COMPLETING THE REVOLUTION

Transforming mental health and tackling poverty

A policy report by the Mental Health Working Group
Chaired by Dr Samantha Callan

October 2011

Contents

About the Centre for Social Justice

The Centre for Social Justice (CSJ) aims to put social justice at the heart of British politics.

Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our Working Groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities.

We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

Executive Director: Gavin Poole

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Foreword

Mental health is an issue the CSJ has considered in many of our previous reports, particularly those relating to family breakdown, criminal justice (courts and sentencing and prison reform), children in care and street gangs. Our work focusing on the poorest communities has highlighted time and again the extremely high prevalence of mental ill-health and the compounding effect that it has on people and families already battling to live amongst challenging circumstances.

We undertook this Review so that we could investigate precisely why this is the case and found that the 'pathways to poverty' that are the focus of our work, are heavily implicated in the development of poor mental health. Worklessness and welfare dependency, the propensity to get into debt, poor educational attainment, family breakdown and addiction to drugs and alcohol; research has shown that all five of these pathways are also risk factors for the development of mental ill-health – and make personal recovery much harder.

In the same way that these drivers of poverty are also its effects, the underlying reasons for people suffering poor mental health are reproduced in their lives. Many people with mental ill-health often find it very hard to hold down a job, get a good education, or sustain healthy and positive relationships. People with mental health problems often self-medicate with drugs and alcohol. Reversing these drivers is vital if people are to achieve strong mental health. Perhaps this is best-exemplified in employment: 'good' work can make a momentous difference to someone's well-being. If the full potential of the Government's welfare reforms are to be truly realised, mental health services have to see themselves as crucial players in helping people become work-ready, wherever feasible and however long it takes.

It is also clear that while prevention, early intervention and effective treatment are indispensible, so too is a multi-faceted, community-based response that helps people become well by making sure that their physical, social, emotional and psychological needs are met. This was the great promise of the healthcare reforms initiated half a century ago – and is the potential for those currently going through Parliament. We called this report 'Completing the Revolution' because there is unfinished business dating from the closing of the asylums that began in the early 1960s.

Medical advances in treatment and changes in public attitudes made it indefensible to keep those who were mentally ill locked up with little chance of progress or eventual discharge. 'Care in the Community' was embarked upon with the goal of supporting them in their daily

circumstances, helping them to build lives of interdependency in families and the community rather than dependency on institutions. However, the wide range of support people needed to achieve this has been highly patchy in its availability, and especially lacking for those living in the most disadvantaged circumstances. Moreover, the last half century has seen sustained levels of family breakdown and erosion of communities themselves.

Yet, as we have found in so many other areas of our work, from the grassroots of these communities many voluntary (and private) sector organisations have sprung up. Many were started by people who have themselves recovered from mental illness or who have relatives or close friends who have needed the bespoke help that is often the strength of smaller organisations.

Now more than ever they are struggling to keep providing the services that are a lifeline for many. This report does not call for a huge increase in spending on mental health but argues that if effective and evaluated grassroots services were properly integrated into care pathways, through mechanisms provided by current health reforms, they would be far more sustainable and available to those people who need them.

The report highlights where the revolution that intended to give the mentally ill freedom from the high walls of the asylums and release, where possible, from the chains of their health conditions, has stalled. Money is still concentrated in hospital care and only trickles into the community – yet hospitals are where in-patients report being fearful for their safety and do not consider they are being helped to make progress. We make policy recommendations across primary and secondary care and focus on children, young people, older people, military veterans and those from BME communities. All are framed from the perspective of needing to complete this revolution for the most vulnerable in society.

As an organisation we are looking forward to working with current and future partners to see these implemented. But it is also our intention to spark a revolution in thinking around the design and delivery of mental health services that will assist policy makers and commissioners in areas beyond those covered in this report. Psychological therapies, for example, are ripe for fresh thinking.

In publishing this report the CSJ would like to thank the Mental Health Working Group, our three sponsors and several key individuals and organisations whom we name in the Special Thanks section. This Review would not have been possible without the wisdom, experience and generosity of time of a very large number of people from a wide range of other organisations in the statutory, voluntary and private sectors. Finally, we are particularly grateful to the people who have experienced mental health conditions but who did not want to be named – their insights and honesty were invaluable.

Gavin Poole, CSJ Executive Director
Dr Samantha Callan, Chair of the Mental Health Review

Members of the CSJ Mental Health Working Group

Dr Samantha Callan (Chair)

Samantha is recognised as a research and policy expert in the field of family relationships, the early years and work-life integration. She is an honorary research fellow at Edinburgh University, a published academic, and formerly a research consultant to major UK and international non-governmental organisations aiming to strengthen family life. In this capacity she chaired the Family Breakdown Working Group of the Social Justice Policy Commission, the Family Law Review and Early Years Commission for the Centre for Social Justice. Prior to joining the CSJ full-time she was the Family and Society Policy adviser in the Conservative Policy Unit. Samantha is on the Department of Health's Ministerial Working Group on Mental Health and Equalities.

Dr Martin Baggaley

Dr Baggaley qualified from St Bartholomew's Hospital in 1984. He served in the British Army from 1985 until 1997. He trained as a psychiatrist in the Army and at Guy's Hospital London. He has been a full-time psychiatrist from 1986 and has been a consultant from 1993. He worked as Senior lecturer in Military Psychiatry for four years and for two years was Head of Division at the Defence Services Psychiatric Centre, Catterick. He left the British Army in 1997 and was appointed to the post of consultant psychiatrist for the South London and Maudsley NHS Trust. He was Clinical Director of Adult Mental Health in Lewisham for five years. He was involved in the development of a Triage Ward at the Ladywell Unit Lewisham. He worked for two years for the National Programme for Information Technology as Clinical Lead for London. He is now working for the newly opened Triage Ward at Lambeth Hospital. He is the secondary care lead for the London Mental Health Case for Change.

David Bolton

David Bolton lives in Northern Ireland. As a social worker he has worked in the public sector in the largely rural area of the south west since the late 1970's, undertaking work with families, people with disabilities, people with mental health difficulties and older people with care needs. He has occupied a number of middle and senior managerial roles within the public health and social services and in this capacity was responsible for coordinating the response to a number of major events associated with the conflict in Northern Ireland. In 2001 he helped to found the Northern Ireland Centre for Trauma and Transformation, a charitable trust set up to build upon the therapeutic advances made in response to the trauma related needs of people affected by the Omagh bombing of August 1998. The Centre's research has provided important insights into the epidemiological impact of the years of conflict and into the treatment of trauma related disorders.

Paul Farmer

Paul has been Chief Executive of Mind, the leading mental health charity working in England and Wales since May 2006. Paul is a member of the NHS Futures Forum and the Harrington Review of the Work Capability Assessment. He is Chair of the Disabilities Charities Consortium and Vice-Chair of the Talking Therapies Programme Board. He is also a member of the BBC's Appeals Advisory Committee. Before becoming Chief Executive of Mind, Paul was Director of Public Affairs for Rethink and was Chair of the Mental Health Alliance from 2001-2006. Paul was also a trustee for the Directory of Social Change, a campaigning voluntary organisation that provides the sector with training and publications and is currently a member of the Mental Health Providers Forum, an umbrella body for voluntary organisations supporting people with mental distress.

Professor Peter Fonagy

Professor Peter Fonagy, PhD, FBA, is Freud Memorial Professor of Psychoanalysis and Head of the Research Department of Clinical, Educational and Health Psychology at University College London; Chief Executive of the Anna Freud Centre, London; and Consultant to the Child and Family Programme at the Menninger Department of Psychiatry and Behavioral Sciences at the Baylor College of Medicine. He is also Director of UCL Partner's Mental Health and Well-Being Programme and is National Clinical Lead of Improved Access to Psychological Therapies for Children and Young People. He is a Senior Investigator for the National Institute of Health Research. He is a clinical psychologist and a training and supervising analyst in the British Psycho-Analytical Society in child and adult analysis. His clinical interests centre around issues of borderline psychopathology, violence and early attachment relationships. His work attempts to integrate empirical research with psychoanalytic theory.

Ivor Frank LLB, LLM

Ivor Frank is a human rights barrister. He is also a member of the Associate Parliamentary group for children in care and has personal experience of the care system as he himself was brought up in residential care from the age of three.

Maggie Gairdner

Maggie has worked within health for over 20 years and completed a masters in Health Management in 2003. She originally trained as a General Nurse at Addenbrookes Hospital in Cambridge before taking her post registration course in Mental Health at the Bethlem and Maudsley Hospitals in London. Maggie has worked in the prison service both as the senior nurse for Eastern Region and also as healthcare managers in a number of different prisons, including Holloway. On returning to the NHS she became Operational Manager and Strategic Planning Manager in Buckinghamshire, then Service Director at Broadmoor. Most recently, Maggie has worked as Associate Director for Young People and Substance Misuse, Deputy Director for Working Age Mental Health Services and as Deputy Director for Secure and Forensic Services for Sussex Partnership Trust. She is now the Head of Community Care Services for West London Mental Health Trust.

Professor Richard Gray

Professor Gray has over 20 years' experience working in mental health practice, education and policy. Challenging convention and conducting research to better understand and improve patient adherence has been at the core of Richard's scientific endeavour. He has conducted many pivotal studies that have tested adherence interventions across a range of long term conditions. His work on physical health is an exemplar of his passion for ensuring that every patient should benefit from advances in health science not just those close to centres of excellence. He is highly critical of complex interventions such as cognitive behavioural therapy which, although effective, is impossible to deliver to the population of patients that would benefit. He has championed simple interventions, such as health checks, that can influence health and wellbeing at the population level. The author of over 100 peer reviewed scientific papers, Richard is passionate about promoting public understanding of science and regularly writes articles for a range of publications.

