff available for every birthing unit by 2017.

The Institute for Health Visitors is also updating the training given to all health visitors around mental health, so that they are better able to identify mothers who are at risk, and able to support them in a more targeted and effective way.

Improved training and support for health visitors and midwives will enable them to spot the early signs of maternal mental health problems and work together in pregnancy and the first postnatal year to meet the physical health, mental health and wellbeing needs of parents, babies and families. Where mothers are identified as needing support, services should not only support recovery from depression, but also look to help mothers to care for their babies.

This is in line with the Government's wider strategy to ensure families and children have the best start in life: we are expanding the health visitor workforce by 4,200 (over 50%), by 2015. More than 5000 new midwives are now in training and we are ensuring more vulnerable women and families benefit from the support of family nurses. Having more health visitors and midwives will help to ensure that women have personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period.

17. Schools will be supported to identify mental health problems sooner

We know that many schools want to do more to help children who are, or may be, experiencing mental health problems. Many now have their own programmes and mental health support – such as a school-based counsellor, whilst others have whole school approaches to mental and emotional health. We want to ensure that such programmes offer the best support possible, but also that schools are better able to identify mental health problems in their pupils sooner.

This requires health and education professionals to work collaboratively so that the right decisions can be made to support each child - referring those who need extra support to the right places sooner.

The new Special Educational Needs (SEN) Code of Practice, which is expected to be introduced in September 2014, will provide statutory guidance for education and health services on identifying and supporting children and young people with mental health problems who have a special educational need. It will ensure a child's mental health needs are captured within any assessment of their educational, health and social care needs. It sets the expectation that there should be clear arrangements in place between local health partners, schools, colleges, early years providers and other organisations for making appropriate referrals to Child and Adolescent Mental Health Services (CAMHS).

To help them do this, the Department of Health is funding the development of an interactive e-Portal that will bring together the latest evidence and guidance around mental health problems in children and young people. This will be launched in early 2014, and provide e-learning materials as well as signposting further support. It is designed to be used by all those working with children and young people – including in health and social care and the police, as well as schools. It will also be a useful reference for Clinical Commissioning Groups who are required, under the new SEN duty, to ensure that schools have access to SEN services.

Clearly, schools can contribute to mental wellbeing and our bigger ambitions in many other ways – like in the way they tackle bullying, or how they address discrimination. The mental health strategy implementation framework includes a number of actions schools and colleges can take. Many already are, and we urge those that have not yet considered the actions to do so as a priority. PHE will provide national leadership in this area with its focus on supporting families to give children and young people the best start in life.

18. We will end the cliff-edge of lost support as children and young people with mental health needs reach the age of 18

It has long been recognised that far too many young people who rely on mental health services are ‘lost’ to the system when they reach adulthood. From a point where they receive regular, focused support for their mental health needs, they find themselves on their own, unprepared for the abrupt cultural shift from a child-centred developmental approach to an adult care model. They may disengage, in many cases dropping through the care gap between the two services and losing much needed continuity of care. Those affected are often the most vulnerable and disadvantaged; getting lost in transition only adds to this – and makes them more likely to end up out of work and not in education or training. It can also mean their physical health deteriorates. For a significant number therefore, transition is poorly planned, poorly executed and poorly experienced.

For so many reasons, this “cliff-edge” situation must end.

We support the NHS England work to develop a service specification for transition from CAMHS. Monitoring the outcomes of transitions from CAMHS to adult mental health services or to other services such as the voluntary sector or primary care is neither universal nor robust. CCGs and Local Authorities will be able to use the specification to build on best practice and the evidence from a range of service models to commission high quality, measurable person-centred services that take into account the developmental needs of the young person as well as the need for age appropriate services. The service specification will include a range of quality indicators such as personalised transition plans that include, for those young people who do need to transfer to adult services, joint meetings with CAMHS and adult mental health services. For those who do not, it will include information on how to access services if they become unwell. We will need to take a cross-service approach, involving housing, employment services and social workers – and not least, the young person themselves – so that we can ensure they get the support they want.