Matilda MacAttram

Matilda is founder and director of Black Mental Health UK, a human rights campaigns group established to raise awareness and address the stigma associated with mental illness within

African Caribbean communities. Matilda is a member of the Ministerial Working Group on Mental Health and Equalities. She also sits on the advisory board of Mental Health and Justice Research Project, which is examining how law enforcement agencies treat victims of crime who have used mental health services. Matilda is on the Community Channel's advisory board as well as the editorial board for the Journal of Ethnicity and Inequalities in Health and Social Care. She is also part of the stakeholder group working with the Independent Advisory Panel on Deaths in Custody, which is part of the Ministerial Council on Deaths in Custody. In September this year she launched The Solution, the only magazine to focus on the African Caribbean experience of mental health services, which is circulated to over one million readers.

Professor Chris Thompson

Professor Thompson is a practising psychiatrist and has been the Chief Medical Officer of Priory Group since the beginning of 2004. He has carried out extensive research into depression, especially in the primary care setting, and chaired the UK government enquiry into depression services (CSAG, 1999). The other main strand of his research was into seasonal affective disorder. Altogether he has published nearly 100 peer reviewed research articles and edited or co-authored seven books. He chaired the UK Department of Health's Confidential Enquiry into Suicides and Homicides by People with a Mental Illness. Chris has committed his working life to improving knowledge, treatment and care for depression, as a psychiatrist; a researcher; a teacher; and in a leadership capacity for organisations that can make a difference like Depression Alliance.

Dr David Shiers (Primary Care Consultant)

Dr Shiers has been actively involved in UK Mental Health development over the last 15 yrs. He jointly led with Dr Jo Smith the National Early Intervention in Psychosis Programme (2004-10). Most recently he has become a trustee to Rethink, a major UK mental health charity. A General Practitioner by background, his special interest in mental health stems from personal involvement as carer to a daughter with schizophrenia. This experience convinced David of the need to improve services for young people with early psychosis, particularly their physical health and how an early intervention approach can be applied for bodies as well as minds.

David Shiers is currently a member of the Guideline Development Group (GDG) for new NICE guidance for children and young people affected by psychosis and schizophrenia and the views expressed are not those of the GDG, NCCMH or NICE. In his contribution to the Review David particularly wanted to acknowledge co-authors of papers that greatly influenced his work: Dr Dave Tomson, Dr Maryanne Freer, Dr Dick Churchill, Professor Helen Lester, Professor Peter Jones and Professor Steve Field.

Special thanks

The CSJ would like to express special thanks to The Doha International Institute for Family Studies and Development, member of Qatar Foundation, Doha, Qatar for their instrumental support of this paper. The CSJ would also like to thank St Andrew's Healthcare, the largest mental health charity, and Partnerships in Care for their support. We are deeply grateful to them for their generosity.

The Working Group like to thank the many individuals with historical or current mental health problems for their generosity in sharing their stories. Many of them preferred to remain anonymous but we are particularly grateful to Michael Crump of My Time who advised us on the final draft of the report.

We would also like to acknowledge the following people who were not on the Working Group but made a sustained contribution to the Review:

- Andy Bell, Deputy Chief Executive, Centre for Mental Health
- Gavin Poole (Executive Director), Christian Guy (Director of Policy) and Harriet Crawford (Policy Researcher), Centre for Social Justice
- Caroline Hawkings, Policy Consultant, Mind
- Colin Senez, formerly Centre for Social Justice
- Steve Shrubb, Director and Rebecca Cotton, Policy Manager, Mental Health Network, NHS Confederation
- The Mindful Policy Group
- Dr Nini Adetuberu
- Dr Maria Kee, Northern Ireland Centre for Trauma and Transformation

Finally we would like to thank the patron to the Review, Baroness Professor Susan Greenfield CBE, Professor of Pharmacology, University of Oxford.

Executive summary

This is the Executive Summary of *Completing the Revolution: Transforming mental health and tackling poverty.* To download the full report and complete list of recommendations, visit www.centreforsocialjustice.org.uk

1. Introduction

In whichever area of social policy it researches, the Centre for Social Justice (CSJ) is primarily concerned with how the most vulnerable in society are affected. The 'pathways to poverty' that the CSJ has identified also contribute to the development or sustainment of poor mental health:

- Worklessness, welfare dependency and the propensity to get into debt;
- Poor educational attainment;
- Family breakdown which leads to social isolation; and
- Addiction to drugs and alcohol.

Just as the causes of poverty are also its effects, the underlying contributory reasons for people suffering poor mental health are reproduced in their lives. It is therefore vital that all who are working with the mentally ill should see themselves as integral to the wider social movement to tackle these drivers and effects of poverty.

There is an unfinished revolution in mental health care in the UK that began half a century ago when the mentally ill were moved out of asylums so they would get the treatment and support they needed 'in the community'. The aim was to help them achieve as full a recovery as possible, but realising the full potential of this shift required a far-reaching cultural change that has stalled and many needs currently go unmet. Opportunities provided by the current health reforms can and must be maximised to take the necessary quantum leap forward in 'care in the community' and complete that revolution.

Money is still tied up in in-patient care because the services people need are not available in the community. Hospitals tend to be untherapeutic and dangerous places. Risk aversion drives much detention and insistence on medication but other psychosocial interventions and meaningful activity are often unavailable for patients who also have to cope with the fear of attack from fellow patients. The most disadvantaged are those who are most likely to lose their liberty because of a lack of basic social support.

Bureaucracy hampers the creativity that is so often necessary to transform people's mental health. The bespoke 'human' needs that are often the sphere of excellence of grassroots third sector charities or social microenterprises are not being addressed in the community, largely due to imbalances in funding arrangements at a local level. Communities themselves need to become 'neighbourly' and places where social isolation is the exception to the norm.

Certain groups in society appear to have a higher prevalence of mental health problems and do not seem well served, such as people in some Black and minority ethnic (BME) communities. As well as poor access to treatment, they can also experience greater deprivation of liberty. Concern has also been raised about the effects of wartime service on the mental health of military veterans.

The family is largely neglected in mental health policy. Although one's family can be at the root of the mental health problems faced, it can also be at the heart of the solution. The first onset of mental health problems is commonly in childhood or adolescence; half of all lifetime cases have started by the age of 14 years.[1] This report takes a public health approach to mental illness; despite research implicating family breakdown as a cause (and effect) of mental illness, its prevention has never been recognised as a public health priority.

Working Group members receiving evidence from a range of organisations working with homeless people who are mentally ill in Brighton

Stigma is the biggest barrier to tackling mental ill-health; tackling it will require unprecedented and concerted effort to achieve the necessary cultural change.

Prevention of mental ill-health is vital but so is early intervention and treatment; where help and support is lacking and needs go unmet, people can sink into dependency and become trapped. Employment can greatly improve wellbeing; primary care and other mental health services have a vital role in helping people become work-ready, even if that journey may be a long one. Yet less than one-third of mental illness is reduced by treatment. NHS mental health providers have to be better integrated with a full range of other agencies (from the public, private or voluntary sectors) given the complex social, physical and psychological needs of people with mental ill-health.

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1   Kim-Cohen J et al, 'Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort', *Archives of General Psychiatry,* 60, 2003, pp709-717

All these agencies should be focused on outcomes not process, with 'just enough' administration so that clinicians are neither prevented from caring because of the burden of administrative tasks, nor able to 'hide behind' those tasks. Accordingly, community-based services should not be deployed on the grounds that they save money but that they are most effective. There needs to be a rebalancing of existing funding that integrates these providers far more in paid-for care pathways.

2. Polling

Confirming our analysis, our polling found that:

- Almost a third thought poverty was a major cause of poor mental health – but 40 per cent considered mental health to be a major contributor to poverty;
- More than 60 per cent cited poor mental health as a major contributor to family breakdown and half thought family breakdown caused poor mental health;
- 43 per cent said they or their relative/close friend received 'a lot' of help and support from their GP, a much greater proportion than those who said a psychiatrist (18 per cent), a therapist (26 per cent) or their friends (29 per cent), but 51 per cent said their family;
- 92 per cent agreed we should do more to safeguard the mental health of adolescents (the same number said the same thing about the elderly), and 88 per cent agreed we should do more to safeguard the mental health of children;
- Two-thirds agreed that gaining access to the correct mental health services means coping with a lot of red tape; and
- Of those with experience of hospitalisation, more than half did not feel that the settings and facilities aided recovery and 44 per cent felt the treatment they received was fairly or very ineffective; 14 per cent of those felt very unsafe and only 15 per cent felt very safe.[2]

Our recommendations summarised below are spread over six major subject areas:

1. Tackling mental ill-health and stigma through a public health approach;
2. Trauma and the mental health of military veterans;
3. Children and young people;
4. BME groups;
5. The role of primary care; and
6. Secondary care – hospitals and 'care in the community'.

3. Putting mental health at the heart of public health

The contribution a successful public health approach could make to improving mental health at a population, community, family and individual level is potentially enormous not least by helping to reduce misconceptions and stigma surrounding mental illness. Associations between mental health and violence are vastly exaggerated but persist partly because of over-

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2   CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010

emphasis in media reporting. It is essential to put the dangerousness associated with mental illness in its appropriate and proportionate context. Risk is often displaced onto the mentally ill person themselves. Their recovery and quality of life are placed at risk by depriving them of liberty. This is sometimes though not always necessary, and it can take the place of finding creative and flexible ways to provide social and other support in the community.

3.1 Our recommendations to central and local government on public health include:

- Professor Eileen Munro, in her recent review, challenges the current risk-aversion that characterises child protection; her conclusions apply equally as well to mental health, therefore we are calling for the same cultural change in mental health that Professor Munro is calling for in child protection.
- Ensuring that vision, priorities, provision and outcomes for public health and mental health are more closely aligned to transform the outcomes for vulnerable people with a range of overlapping needs. It is essential that mental health is a higher priority for the cross-cutting Cabinet Committee on Social Justice, as they address the interlocking causes of poverty in which mental health is so heavily implicated.
- Revoking discriminatory legislation, either directly or through Lord Stevenson's Private Members Bill which seeks to repeal discriminatory legislation relating to jury service, school governance and company directors.
- Investigating ways to encourage GPs to work in deprived areas.
- Fulfilling Coalition pledges to tackle binge drinking by banning the sale of alcohol below cost price and reviewing alcohol taxation and pricing.
- Health and wellbeing boards should ensure the public mental health of the community is addressed by commissioners locally and be accountable for this.

4. Addressing trauma and the mental health of military veterans

Around two-thirds of the population experience one or more traumatic event in their lifetimes.[3] Those who are the most socio-economically disadvantaged tend to be more at risk of being exposed to traumatic events and more vulnerable to the effects of such trauma. Military mental health has been of significant public and political concern because of British Armed Forces' involvement in a series of major military operations over the last 20 years.

While there is some evidence of higher levels of mental health problems among ex-service personnel, prevalence is to some extent distorted by those who leave the Forces prematurely (although alcohol misuse is a pervasive issue among all troops who have deployed). Early leavers tend to have higher levels of *pre-existing* risks for adverse mental health outcomes. We note the concerns of ex-service organisations and recognise the valuable advocacy, services and practical care they offer former service personnel and their families but occasional differences exist between their views and conclusions of research.

3   Galea S, Nandi A and Vlahov D, 'The Epidemiology of Post-Traumatic Stress Disorder after Disasters', *Epidemiologic Reviews,* 27, 2005, pp78-91

4.1 From the range of evidence on trauma and military mental health our recommendations include:

- All health and support services should be mindful of the unique experiences of deployment and war and of the distinctive self-identity of ex-service personnel. Their needs should be understood within the context of the culture and community of the Armed Forces, and the challenge of adjustment and integration some face on leaving the services. Specific efforts must be made to ensure health (and other public service) organisations and staff recognise and positively respond to their specific cultural traditions, expectations and perspective.

- Efforts should be made to reduce the stigma and improve access to appropriate therapy for ex-service personnel with mental health problems. There may be more of a need for specific ways to signpost and facilitate ex-service personnel into mainstream therapy as opposed to particular treatment programmes for the ex-military.

- Benefits of military Trauma Risk Management (TrIM) should be more widely distributed to civilian organisations where there is an increased risk of exposure to trauma.

- The Armed Forces should do more to reduce alcohol consumption in service personnel as part of a wider societal acknowledgement of the public health dangers of excessive alcohol consumption that is addressed, for example by a minimum unit pricing policy or an alcohol treatment tax.

- There should be more emphasis placed on dealing with multiple social disadvantages and life problems, particularly in the early leavers group, than on imagined high-prevalence PTSD in longer serving ex-servicemen.

5. Improving mental health of children and young people

Childhood mental disorder in the UK is closely related to poverty: children from the poorest 20 per cent of household income are three times more likely than those in the richest 20 per cent to have common mental health problems[4] and nine times as likely to have psychotic disorders.[5] Children's future relationships, their ability to fulfil their potential both educationally and in the workplace, and their basic enjoyment of life are all threatened by mental illness and unmet emotional needs. Interventions need to be grounded in an understanding of mental health's continuity from conception to adulthood.

> In our polling 25 per cent said mental health treatment should be focused mostly upon the individual patient themselves but two-thirds said mental health treatment should be focused on the patient, their family and relationships.[6]

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4   Green H et al, *Mental Health of Children and Young People in Great Britain,* London: Office for National Statistics, 2005
5   Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010,* The Marmot Review, London, 2010
6   CSJ/YouGov polling of 2,084 British adults, September 2011

There must be an obligation built into services that they meet the needs of children and their families; they are designed not for the convenience of professionals but user-led to the greatest degree possible, with an appropriate level of power resting with those whose lives are most affected. Evaluating the long-term impact of services, given that much of mental illness is chronic and episodic is vital as families need help in the long term.

> Three quarters of those polled agreed that councils should have a duty to monitor children whose parents are in prison.[7]

5.1 To tackle children and adolescents' poor mental health our recommendations include:

■ Local health commissioners should ensure provision for premature babies (and their parents) is commensurate with the need and opportunity to prevent subsequent development of physical and mental health problems.

■ Maternal mental health must be recognised as a priority, on a par with maternal physical health, and health professionals must be better trained to identify symptoms of depression. Health and wellbeing boards have an important role to play in ensuring adequate resources are provided by local commissioners of services, and in recognising the strong role to be played by the voluntary sector and wider community.

■ The provision of infant mental health services should be seen as the next frontier for early intervention in every locality where high levels of need are identified, to ensure good foundations are laid for future development.

■ The establishment of a family-centred mental health service where parents are supported rather than blamed, and helped with their as well as their children's mental health needs with timeliness and sufficient resource.

■ The Government should require local authorities to collect data on children whose parents are in custody, not only to track their welfare, but also to ensure that planning and delivery of services provide effective support.

■ Prison mother and baby units should, as standard, take the opportunity to help these often highly vulnerable mothers and their babies with evidence-based courses that can give infants a better relational start in life and provide a range of support to mothers.

■ Wherever possible and appropriate, Children and Adolescent Mental Health Services workers should be integrated with other agencies as part of an interdisciplinary team.

■ More universal and targeted mental health services must be available in schools as a key component of a public mental health approach. A whole-school approach which promotes a positive school ethos and culture will more effectively promote the mental health of children than 'bolt on' programmes.

■ Central government should give a strong lead by setting outcomes for local commissioners to deliver against so they find the best ways of supporting families and autistic young people make key transitions to adulthood in their area.

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7   Ibid

■ Local commissioners should ensure authentic services, genuinely fit for purpose for the modern teenager are available, easily accessible, non-stigmatising, integrated with other services and designed with the involvement of the young people in the target population.

6. Black and minority ethnic groups – a priority area for action

The problems BME communities face in the health system highlight the general failings of mental health care for the most vulnerable people throughout wider society. BME mental health has been the subject of many official enquiries and policy initiatives yet has seen little or no progress in some of the most important indicators. Surveys show BME patients' dissatisfaction with mainstream services (although voluntary and community sector organisations receive higher scores), high detention rates and excessive restraint, seclusion and medication.[8, 9]

One voluntary sector organisation visited by the Working Group has a garden, which provides therapeutic and purposeful activity for people with mental health difficulties

Research suggests that family breakdown and early separation as well as unemployment, living alone and limited social networks, affect rates of psychosis in the African-Caribbean population where there is a greater prevalence of these factors.[10]

6.1 To improve mental health in BME communities our recommendations include:

■ Implementing and evaluating the 'locked hexagon' approach with its six elements of: clear, locally set targets for improvement in outcomes; service users shaping services; use of narrative approaches; promotion of education, employment, training and volunteering; staff and manager knowledge and skill development; and carer and community engagement.
■ Acting to ensure no people with severe mental health problems are in prison, but instead in secure hospitals, through early and appropriate diversion, greater use of independent sector providers where necessary and freeing up secure services by tackling risk-aversion and other causes of bed-blocking involving non-forensic patients.

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8   Keating F and Robertson D, 'Fear, black people and mental illness: a vicious circle?', *Health and Social Care in the Community,* 12, 2004, pp439-447
9   University of Central Lancashire International School for Communities, Rights and Inclusion, *Delivering Race Equality in Mental Health Care: Report on the findings and outcomes of the community engagement programme 2005-2008*, Preston: University of Central Lancashire, 2010, p19
10   Morgan C and Fearon P, 'Social experience and psychosis: insights from studies of migrant and ethnic minority groups', *Epidemiologia e Psichiatria Sociale,* 16, 2007, pp118-123

- The use of health- and community-based places of safety rather than police stations.
- Right to advocacy *before* detention, when patients attend tribunal hearings and on discharge to help them access aftercare services.
- Innovative outreach projects based around statutory services for 'hard to reach groups' to enable a shift to a more community-based and culturally appropriate pattern of care for this group.
- Community 'places to go' for refugees and asylum seekers should be prioritised in local mental health service planning, one-stop agencies that can provide a range of person-centred services including therapy and work-related training.

7. The role of primary care

GPs and nurses play a significant but often unacknowledged role across the full spectrum of mental health needs; primary care helps people struggling with everyday, but profoundly demanding life events and problems as well as with severe disorders. Current health reforms provide a significant opportunity to integrate mental and physical health and social care to address more effectively the complex and entrenched difficulties in vulnerable people's lives. But primary care will have to maximise the unique contributions of voluntary and private providers. Forming strong, properly resourced partnerships is vital but the current funding 'playing field' is tilted against them and towards statutory services.

7.1 Our recommendations on primary care include:

- Secondary mental health services should be closely aligned to primary care practices to reduce barriers to referral and facilitate advisory conversations between specialists and GPs.
- The commissioning reforms offer an opportunity for creative and flexible service design that breaks out of current professional silos. We recommend that CCGs, especially those serving the more deprived areas, should make this a priority and vigorously use the new paradigm of competition, choice and payment by results/outcomes to increase access (for example to psychological therapies) and drive up quality.
- Mental health should form a greater part of postgraduate training for GPs and the Royal College of GPs should review their curriculum accordingly.
- There should be more specialist GPs in mental health (GPSIs) and the qualification required to be a GPSI should be clearer.
- Social prescribing should become a common feature of local health economies and increasingly pervasive where appropriate to meet local need, with a clear role for health and wellbeing boards to facilitate local partnerships that can deliver more comprehensive solutions to mental ill-health.