At all times our focus will be on what works best from the perspective of young people, their own experiences and the perspective of families and carers. We will undertake a high-level scoping study to examine evidence for both physical and mental health services focused on the 15-24 year age group and the implications this might have for care pathways, social workers and health professionals in the UK.

We will also continue to examine how we can best ensure information about mental health problems in childhood – and what support has worked – is included within individual medical records for future reference.

Improving the quality of life of people with mental health problems

19. People with mental health problems will live healthier lives and longer lives

We want people with mental health problems to live as long, and full a life as the rest of the population. As set out in our strategy, having a mental health problem also increases the risk of physical ill health. Currently, men with a severe mental illness die on average 20 years earlier than other people; women 15 years earlier. They have higher rates of cancer, heart disease, respiratory disease and diabetes.

We have made it clear that we expect the NHS to narrow this gap and reduce the number of premature deaths in people with mental health problems. Building on the principles in the strategy and in the NHS and Public Health Outcomes Frameworks, we will shortly be publishing a five-year action plan on how to reduce avoidable deaths. This will include specific actions aimed at people with common mental health problems, and for those with more serious mental health problems. NHS England and PHE will lead this work.

People with mental health problems have higher levels of alcohol misuse and obesity than the population as a whole, and do less physical activity. Some 42% of all tobacco smoked is by people with mental health problems. These difficulties are frequently exacerbated for people with mental health problems who often live in poverty, have poorer social networks, and more difficulties accessing housing, employment, education and other opportunities. These issues are, of course, heightened by the stigma and discrimination still experienced by people living with mental health problems.

PHE and its partners are exploring a range of ways to highlight these issues and address these inequalities. By raising awareness, the first steps can be taken to improve outcomes.

For example, GPs, health care professionals and social workers can alert people to the importance of their physical health needs. Mental health support workers and carers can encourage people to cut down and stop smoking and become more active. Services themselves, such as stop smoking support, then may need to be adapted to ensure they are relevant and effective for people living with and recovering from mental health problems.

We also need to do more to support people with mental health problems to take care of their physical health, encouraging them to access existing health and dental checks, and to understand the effects of medication and the need for screening and immunisation. We have to ensure people living with mental health problems have the same levels of access to and outcomes from these as the general population.

These changes will not deliver results overnight, but they can make a difference. The more we can do to help people with mental health problems live healthier lives, the more progress we can make in preventing these shockingly early deaths.

Changing the way we help missing people

It is estimated that four out of every five adults who go missing are experiencing a mental health problem at the time they disappear. This ranges from those who deliberately run away to escape a crisis, or those who go missing from mental health hospitals and care homes, to those who simply get lost out of confusion brought on by dementia.

The consequences can be tragic. Someone who is unwell and who has no support can rapidly come to harm through suicide, neglect or self-harm. They may be fearful, confused and disorientated. Their health may deteriorate rapidly. The sooner they are identified and supported, the better the chances of safeguarding their wellbeing.

We want to ensure that they get the best possible response. That is why we are contributing to the National Crime Agency's Missing Person's Bureau national framework for police, NHS and health care providers which sets out agency responsibilities in protecting adults who go missing and also how to carry out the most effective and successful enquiries. The framework also sets out preventative measures to reduce missing incidents.

We will distribute this framework to care providers and health staff when it has been published early next year.

20. More people with mental health problems will live in homes that support recovery

We know that having settled accommodation can be invaluable for people living with a long-term mental health problem. When people live in a place that helps them feel safe and secure, it can support recovery and reduce the likelihood of further episodes of mental illness. It can also help safeguard their physical health. However, there are currently no clearly defined models for what such accommodation should look like.

To help define models, we would like to allocate up to £43 million from the Care and Support Specialised Housing (CASSH) Fund to support the construction of a small number of housing projects for people with mental health problems or learning disabilities. These projects will be designed in close conjunction with mental health and learning disability policy experts and representatives of relevant charities.

Our ambition is to receive bids from potential developers by 2015 and we would hope to see some homes available by 2017. By using some of the Care and Support Specialised Housing Fund to encourage developers to think specifically about homes that can support people who have a mental illness or learning disability to live safely and more independently for longer we can help showcase some good practice for future developments.