In our polling six in ten people supported or strongly supported using health budgets to pay community organisations or charities to support patients.[11]

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11 CSJ/YouGov polling of 2,084 British adults, September 2011

- Smoking cessation services should be properly designed for and focused on the mentally ill given evidence of effectiveness and smoking's huge negative impact on their life expectancy and overall experience of health inequalities.

8. Secondary care – hospitals and 'care in the community'

Even though secondary care services address more severe need, they should be focused to a much greater extent on helping people break out of vicious cycles of mental illness, disadvantage and worklessness. 'Completing the revolution' to embed high quality, integrated and recovery-oriented care in the community requires secondary care to be a) much more of an enabling gateway to the whole range of support many people need, and b) guided by an early intervention approach. These are essential if the most vulnerable are to be cared for in the least restrictive setting and in such a way that their human potential is unleashed.

Too often dependency on costly and more restrictive services is inappropriately maintained because of defensive practice, a lack of therapeutic intervention or perverse incentives in funding structures.

8.1 To improve the care patients receive in hospital and the community our recommendations include:

- Acute inpatient psychiatric wards should become Psychiatric Intensive Care Units which have higher status, better defined models of care and work more intensively with the patient, so their care can be 'stepped down' to a community setting at the earliest, most therapeutically appropriate point.
- All nurse training should start with generic skills and knowledge, including about mental illness. It should reflect the prevalence of mental health problems, the co-existence of mental and physical ill-health and the need to avoid stigma and promote good mental health behaviours in whichever specialism they practice.
- Local authorities should bolster the provision of 'family-sized' care through initiatives such as Shared Lives that provide viable and more compassionate alternatives to residential care.
- Forward funding models which ensure money follows the patient into the community and is not tied up in hospitals should be adopted by local commissioners as part of the broader project of aligning social and mental health care funding and delivering services through Payment by Results/Outcomes. Patients' needs should not be at the mercy of inflexible and disconnected funding and organisational structures.
- Shift responsibility for care brokerage over to independent voluntary sector services, to ensure better access to specialist treatment and all the other support patients need to break out of vicious cycles of dependency and poverty.
- A major review of the use and impact of the 2007 Mental Health Act after a sensible waiting period. This should prioritise positive risk taking, for example by scrutinising how Community Treatment Orders are being used if numbers remain high and ensuring the law is fit for purpose for twenty-first century expectations surrounding mental healthcare.

Introduction

1. Introduction

In whichever area of social policy it researches, the greatest concern of the Centre for Social Justice (CSJ) is how the most vulnerable in society are affected. This is both in terms of the problem that policy is trying to address and the extent to which current policy can facilitate the necessary transformation in their circumstances. Previous CSJ reports on criminal justice (courts, sentencing and prison reform), asylum, family breakdown and children in care, *inter alia* have shown that mental ill-health compounds poverty and is possibly more effective at bringing people down and keeping them down than anything else.[1]

> Depression, anxiety and trauma do not discriminate in who they affect. Once they have hit at concentrated, disabling levels, they can take the individual on a whirl-wind rollercoaster ride to decline from a secure life to extreme poverty, homelessness, debt, unemployment, family breakdown, stigma, and social exclusion in less than three months (even quicker). Recovery could take years and the fall-out effects on other family members (children, parents, siblings, grand-parents, cousins) can mean that this individual nuclear bomb of depression and anxiety can cascade to others and affect others for further generations.[2]

Various other studies show that mental health is closely linked to many forms of disadvantage:

- In the case of psychotic disorders, the prevalence among the lowest quintile of household income is nine times higher than in the highest quintile.[3]

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1   See our full bank of policy reports at www.centreforsocialjustice.org.uk
2   My Time CIC, *Evaluation Report: Family Action for Choice Tomorrow* (2009-2011), p2 (project validated by C4EO; for more details see C4EO, Early Intervention [accessed via: http://www.c4eo.org.uk/themes/earlyintervention/vlpdetails.aspx?lpeid=312 (11/11/10)]
3   Centre for Social Justice, *Mental Health: Poverty, Ethnicity and Family Breakdown, Interim Policy Briefing*, London: Centre for Social Justice, 2011, p4

- In the UK, the highest prevalence of anxiety and depression is found among the 20-25 per cent of the population living in poverty – where the 20-25 per cent of people who are obese or smoke are also concentrated.[4]
- In London, self-reported mental health problems are around five times higher among refugees than in the rest of the population.[5]
- 'In-patient mental health services are dominated by the most vulnerable people – from disadvantaged inner-city areas, Black and minority ethnic (BME) groups and immigrants.'[6]
- Many of the most vulnerable individuals will have been detained under the Mental Health Act and will, effectively, have lost their liberty. The lower the level of social support available to them in the community, the greater the likelihood of being detained.[7]

For these reasons it is vital that all those who are working with the mentally ill should see themselves as an integral part of the much wider social movement to tackle welfare dependency and the other main drivers and effects of poverty: family breakdown, addictions, serious personal debt and educational failure. This is led nationally by the cross-departmental Social Justice Cabinet Committee in central government and similar structures should be put in place at the local authority level to keep this agenda on track and coordinate the full range of health, social care, educational and other sectoral efforts that are vital to transform outcomes.
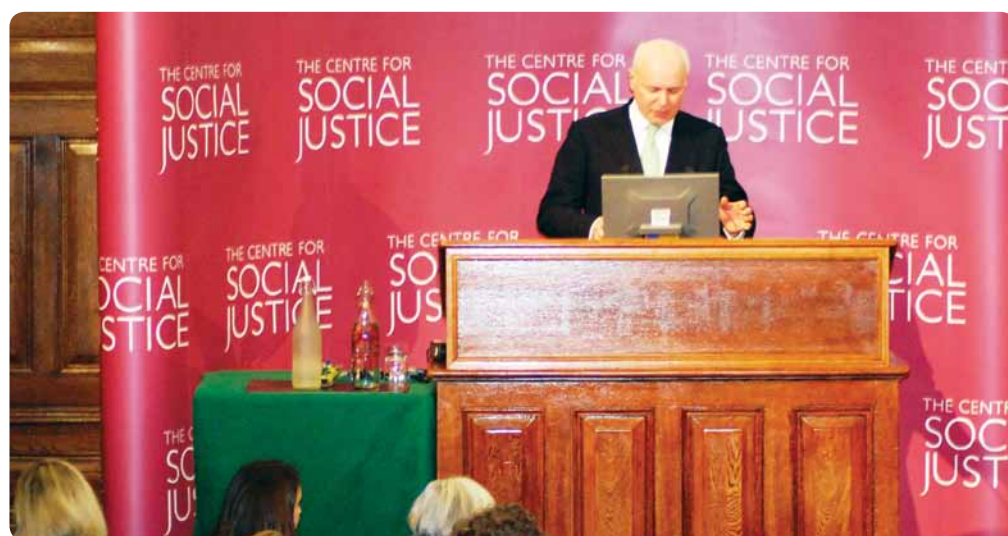
Rt. Hon. Iain Duncan Smith MP speaking at the launch of the CSJ Mental Health Review

The Department of Health (DH) is fully aware of the need to work closely with the rest of Government if outcomes are to be radically transformed:

'Mental health policy cannot be devised and implemented by any single government department or the NHS alone – it requires collaboration across central government, local government and the independent sector'.[8]

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4   World Health Organisation Regional Office for Europe, *Mental health, resilience and inequalities*, Denmark: World Health Organisation, 2009, pIII
5   Norman W and Ali R, *Stuck on London's hard shoulder: Social needs in a fast moving city*, London: The Young Foundation, 2010, p17
6   Quote from Professor Philip Sugarman, CEO and Medical Director of St Andrew's Healthcare at CSJ evidence hearing, 19 April 2010
7   Glover N, *An Investigation into Initial Institutional and Individual Responses to the Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-Making – Final Report, Thomas School of Law and Social Justice University of Liverpool* [accessed via: http://www.liv.ac.uk/law-and-social-justice/research/health/publications/An_Investigation_into_Initial_Institutional_and_Individual_R.pdf] (12/10/11])
8   Department of Health, *Mental Health and well-being* [accessed via: http://www.dh.gov.uk/en/Healthcare/Mentalhealth/index.htm (07/10/11)]

2. The Mental Health Review

In the process of conducting this Review we talked to individuals in over 100 organisations, a wide variety of people who used mental health services and who worked within them, and visited both Northern Ireland (where health is a devolved responsibility to the NI Assembly) and Norway. The Working Group is most grateful to the organisations and individuals who provided evidence, presentations, and caring or first-hand experience of mental ill-health, from which a wide perspective of observations and evidence was shared. We also commissioned two rounds of YouGov polling. The first, in July 2010, was of 1,005 people who had experienced mental health problems, or were a close friend or relative of someone who had, to identify the main concerns of those most closely affected. Our second, 'general population', poll tested some of our policy recommendations with more than 2,000 people in September 2011.

We found that the UK mental health system is perceived abroad as an international exemplar, particularly in terms of the extent to which we have deinstitutionalised our services. Enshrined in our legislation is the principle that people with mental illness should not be routinely shut away from the rest of society, but rather cared for in the least restrictive environment, usually in a community setting.

However, in terms of the extent to which our mental health services help the most vulnerable in society to recover, the UK has less to be proud of. Despite sustained policy attention, particularly since 1998, (important milestones from which are laid out in Chapter One) the inverse care law still dominates the delivery of mental health services; people with the 'protected characteristics' recognised in the 2010 Equality Act and particularly those of certain minority ethnic groups, are still more likely to be maintained or even simply 'contained' by the care they receive. Of most concern is the fact that they are far more likely to lose their liberty and to be detained against their will. This makes a mockery of the notion of 'care in the least restrictive environment', because these individuals are not getting the range of help they need to regain the level of function and quality of life necessary to live and indeed flourish in the community.

3. Completing the revolution

In this report we argue that there is an unfinished revolution in mental health care in the UK. The move out of the asylums, away from all the isolationist connotations these institutions evoked, did not simply require dismantling a physical infrastructure but also a far-reaching cultural change. Although achieved to a certain extent, this has, we will argue, stalled in spite of an abundance of initiatives to improve care in the community. The overarching reason it has lost momentum in the face of almost ceaseless NHS reform and change, is precisely because NHS activity, by itself, will always be only a small (albeit highly significant) contributor to what is ultimately required to complete the revolution.

This Review found that money is still tied up in in-patient care because the services people need are not available in the community. The bespoke 'human' needs that are often

the sphere of excellence of grassroots third sector charities or social microenterprises go unmet, largely due to imbalances in funding arrangements at a local level despite central rhetoric about 'any qualified provider'. Communities themselves need to become 'neighbourly' and places where social isolation is the exception to the norm. Stable and supportive environments are conducive to mental wellbeing. They are thus a protective factor against the development of mental illness and are more likely to be places where the mentally ill feel accepted and safe.[9] No matter how excellent the services delivered in the community, people's general milieu greatly influences their progress and recovery. The need to re-build communities is not limited to the issues surrounding mental health; the effects of community breakdown constitute a wider societal problem. While this report acknowledges and explores the effects of community breakdown in regards to mental health, it does not describe effective community building strategies as a distinct issue. For policy solutions on this subject, we direct our reader towards our recent reports on older age.[10]

Equally necessary for the successful completion of the revolution, is the institution that is the basic building block of community – the family. It so often is or could be the first port of call for those suffering mental distress, and yet is largely neglected in mental health policy. Although one's family can be at the root of the mental health problems faced, it can also, very often, be at the heart of the solution. Despite the large body of research implicating family breakdown as a cause (and effect) of mental illness, its prevention has never been recognised as a public health priority. Family members are often disregarded when care in the community is being designed around the patient and the therapeutic value of a loving family is often discounted. As a result, they receive little or no education to help them understand what their loved one is going though, which can fuel a sense of powerlessness and fear.

For example, late adolescence or early adulthood is often the age when symptoms of psychosis first emerge. Frequently this coincides with going to university or starting work for the first time. Families rapidly have to come to terms with the fact that their son or daughter has a mental illness, learn how to care and support them and work out how to navigate the mental health care system. We have, perhaps, forgotten the important role that families can play in caring for people with mental illness. Even if patients do not physically live in the home, they can still be part of a family that provides care and support.

Finally, family-sized and family-oriented solutions (such as Shared Lives care) when someone's birth family is unable to provide them with care and dedication, are often overlooked by commissioners. Yet such models have the power to deal with what are often the fundamental problems at the root of people's inability to function well. We look at examples of these in Chapter Seven on secondary care.

9   Scottish Development Centre for Mental Health, *National Programme for Improving Mental Health and Well-Being: Addressing Mental Health Inequalities in Scotland – equal minds*, Edinburgh: Scottish Development Centre for Mental Health, 2005
      [accessed via: http://www.scotland.gov.uk/Publications/2005/11/04145113/51151 (21/09/11)]
10   Centre for Social Justice, *The Forgotten Age: Understanding Poverty and Social Exclusion in Later Life, An Interim Report from the CSJ Older Age Working Group*, London: Centre for Social Justice, 2010; Centre for Social Justice, *Age of Opportunity: transforming the lives of older people in poverty*, London: Centre for Social Justice, 2011

This report will make recommendations in line with many of the Government's own priorities but also aim to challenge the institutional barriers that we feel could hamper a) their reforms for health, and mental health in particular, and b) the progress of the revolution in care that needs to be completed. We also draw on the deep seam of evidence that has been made available by other major pieces of research over the last 18 months and site our conclusions in the context of these.

4. The social gradient in health

Across all aspects of health, there is a pronounced and well-documented social gradient – the better the socio-economic position, the healthier the person – and in the area of mental health this is no less evident. Professor Marmot's 2010 *Strategic Review of Health Inequalities in England* found that people living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods. They will also spend more of their lives with a disability, on average a total difference of 17 years.[11]

This Review incontrovertibly demonstrates that health inequalities are caused by a complex web of diverse factors including income, education, disability and social isolation. They are strongly influenced by economic and social status and are more acutely felt by disadvantaged groups including people with mental health problems. As a World Health Organisation (WHO) report concludes, mental health is the key to understanding the impact of inequalities on health and other outcomes.[12]

Certain groups in society seem to have a higher prevalence of mental health problems which do not seem to be particularly well resolved, such as people from Black and minority ethnic (BME) communities and military veterans (although enormous variation exists within all of these categories). As well as poor access to treatment, they can also experience greater deprivation of liberty during treatment; the 2010 Count Me in Census showed once again that among Black people with mental health problems, rates of detention, seclusion and use of community treatment orders are higher than average. This is discussed in greater detail in Chapter Five.

Several other important recent reports have highlighted the strong link between mental health problems and other forms of disadvantage, most notably the wide-ranging Foresight Report.[13] This and the Marmot Review both emphasise the need for early intervention in the broadest sense and for a preventive, public health approach that stretches across society and goes far beyond health care, which is particularly necessary because mental health touches so many aspects of daily life.

11   Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England*, London: The Marmot Review, 2010

12   World Health Organisation, *Mental health, resilience and inequalities*, Copenhagen: World Health Organisation, 2009

13   The Government Office for Science, *Foresight Mental Capital and Wellbeing Project, Final Report, Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*, London: The Government Office for Science, 2008

5. A public health approach

The CSJ's aim is to tackle the underlying causes, not just the symptoms of social disadvantage, so throughout this report we take a public health approach to mental illness. We also take a lifespan approach, and consider how unmet needs and untreated trauma in the early years, school years and early adulthood can affect later mental health. However, we are not just concerned with prevention but also with treatment; where help and support is lacking or inappropriate and needs go unmet, people can sink into dependency and become trapped.

Public health is defined as improving, promoting and protecting health and wellbeing, preventing ill-health and prolonging life. The DH adopts a broad definition of health that encompasses both physical and mental health, as well as wellbeing: 'This means we are not only interested in whether or not people are ill or have a health condition, but also in how healthy and well they are'.[14]

Public health interventions have a significant impact on preventing mental health problems from developing or escalating further; they should complement, but not undermine mental health treatment services:

- A public health approach is not sufficient in itself to treat mental health conditions, nor is it a substitute for properly resourced specialist services and trained practitioners.
- Public health should have a stronger focus in mental health policy making, *alongside* addressing existing and future unmet need but should not detract from mental health provision.
- Public health is preventive, but services coming into the category of public health are valuable throughout a person's life; they are particularly relevant to mental health, where a person is likely to dip in and out of a range of services at different times.

Given the potentially enormous contribution a public health approach can make in improving mental health, it is one of the most important guiding principles of the Review. (A full summary of guiding principles is provided at the end of this Introduction.) Similarly we emphasise the importance of tackling stigma through a multi-faceted and society-wide strategy that is achievable by making mental health a key aspect of public health. Placing it at the heart of public health should greatly increase awareness and therefore openness around the issue of mental health. Chapter Two will take a more detailed look at these two vital issues which are major threads that run through the report.

First, however, we provide a *tour d'horizon* over the extent and major categories of mental illness, and its causes and effects as an aid to readers with less familiarity with the subject before briefly describing overarching factors associated with poor mental health.

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14   Department of Health, *Our Health and Wellbeing Today*, London: HM Government, 2010

5.1 A rough guide to mental health in the UK

The extent of the problem

- Mental illness is highly prevalent in the UK today; one in six of the adult population experiences mental ill-health at any one time.[15]
- Mental illness occurs at all ages and many people suffer problems throughout their lives.
- Half of all mental illness (excluding dementias) starts by the age of 14, so early intervention to prevent such illness will often mean in early childhood.[16]
- The population is aging and dementia will be an increasing burden; dementias currently affect one in 14 of people over 65 and one in six of those over 80.[17]
- Mental illness accounts for over 20 per cent of the total burden of disease in the UK, more than cardiovascular disease or cancer.[18] The NHS spends 13.8 per cent of its annual budget on mental health services.[19] The wider economic cost of mental health problems is around £105 billion.[20]

Categories of mental ill-health[21]

Terminologies for mental health problems vary considerably across professions and cultures: mental illness is sometimes described as a continuum with mild to moderate disorders/conditions at one end, and those which are severe and enduring at the other. So depression is known as a common mental disorder and might be mild to moderate in intensity, but it can also exist in severe forms and is classed as such when, for example, it co-exists with manic episodes.