In 2014, the Department of Health will host a national forum on mental health and housing. This will be an opportunity to bring together government departments, system partners and stakeholders to explore the barriers and issues in relation to access to suitable housing for people with mental health problems and share good practice. It will also help understand how national policy can best be used to support.

21. We will introduce a national liaison and diversion service so that the mental health needs of offenders will be identified sooner and appropriate support provided

People of all ages with mental health problems come into contact with the criminal justice system in a range of different ways – as victims, witnesses, suspects or offenders – and a bad experience can make them feel unsafe and increasingly vulnerable. This can lead to their condition deteriorating.

Clearly a sensitive and appropriate response is vital – both in terms of managing the immediate situation and enabling the right justice outcome, for the individual and for society.

To help achieve that, we want to ensure that as soon as someone comes into contact with the criminal or youth justice system, their needs are assessed. For some, particularly young men from black and minority ethnic communities, or those involved in gangs, this may be the very first time their mental health problems are identified and assessed. If a mental health issue is identified, appropriate support should be offered from the outset, as well as further down the line – in court, in the aftermath of an incident or during sentencing.

One way we are doing this is to introduce ‘Liaison and Diversion’ services at police interview and custody suites, and at courts. Liaison and Diversion services will also link up to other parts of the justice process, such as prison and probation.

These services mean that as soon as someone is suspected of committing an offence, their needs are assessed quickly by professionals and relevant support is provided – whether in custody, or in a place of safety. Accurate, timely information on the person will be shared with police and the courts so that decisions about charging, sentencing or disposal are based on an authoritative assessment of their mental health, any learning disability and whether they have a substance misuse issue.

This model is being trialled in 20 areas over the next two years, and will be evaluated in depth to see what impact it has. We aim to roll it out quickly across England after that – reaching 50% coverage by 2015/16 and full national coverage thereafter, subject to the full business case.

We are also looking to change the way that people with mental health problems are supported post-sentencing. For example, it may be that where courts have wanted to impose a

community sentence with a Mental Health Treatment Requirement, lack of suitable mental health services means that has not been possible, and a different sentence has to be imposed. This is something that needs to be considered within local commissioning, with the aim of ensuring that any Mental Health Treatment Requirement can be met locally. It also requires greater integration between justice services and local commissioners.

22. Anyone with a mental health problem who is a victim of crime will be offered enhanced support

People with mental health problems are far more likely to be victims of crime than perpetrators. We want to ensure that when they are victims, they get all possible support to cope in the aftermath – and where necessary to ensure justice is done.

The new Victims' Code, which came into force on 10 December 2013, makes it clear that anyone with a mental health problem should be offered enhanced support at every stage of the criminal justice system. That includes having the right to ask for special measures – such as being able to give testimony by video link rather than in person – to be used in court.

To ensure that people who need this enhanced support get it, the police and the Crown Prosecution Service have a duty under the Victims' Code to assess victims at an early stage, and to refer any victim eligible for enhanced services for pre-trial therapy, if it is deemed necessary.

In addition, to help protect victims of crime from developing mental health problems, every victim is entitled to have their details passed on to services who offer emotional and practical support to help victims to cope with and, as far as is possible, recover from the impacts of the crime. These services can also be accessed by victims who do not report the crime to the police.

From 1 October 2014 the majority of emotional and practical support services for victims of crime will be locally commissioned by Police and Crime Commissioners (PCCs), rather than Central Government. They will be able to join with commissioners for health and social care locally to ensure a shared approach to support provision for victims and witnesses with mental health problems.

23. We will support employers to help more people with mental health problems to remain in or move into work

Too often, mental ill health can contribute to people falling out of work. We know that appropriate work is generally good for health and wellbeing, including for people who have mental health problems. Furthermore, returning to suitable work can improve mental health.

Helping more people who have mental health problems to work is a big challenge for health, social care and employment services and for employers themselves and it is therefore vital that services work together to find a solution.