A number of diagnostic and classification frameworks have been developed which classify mental health problems into categories. The most common are the WHOs International Statistical Classification of Diseases and Related Health Problems (version 10 is known as the ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (version 4 revised, DSM-IV-TR) by the American Psychiatric Association.[22, 23]

1. Common Mental Disorders: Anxiety and depressive disorders are often called 'common mental disorder' and are largely treated by primary care (GPs). Research has indicated that 20 per cent of women and 13 per cent of men over the age of 16 are found to have a 'common mental disorder'.[24] These include:

15   National Mental Health Development Unit, Factfile 3: *The cost of mental ill health*, London: National Mental Health Development Unit, 2010, p3

16   Ibid, p4

17   Alzheimers Society, *Dementia UK: The Full Report*, London: Alzheimers Society, 2007

18   Department of Health, *Public Mental Health and Wellbeing*, London: Department of Health, 2011

19   National Mental Health Development Unit, *Factfile 3: The costs of mental ill health*, London: National Mental Health Development Unit, 2010, p5

20   Centre for Mental Health, *The Economic and Social Costs of Mental Health Problems in 2009/10*, London: Centre for Mental Health, 2010 [accessed via: http://www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf]

21   Bebbington P et al, *Adult Psychiatric Morbidity Results of a Household Survey*, Leeds: The NHS Information Centre for health and social care, 2009

22   The World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems, Version 10*, Geneva: World Health Organisation, 1994

23   The American Psychiatric Association, *The Diagnostic and Statistical Manual of Mental Disorders Version IV, Text Revision*, Washington DC: American Psychiatric Association, 2000

24   King M et al, 'Prevalence of common mental disorders in general practice attendees across Europe', *The British Journal of Psychiatry*, 192, 2008, pp362-367

- *Depression:* one of the most frequent mental disorders; it is estimated that half of all women and a quarter of men will be affected by depression at some time in their life, and 15 per cent experience a disabling depression.[25]
  - Ten per cent of new mothers suffer from postnatal depression.[26]
  - Some individuals who experience depression also develop episodes of elevated mood (mania or hypomania) and this is classified as bi-polar affective disorder or manic depression (and as a serious mental illness).
  - If there have been more than two discrete episodes of depression in a life time, the term recurrent depressive disorder is used.
  - After one episode of depression the risk of a further lifetime event is increased to 40–50 per cent and after two previous episodes to 60 per cent.

- *Anxiety disorders:* anxiety is also very prevalent and symptoms of anxiety frequently co-exist with low mood and depression. It is categorised according to the situation in which it occurs and whether or not it is associated with acute attacks of panic.
  - In generalised anxiety disorder, individuals are anxious without any particular situational trigger.
  - The evidence suggests that at any one time, five per cent of women and three per cent of men over the age of 16 have generalised anxiety disorder.
  - Some people suffer from both anxiety and depression in equal measure and this is a mixed anxiety and depressive disorder. Approximately 11 per cent of women and seven per cent of men over 16 have mixed anxiety and depressive disorder at any one time.
  - Some suffer from acute attacks of anxiety known as panic. Approximately one per cent of women and men over 16 have panic disorder at any one time. In some cases this is associated with a fear and avoidance of crowded places (agoraphobia).
  - In obsessive compulsive disorder individuals suffer from obsessional thoughts (for example, about contamination) and engage in obsessional rituals. It is estimated that one per cent of women and men over 16 have obsessive compulsive disorder at any one time.

- *Post traumatic stress disorder (PTSD):* this was first described in 1980, following research into Vietnam veterans and the survivors of a number of civilian disasters.[27] However looking back in history, it has long been known that psychiatric disorders arise in response to traumatic events such as war, assaults and disasters. Railway accidents, the American Civil War and subsequent world wars were all associated with such conditions. The First World War was important in increasing the understanding of the effects of trauma on psychiatric disorders.
  - Amongst the general population, it is estimated that one per cent of men and two per cent of women have PTSD.
  - US research has indicated that the prevalence may be six times higher in veterans from Iraq or Afghanistan. However current research has shown no great increase in the prevalence of PTSD in UK veterans returning from Iraq or Afghanistan.[28]

- *Somatoform disorders:* these conditions are a significant burden on the NHS and essentially are when individuals express psychological distress as physical symptoms. Up to 40 per cent of patients attending general medical clinics at acute hospitals are thought to have no physical explanation for their symptoms, which are also known as medically unexplained symptoms or MUS (and include individuals with anxiety and depression as well as somatoform disorders).[29]

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25   National Institute for Health and Clinical Excellence, *Depression: the treatment and management of depression in adults,* London: National Institute for Health and Clinical Excellence, 2009

26   Ballard CG et al, 'Prevalence of postnatal psychiatric morbidity in mothers and fathers', *The British Journal of Psychiatry,* 164, 1994, pp782-8

27   The American Psychiatric Association, *The Diagnostic and Statistical Manual of Mental Disorders Version III,* Washington DC: American Psychiatric Association, 1980

28   Iversen A et al, 'The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study', *BMC Psychiatry,* 9, 2009, pp2-5

29   Page LA and Wessely S, 'Medically unexplained symptoms: exacerbating factors in the doctor-patient encounter', *Journal of the Royal Society of Medicine,* 96, 2003, pp223-227

2. Serious mental illness: It is estimated that between 0.5 per cent and one per cent have a serious mental health problem. These illnesses comprise of psychotic disorders such as schizophrenia (which involve a severe distortion of a person's perception of reality), bi-polar affective disorder and related disorders. Schizophrenia in particular has been shown to be closely linked with psychosis. One estimate cited by Mind suggests that around 37-40 per cent of people diagnosed with the highly prevalent mental symptom of psychosis will fit the diagnostic criteria for schizophrenia.[30]

The majority of the resources of secondary mental health services (mental health trusts) are directed at the treatment of those with so called serious mental illness. 'Figures from 2009/10 show that where a diagnosis was included for those who spent time in hospital, schizophrenia accounted for the most bed days. It is nearly double that of the second most common diagnosis which was mood affective disorders.'[31] Mind states that hospital admission rates are comparatively high for bipolar disorder, owing to the recurrent nature of the illness.[32]

3. Personality Disorders: these refer to enduring and inflexible patterns of behaviour that are abnormal (deviating markedly from the expectations of the individual's culture) and damaging to individuals or others. They are pervasive (affecting the whole of life), have an onset in adolescence or early adulthood, are stable over time and result in distress or impairment.

- It is estimated that six per cent of children aged five to16 have a conduct disorder, many of whom go on to have personality disorder in later life (for example anti-social personality disorder).[33]
- Personality disorder appears in 54 per 1,000 men and 34 per 1,000 women.[34]
- There is considerable comorbidity and many individuals with mental illness have comorbid personality disorder which worsens the outcome and associated disability. Some types of personality disorder are associated with criminal offending.

4. Addiction: Misuse and dependence on alcohol and other drugs is extremely common and places a huge burden on the individual, their family and society. This is also true of other forms of addictive behaviour such as gambling.[35]

- The prevalence of alcohol dependence in 2007 was 5.9 per cent (8.7 per cent in men and 3.3 per cent in women).[36] 24 per cent of the adult population have a hazardous pattern of drinking.[37]
- Comorbidity of alcohol and substance misuse with other psychiatric disorder is common. For example 80 per cent of people receiving treatment for alcohol misuse also experience anxiety and depression.[38]
- Up to half of people with mental health problems may misuse alcohol or drugs.
- Pathological addiction to gambling is increasingly recognised as a mental disorder and it will be in fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSMV).
- 300,000 people are affected at any one time in UK by problem gambling and it is estimated that 40 per cent had parents who were pathological gamblers.[39]

30 Mind, 'How common are mental health problems?' [accessed via: http://www.mind.org.uk/help/research_and_policy/statistics_1_how_common_is_mental_distress#_edn26]
31 Mental Health Network NHS Confederation Factsheet 2011
32 Ibid
33 Green H et al, *Mental Health of children and young people in Great Britain*, London: Palgrave Macmillan, 2004, p24
34 Coid J et al, 'Prevalence and correlates of personality disorder in Great Britain', *The British Journal of Psychiatry*, 188, 2006, pp423-431
35 National Institute for Health and Clinical Excellence, *Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence,* London: National Institute for Health and Clinical Excellence, 2011
36 The NHS Information Centre, Lifestyle Statistics, *Statistics on Alcohol: England, 2010*, Leeds: The Health and Social Care Information Centre, p54
37 Ibid, p8
38 Hawkings C et al, *Developing Service User Focused Outcomes in Dual Diagnosis: A Practical Tool*, National Mental Health Development Unit 2007
39 Sproston K, Erens B and Orford J, *Gambling Behaviour in Britain, Results from the British Gambling Prevalence Survey,* London: National Centre For Social Research, 2000

5. Attention deficit and hyperactivity disorder (ADHD): This is a relatively recently recognised disorder primarily characterised by co-existing attention problems and hyperactivity. It is most often detected in childhood (with symptoms starting before the age of seven) but then goes on into adult life, and is associated with conduct disorder and educational under-achievement.[40] It is estimated that 1.5 per cent of five to 16 year olds have hyperkinetic disorder (another name used for ADHD).[41]

Causes and effects of mental illness

Causes

The cause of individual mental health disorders is not clearly understood. A common way of classifying causes is to divide them into biological, social and psychological. Invariably, there are also interactions between the three, such that early childhood deprivation (psychological and social factors) can cause biological changes to brain structure and neuroendocrine function (the way the nervous system interacts with hormonal regulation). Therefore disorders which are associated with biological changes may be preventable/treatable by non-biological interventions early on. We go into more detail on these three causes in the summary of overarching factors at the end of this chapter.

- *Biological:* These include genetic vulnerability and are almost always not a single gene effect but the presence of multiple genes that increase the vulnerability to develop a psychiatric disorder, by for example altering the level of particular neurotransmitter receptors.
    - Brain injuries, either through trauma in adult life or at birth can cause psychiatric disorder by disrupting brain function and development.
    - Exposure to noxious substances during development *intra utero* can lead to psychiatric disorder as can levels of hormones and the general functioning of the neuroendocrine system.
    - Infection (such as encephalititis) can lead to psychiatric disturbances as can both illicit and prescribed medications.
    - Drug misuse can be both a cause and effect of mental and physical illness. Specialist psychiatrists report that 80 per cent of first episode psychiatric disorders, schizophrenia or schizophrenia-like illnesses, occur in either heavy cannabis users or cannabis dependents.[42] On an individual level, overall, cannabis use doubles the relative risk for later schizophrenia.[43]

- *Psychological:* in addition to biological (and social) factors, the psychological environment in which people are brought up is extremely important.
    - This includes poor or absent parenting.[44]
    - Sexual and physical abuse as a child is a very potent and common cause of mental illness in childhood and adult life.[45]
    - Bullying and harassment, both at school and in the work place are important. Research has shown too that some factors may be protective, such as the presence of an emotionally confiding relationship.
    - Bereavement, unemployment and the loss of a relationship can all lead to mental illness.
    - Trauma.

- *Social:* there is a large body of evidence that social factors and social deprivation are associated with increased rates of mental illness.[46]

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40   Biederman J, 'Attention-Deficit/hyperactivity disorder: a life-span perspective', *The Journal of Clinical Psychiatry, 59,* 1998, pp4-16

41   British Medical Association, *Child and adolescent mental health – a guide for healthcare professionals,* London: British Medical Association Science and Education department and the Board of Science, 2006, p9

42   Johns A, 'Psychiatric effects of cannabis', *The British Journal of Psychiatry,* 178, 2001, pp116-122

43   Arseneault L et al, 'Causal association between cannabis and psychosis: examination of the evidence', *The British Journal of Psychiatry,* 184, 2004, pp110-117 [accessed via: http://bjp.rcpsych.org/content/184/2/110.full?ijkey=bc8ea43b2ea3476b40abe7f5dfee2171463cf7a3 (12/10/11)]

44   Meltzer H et al, *Persistence, onset, risk factors and outcomes of childhood mental disorders,* Norwich: The Stationery Office, 2003

45   Collishaw et al, 'Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample', *Child abuse and neglect,* 31, 2007, pp211-229

46   Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England,* London: The Marmot Review, 2010

- Social isolation is a relevant factor, particularly in areas of rapidly moving population and when there is separation from the extended or nuclear family and other means of social support.
- Housing is very important as various factors such as a lack of space, excessive noise, and very poor or unsafe living conditions have been shown to negatively affect mental health. Homelessness is also correlated with increased levels of mental illness.[47]
- Inadequate health care, poverty in general (people in the lowest 20 per cent of household income have increased rate of mental disorder compared with those in the top 20 per cent), and racial or sexual discrimination, are all associated with increased rates of psychiatric illness.[48]

Effects

- In addition to the stress of mental illness itself, there are significant associations with physical health:
  - Increased psychological stress is associated with an 11 per cent increased risk of stroke.[49]
  - Depression predicts later colorectal cancer, back pain, irritable bowel syndrome and multiple sclerosis.[50]
  - There is also a significantly increased mortality: standardised mortality rates for those with serious mental illness are (scores of above 100 equate to above average death rates; a value of under 100 implies a below average death rate) 150 for all causes, 250 for respiratory disease 250 for cardiovascular disease and 500 for infectious disease.[51]
  - A diagnosis of depression in those over 65 increased subsequent mortality by 70 per cent.[52]
- Apart from the physical effects there is widespread social impact of mental illness. These include social isolation and the breakup of family and intimate relationships.
- There is a significant stigma associated with mental illness, both for those suffering with mental disorder but also those who care and treat such individuals. Such stigma includes a lack of economic opportunity in terms of less work, lower incomes and fewer qualifications.
- There is a strong association with both homelessness and an increased likelihood of contact with the criminal justice system.
- Mental illness is also strongly associated with suicide. The three-year average suicide rate for 2006-08 was 7.8 deaths per 100,000 population; 90 per cent of those who complete suicide are thought be suffering from mental illness.[53]

6. Overarching factors in mental health: a brief summary

Mental health – and ill-health – of every type and in every population is related to the same few interrelated and overarching factors. Quite how these factors interact is still not as clear as it might be and requires ongoing research. Tackling these interlocking drivers of mental ill-health requires designing integrated and preventive solutions. Thus, designing policy which has a broad understanding of the overall wellbeing of the population requires seeing mental health in the context of a public health perspective, and joining mental and physical health together, not only to better manage established illness but also to prevent it – often by intervening early in the life cycle.

47   Barnardos, *The Mental Health Needs of Homeless Young People Bright Futures: Working with Vulnerable Young People*, London: Mental Health Foundation, 2002
48   McManus S et al, *Adult psychiatric morbidity in England, 2007: Results of a household survey,* London: NHS Information Centre for health and social care, 2009
49   Surtees PG, 'Psychological distress, major depressive disorder, and risk of stroke', *Neurology,* 70, 2008, pp788-794
50   Grant I et al, 'Severely threatening events and marked life difficulties preceding onset or exacerbation of multiple schlerosis', *Journal of Neurology, Neurosurgery and Psychiatry,* 52, 1989, pp8-13
51   McEvoy JP et al, 'Prevalence of metabolic syndrome in patients with schizophrenia: Baseline results from the Catie trial and comparison with national estimates from NHANES III', *Schizophrenia Research,* 80, 2005, pp19-32
52   Saz P and Dewey ME, 'Depression, depressive symptoms and mortality in persons aged 65 and over living in the community: a systematic review of the literature', International *Journal of Geriatric Psychiatry,*16, 2001, pp 622-630
53   Hawton K and van Heeringen K, 'Suicide', *The Lancet,* 373, 2009, pp1372-1381

6.1 Biological/genetic factors

It is now ten years since the Human Genome Project was established and its importance in helping to explain some of the overarching features of our psychological wellbeing has become recognised. Understanding how our genetic background interacts with our environment is crucial in terms of early intervention and ultimately, prevention. Personalising both physical and mental health and establishing bespoke risk factors is within reach.[54]

The potential starting point for any intervention is also getting increasingly early due to the progress being made in the field of *epigenetics* (see below). This is the study of changes in gene activity that do not involve alterations to the genetic code; environmental factors can make an 'imprint' on genes that is passed onto one's offspring. 'Epigenetic marks' instruct genes to turn on or off, or to act more or less powerfully. It is through those 'marks' that environmental factors such as diet or stress can make an imprint on genes that is passed onto at least two successive generations. For example, the infant who is being carried in the womb of a starving mother will be affected by her malnutrition, and so too will the baby to whom the infant gives birth a generation later, after a well-nourished pregnancy and upbringing.[55]

What might be the implications for mental health? If we can, through research, identify key environmental triggers that have influence on brain function via the activation or deactivation of genetic potential, this will finally make the prevention of mental disorder an attainable objective by enabling interventions to be highly targeted at specific developmental processes and on individuals with genetic vulnerabilities.

6.2 Epigenetics

Until recently, scientists were convinced that genetic influences were determined effectively at conception. Environment could influence development within the constraints of what was determined by heredity. The interaction between genes and environment was seen in a fairly limited way in terms of inherited vulnerability to particular experiences. The potential for the interaction of nature and nurture became much greater once scientists realised that the genome (genetic material) itself was sensitive to its surroundings.[56]

Molecular mechanisms are available that could activate or deactivate a gene. These mechanisms are highly sensitive to the bodily, the physical and the social environment. Genes that coordinate the development of the brain may be particularly sensitive to experience in infancy. Early stress signals to the organism, via its genes, that it is born into an environment

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54   John Sulston and Francis Collins, Founders of the Human Genome Project [accessed via: http://genome.wellcome.ac.uk/node30075.html (21/09/11)]

55   Bygren LO, Kaati, G and Edvinsson S, 'Longevity Determined by Paternal Ancestors' Nutrition During Their Slow Growth Period', *Acta Biotheoretica,* 49, 2001; Meaney MJ, 'Epigenetics and the Biological Definition of Gene X Environment Interactions', *Child Development,* 81, 2010, pp41-79

56   Every organism, including humans, has a genome that contains all of the biological information needed to build and maintain a living example of that organism. The biological information contained in a genome is encoded in its deoxyribonucleic acid (DNA) and is divided into discrete units called genes. Genes code for proteins that attach to the genome at the appropriate positions and switch on a series of reactions called gene expression [accessed via: www.ncbi.nlm.nih.gov/About/primer/genetics_genome.html (16/09/11)]

filled with dangers and that it may need a stress response system which is quickly activated to respond to danger by flight or fright. The expression of other genes may take place later and the environmental influences on their functioning are only gradually becoming understood.

Personal meaning in mental illness

The evidence that mental illnesses, like physical illnesses, are caused by a mixture of genetics, environment, and the interaction between them, is just as strong as it is for most illness groups. However, there is a crucial difference between mental illnesses and illnesses of say, the liver or the heart. Mental illnesses affect the experience of the self in a way that physical illnesses do not and therefore, in a very real way, each person's own experience of, for example, depression or schizophrenia, is different from every other person's.

The symptoms may be characteristic of the illness, even identical from one person to another, but the meaning the person ascribes to the illness experience is unique to them. Moreover, this can affect the way they interpret the illness as part of their life trajectory; the way they seek help; the way they react to professional and family support, and many other aspects of the journey to recovery.

While personality factors certainly play a significant role in physical healthcare, the fact that mental illness fundamentally affects the experience of the self places a greater emphasis on the need to integrate biological, psychological and social aspects of care, and to ensure that all mental health professionals are well trained in understanding this need.

6.3 Psychological/neurological factors

As well as gene-environment interaction being a source of variability of mental health outcomes, psychological dispositions such as self-regulatory competencies, interpersonal expectations and neurobiological dispositions have also proved relevant to mental health outcomes.[57] These in turn are bound up with our relational experiences, particularly in early life.