The positive impact that work can have on health and wellbeing is one of the reasons why increasing employment of people with mental health problems is included within the NHS, Social Care and Public Health Outcomes Frameworks. There are two related objectives here: helping those out of work gain employment and, as importantly, helping employed people with mental health problems remain in work.

We want to support employers to promote workplace wellbeing. By helping staff to cope, employers can increase productivity and prevent the build-up of unmanageable stress at work. Supporting employers to promote mentally healthy workplaces has the potential to prevent or reduce sickness absence: mental health problems are now the single largest cause of sickness absence in England. Given the benefits for both the employer and the employee, promoting wellbeing at work is a vital element of our overall prevention strategy.

Many employers are increasingly sensitive to these issues and want to support their staff at challenging times and build the managers' capacity to organise work to enable all staff to contribute and be recognised. We want to support them, so NHS England is working with the Department for Work and Pensions (DWP) to identify best practice for employers – from recruitment and retention to reducing stigma, as well as in areas such as providing effective workplace support.

We also want to improve the information available to employers and individual line managers so that they can better recognise the signs of stress and mental health problems, and encourage them to talk about issues with their staff. This includes with staff who have had mental health problems in the past, as an understanding employer can make a substantial difference to how quickly people can recover. PHE is taking forward a major programme of work supporting employment and mental health for employers and the wider public health system, including work on PHE staff mental health and wellbeing.

From late 2014, the Government is bringing in a new Health and Work service to provide employers with the advice they need to help more people stay in work when health problems arise. The service will provide advice to employers, employees and GPs and offer return to work assessment and support for employees who have been on sickness absence for four weeks back into work.

Websites such as Time to Change and the Public Health Responsibility Deal provide useful information and links to resources for employers and line managers – see www.time-to-change.org.uk/your-organisation/support-employers - and <https://responsibilitydeal.dh.gov.uk/pledges/pledge/?pl+24>.

24. We will develop new approaches to help people with mental health problems who are unemployed to move into work and seek to support them during periods when they are unable to work

For those out of work, we are looking at how we can better coordinate mental health and employment support services. The Department of Health and the DWP jointly commissioned researchers at RAND Europe to look into the available evidence about what works and we have recently published *Psychological Wellbeing and Work: Improving Service Provision and Outcomes* which sets out their findings.

The report puts forward a number of recommendations about what effective support requires including:

- Evidence-based models of service delivery that combine addressing employment needs and mental health support;
- More integration between existing treatment and employment services to improve outcomes in both areas;
- New applications of evidence-based models (or a combination of approaches); and
- Timely access to coordinated treatment and employment support for a greater number of people with common mental health problems.

The report also put forward proposals which the Government is now considering developing into pilots. These will focus on improving support for people with common mental health problems and better integration between employment and health services. Potential initiatives could include developing the link between psychological therapies and employment support, enhancing support for those out of work to build resilience, and access to a range of work and wellbeing assessments delivered online, by telephone and face to face. Further work will begin in 2014.

Psychological Wellbeing and Work: Improving Service Provision and Outcomes - Main Findings

- a. The interaction between mental health and employment is complex and unlikely to lend itself to a “one size fits all” solution.
- b. Health and employment services are often not joined-up and do not tackle either the mental health problem or the employment need discretely.
- c. Service provision is often delayed and problems can worsen as a result.
- d. The assessment of employment and health needs is poor and there are low rates of diagnosis or referral to specialist health and employment support.
- e. Timely access to psychological therapy varies significantly between areas.
- f. Work Programme employment outcomes are disappointing compared with those for other client groups.
- g. There is no systematic evidence that better health treatment alone will deliver employment outcomes.
- h. Although there is some good evidence for what works to help employees retain work when mental health problems arise, evidence of what works for people in the benefit system is limited.

This work will complement existing programmes designed to help people with severe mental illness gain or maintain employment. These include the Access to Work mental health service which provides additional support to individuals with a mental health condition who are absent from work or finding work difficult, and the Work Choice programme which provides support for people with more intensive needs.

25. We will stamp out discrimination around mental health

The stigma associated with mental health problems and the discrimination people experience needs to be continually challenged – and ultimately, removed. This will help millions of people affected by mental health problems to fulfil their potential as active and equal citizens.

This is one of the principles underpinning the Time to Change campaign. Led by mental health charities Mind and Rethink Mental Illness, Time to Change aims to change public attitudes and behaviour towards mental health and people with mental health problems. It is England’s most ambitious programme to end mental health stigma and discrimination and has already reached in excess of 29 million people.

Discrimination on the grounds of mental health is already unlawful, under the Equality Act 2010. Research has shown a 5.5% reduction in average levels of discrimination since 2008. People with mental health problems already experience less discrimination from friends (14%

less than in 2008), family (9% less) and in social life (11% less). There has been a 3.6% positive increase in public attitudes towards people with mental health problems since 2008.

We've already made a financial commitment of up to £16 million to the Time to Change campaign, and our funding is being used to support activities such as the Time to Talk Day in February 2014. Now we have set an aspiration of leading by example. We want all Government departments and NHS organisations to sign the Time to Change pledge: many already have.

We are also challenging the media to support our efforts, both through news reporting – broadcast and print – and through the depiction of people with mental health problems in dramas and other programmes. There have already been examples of programmes with a hugely positive impact, but these have often had mental health as a focus. The Time to Change website offers a range of resources and information to journalists and scriptwriters: we want these to be more widely used.

Some of the most important audiences for Time to Change are children and young people - whether they have mental health problems, and are looking for guidance, or are being challenged to change their attitudes and eliminate discrimination. The campaign website has a dedicated section for young people and makes extensive use of social media, blogs and videos to get its messages across to this audience in a relevant way. Events are run in schools and a number of celebrities have supported the campaign.

By changing the attitudes of these generations, we will be better placed to achieve our long-term goal, of the stigma of mental illness being removed and discrimination no longer tolerated. That is why Time to Change is at the heart of so much of our public health work, both in terms of supporting people who have a mental health problem, and in terms of prevention. It is the driver of true long-term change.

Mental health is everybody's business

Improvements to mental health services are urgently required – and as we have shown, we are committed to delivering those. But to make the most difference to the most people, we need to look beyond mental health services into wider public services; then beyond public services into our society as a whole.

The 25 priority actions set out in this document demonstrate this. Just like the rest of our mental health strategy, many demand joint working within government, to focus services on the individual. But others require the input of partners, charities and representative organisations – as well as employers, families and carers.

We know that these organisations and individuals – including those working in frontline services – share our hunger for change. So we reiterate our call to action:

As we accelerate our work to improve service delivery, across not only mental health services but the entire public sector, and to deliver our overall ambitions, we ask again for the support and involvement of our societies in achieving those goals.

Further information

No health without mental health: a cross-government mental health outcomes strategy for people of all ages

<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

No health without mental health: implementation framework

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

Integrated care and support: our shared commitment

<https://www.gov.uk/government/publications/integrated-care>

Independent commission on mental health and policing report

<http://www.wazoku.com/independent-commission-on-mental-health-and-policing-report/>

At risk, yet dismissed: The criminal victimisation of people with mental health problems

<http://www.victimsupport.org.uk/about-us/news/2013/10/risk-crime-people-mental-health>

A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs

<http://www.hmic.gov.uk/publication/a-criminal-use-of-police-cells/>

The Victims' Code

<https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime>

New CQC mental health inspection guidance

(http://www.cqc.org.uk/sites/default/files/media/documents/cqc_afreshstart_mental_health_2013_final.pdf)

Mental health sub-group report of the children's outcomes forum

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216853/CYP-Mental-Health.pdf)

Disability and health employment strategy

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

Starting today, the future of mental health services – by the Mental Health Foundation

<http://www.mentalhealth.org.uk/content/assets/PDF/publications/starting-today.pdf?view=Standard>

Alone with my thoughts, MindFull

http://www.mindfull.org/static/mf/pdfs/alone_with_my_thoughts.pdf?245411050713

Building resilient communities, Mind and the Mental Health Foundation

<http://mentalhealth.org.uk/content/assets/PDF/publications/building-resilient-communities.pdf>

Overlooked and forgotten: a review of how well children and young people's mental health is prioritised in the current commissioning landscape
http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/

Care Bill fact sheet
<https://www.gov.uk/government/publications/the-care-bill-factsheets>

Faculty of Public Health - better mental health for all resource
http://www.fph.org.uk/better_mental_health_for_all

Foresight report on mental capital and wellbeing
http://www.bis.gov.uk/assets/BISCore/corporate/MigratedD/ec_group/116-08-FO_b.pdf

Mental health promotion and mental illness prevention: The economic case (LSE)
http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf

Mental wellbeing impact assessment checklist
<http://www.nmhd.org.uk/silo/files/mental-wellbeing-checklist-a4.pdf>

How healthy behaviour supports children's wellbeing
<https://www.gov.uk/government/publications/how-healthy-behaviour-supports-childrens-wellbeing>

Mental wellbeing impact assessment
<http://www.apho.org.uk/resource/item.aspx?RID=95836>

ONS measuring wellbeing
<http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/index.html>

JCPMH guidance for commissioning public mental health services
<http://www.jcpmh.info/resource/guidance-for-commissioning-public-mental-health-services/>

Wellbeing outcomes star
<http://www.outcomesstar.org.uk/well-being-star/>

Warwick Edinburgh Mental Wellbeing Scale
<http://www.healthscotland.com/documents/1467.aspx>

Public Health responsibility deal
<https://responsibilitydeal.dh.gov.uk/>

Lethal discrimination, Rethink Mental Illness
<http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf>

Suicide prevention strategy
<https://www.gov.uk/government/publications/suicide-prevention-strategy-launched>

Faculty of Public Health
http://www.fph.org.uk/further_resources

Crisis care reports

<http://www.mind.org.uk/news-campaigns/campaigns/crisis-care/about-the-campaign/?ctald=/news-campaigns/campaigns/crisis-care/crisis-care-slices/we-need-excellent-crisis-care/>

Talking therapies

http://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf

Public mental health

<http://www.mind.org.uk/news-campaigns/campaigns/public-health/>

User guides for the mental health strategy implementation framework

<http://www.mind.org.uk/about-us/policies-issues/mental-health-strategy/>

The mental health challenge for local authorities

www.mentalhealthchallenge.org.uk

Mental health promotion and mental illness prevention: The economic case

http://www.centreformentalhealth.org.uk/publications/mental_health_promotion_economic_case.aspx?ID=630

Doing what works: individual placement and support into employment

http://www.centreformentalhealth.org.uk/publications/doing_what_works.aspx?ID=592

Bridging the gap: The financial case for a reasonable rebalancing of health and care resources

http://www.centreformentalhealth.org.uk/publications/bridging_the_gap.aspx?ID=679

Implementing Recovery through Organisational Change

<http://www.centreformentalhealth.org.uk/recovery/publications.aspx>

Fulfilling potential: Office for Disability Issues

<http://odi.dwp.gov.uk/fulfilling-potential/index.php>

Crossing boundaries: improving integrated care for people with mental health problems:

<http://www.mentalhealth.org.uk/publications/crossing-boundaries/>

Getting on with life: baby boomers, mental health and ageing well:

<http://www.mentalhealth.org.uk/publications/getting-on-full-report/>

Resilience and results: how to improve the emotional and mental wellbeing of children and young people in your school:

http://www.cypmhc.org.uk/media/common/uploads/Final_pdf.pdf

National Involvement Standards (developed by service users and carers)

<http://www.nsun.org.uk/assets/downloadableFiles/4pi.-ni-standards-for-web.pdf>

Service users' experiences of recovery under the 2008 care programme approach

<http://www.nsun.org.uk/assets/downloadableFiles/service-users-experiences-of--recovery-under-the-2008-care-programme-approach--a-research-study--dorothy-gould-2012.-full-report2.pdf>

Dancing to our own tunes

<http://www.nsun.org.uk/assets/downloadableFiles/dtoots-report---for-website2.pdf>

Values-based commissioning

<http://www.nsun.org.uk/assets/downloadableFiles/values-based-commissioning-report--20132.pdf>