The CSJ's previous report *Breakthrough Britain: the Next Generation* stated that a consistent and significant body of psychological and brain science research identifies the quality of our relationships, especially those in our earliest years, as being key to good emotional and physical functioning. Relationships strongly affect physical as well emotional health, and brain formation itself is crucially dependent on parent-child relationships.[58]

Specific issues with implications for this area include:

■ *Neurological effects of attachment-based trauma*: The experience of severe traumatic attachments in the first two years of life may result in structural limitations of the early developing right brain (which develops first).
■ *Behavioural consequences of early maltreatment:* The immediate developmental outcomes associated with early (and later) abuse.

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57 Kim-Cohen J et al, 'MAOA, maltreatment, and gene-environment interaction predicting children's mental health: new evidence and a meta-analysis', *Molecular Psychiatry,* 11, 2006, pp 903-913
58 Centre for Social Justice, *The Next Generation: A Policy Report from the Early Years Commission*, London: Centre for Social Justice, 2008

6.4 Social/cultural/community factors – poor mental health and poverty

> Children and adults from the lowest quintile (20 per cent) of household income are three times more likely to have common mental health problems (than those in the richest quintile).[59]
>
> Self-harm is more than three times as common in men and 2.5 times as common in women from the lowest 20 per cent of income compared with those from the highest 20 per cent.[60]

Deprivation causes physical health problems which greatly increase the risk of mental illness, particularly depression. The chronic low level stress of coping with daily hardship and disadvantage affects the way the body reacts, damaging people's physical health through higher cholesterol levels, blood pressure and heart disease.[61]

> Polling (of those who had experienced mental health problems or were a close friend or relative of someone who had) found that almost a third of people thought poverty was a major cause of poor mental health – but 40 per cent considered mental health to be a major contributor to poverty.[62]

People living in deprived neighbourhoods are more likely to experience many of the risk factors that have been identified for poor mental health. The 'pathways to poverty' that the CSJ has identified, and are the focus of our work, also contribute to the development or sustainment of poor mental health:

- Worklessness, benefit-dependency and the propensity to get into debt;
- Poor educational attainment;
- Family breakdown which leads to social isolation; and
- Addiction to drugs and alcohol.[63]

Just as the causes of poverty are also its effects, so too are the underlying contributory reasons for people suffering poor mental health reproduced in their lives. Many people with

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59 Green H, et al, *Mental Health of Children and Young People in Great Britain*, 2004. Office for National Statistics, Norwich: The Stationery Office, 2005; McManus S et al, *Adult Psychiatric Morbidity in Eng*land, *2007: Results of a Household Survey,* London: Health and Social Information Centre, Social Care Statistics, 2009

60 McManus S et al, *Adult Psychiatric Morbidity in England, 2007: Results of a Household Surve*y, London: Health and Social Information Centre, Social Care Statistics, 2009

61 Friedli L, *Mental Health, Resilience and Inequalities*, Mental Health Foundation, Geneva, Switzerland: World Health Organisation, 2009 [accessed via: http://www.mentalhealth.org.uk/publications/?entryid5=68603&p=2&char=M (21/09/11)]

62 CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010

63 Centre for Social Justice, *Breakthrough Britain: Ending the Costs of Social Breakdown,* London: Centre for Social Justice, 2007

mental ill-health often find it very hard to hold down a job, get a good education, or sustain healthy and positive relationships. People with mental health problems often self-medicate with drugs and alcohol.[64] In many cases reversing these drivers will help put people onto the road to good mental health, for example, 'good' work can greatly enhance wellbeing.

Family breakdown – both a cause and effect of poor mental health

One's family can be a causal factor in poor mental health as well as a key part of the recovery process, yet patients are often treated as individuals unconnected to a family system. Wider social networks and social support can promote a sense of belonging and wellbeing, and may prevent mental health problems.[65]

Conflict between parents has been associated with an array of adjustment problems in children, for instance: poor peer interaction, conduct problems, ill health, depression and anxiety, low self esteem, eating disorders, substance misuse and poor attachment.[66] Children with separated, single or step-parents are 50 per cent more likely to fail at school, have low esteem, struggle with peer relationships and have behavioural difficulties, anxiety or depression.[67] Yet it is also known that a parent who has a serious drug problem or is addicted to alcohol can exhibit very destructive behaviour patterns which can destroy the quality of life for the other parent and children, leading in turn to family breakdown.[68]

6.5 Implications for service delivery

Although we pay attention to the aetiology of mental ill-health throughout this report, which is vital for informing a preventive, public health approach, we are also focused on ensuring that treatment and care of those who are already in poor mental health is as effective as possible. Throughout this Review we repeatedly heard that mental health services are not adequately joined up either across assessment and treatment, or with other social care services. People's needs tend to be 'shoe horned' into service silos that are managed for the benefit of professionals rather than for the patients they are there to help.

Even providing the best treatment for all those with poor mental health would only reduce the burden of mental illness by 28 per cent.[69] Putting this another way, more than two-thirds of the burden of mental illness is not reduced by treatment. Working with other agencies (from the public, private or voluntary sectors) is essential given the complexity that is typical of the lives of people with mental health needs. This report includes many examples of good practice which showcase genuinely integrated services.

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64   Murali V and Oyebode F, 'Poverty, social inequality and mental health', *Advances in Psychiatric Treatment*, 10, 2004, pp216-224

65   Brugha TS et al, 'Primary group size, social support, gender and future mental health status in a prospective study of people living in private households throughout Great Britain', *Psychological Medicine*, 35, 2005, pp705-14; Melzer D, Fryers T and Jenkins R, *Social Inequalities and the Distribution of Common Mental Disorders*, London: Psychology Press, 2004

66   Cummings E and Davies D, *Children and Marital Conflict: The Impact of Family Dispute and Resolution,* New York: Guilford Press, 2004

67   Layard R and Dunn J, *A Good Childhood: searching for values in a competitive age*, London: Penguin, 2009, p28

68   Centre for Social Justice, *Breakdown Britain: Family Breakdown,* London: Centre for Social Justice, 2006

69   Andrews G et al, 'Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders', *The British Journal of Psychiatry*, 184, 2004, pp526-533

7. Key principles for the Review

We end this introductory chapter by setting out the key principles this Review has concluded are essential for delivering effective mental health care services at both mild to moderate and severe and enduring levels, some of which have already been explicitly stated.

- Stigma is considered by many to present the biggest barrier to tackling mental ill-health but tackling it will require a concerted effort that should include, but go beyond, the current media campaign approach in order to effect the profound cultural change that is required. As the new Government strategy document emphasises, 'Mental health is everyone's business'.[70]

- The national and local design and delivery of services needs to be guided by a public health and early intervention perspective – actively working towards positive mental health and wellbeing to prevent problems developing and intervening early to prevent them becoming more entrenched. This requires promoting protective factors, and identifying and acting upon risk factors.

- This will require a greater degree of joined-up thinking about mental and physical health, both of which should be seen through a public health lens. This has to take place both in a 'top-down' and 'bottom-up' way. Separating body and mind is inappropriate and unproductive.

- We endorse a 'recovery' approach, at the heart of which is 'hope' that people will lead a meaningful life despite having suffered from mental illness. However, it is essential that the concept is demystified for commissioners of services, those suffering from mental illness and ultimately for those in wider society. Specifically, a recovery approach has to tackle the pathways to poverty which contribute to the development or sustainment of poor mental health.

- It requires a diagnostic model that invariably includes the question 'what is the story?' not just 'what is the symptom?' with the aim of getting to the roots of mental health problems where possible.

- No age should be neglected in mental health – it is essential that we recognise the needs of both infants and older people.

- We take a rights-based approach and argue that where mental health services are insensitive to need and particularly if a coercive approach is inappropriately adopted, this can curtail patients' human rights.

- There should be a focus on outcomes not process, with 'just enough' administration so that clinicians are neither prevented from caring because of the burden of administrative tasks, nor able to 'hide behind' those tasks.

- In adult, child and adolescent services there should be an appropriate focus on patients' families, particularly as a potential resource. Family dynamics can contribute to mental distress but, even where this is the case, sidelining the family should not be the default approach. Other family members and relationships have to be considered; adult mental health services need to 'think family, think couple, think child'.

- We welcome the advent of the Improved Access to Psychological Therapies (IAPT) programme for adults and children but consider that it needs building upon and improving, particularly in terms of choice and accessibility if people's needs are to be met.

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70 Department of Health, *No health without mental health, a cross government mental health outcomes strategy for people of all ages*, London: HM Government, 2011, p5

- Mental health treatment is always a mixture of medical (especially pharmacological), psychological and social interventions (such as social networks and community-based solutions).

- Correspondingly, evidence of effectiveness for any approach, intervention or treatment is indispensable. However, the gold standard of the randomised control trial which is the *de minimis* for medical treatment should not be invariably, inappropriately or inflexibly applied to promising psychological and social programmes.

- We need to ensure that community-based voluntary sector services work as effectively as possible. The role of civil society and communities in promoting good mental health tends to be neglected but is essential for 'completing the revolution' which began with the closure of the asylums and the movement of treatment into the community.

- Resources for mental health do not and should not sit exclusively, or even mainly, within NHS mental health services.

- Importantly, community-based services should not be deployed on the grounds that they save money but because they are what will be most effective. All costs need to be justified by evidence of outcomes.

- Issues of public safety should be attended to without neglecting the care or violating the rights of the mentally ill.

- We are acutely aware of the very personal nature of mental disorder and the need for an individualised approach.

chapter one
Mental health policy: The unfinished revolution

1.1 Introduction

This chapter will briefly describe previous governments' approaches to mental health policy. It will touch on the landmark shift away from institutionalised care from the early 1960s onwards, but will focus particularly on the National Service Framework era, which began in 1998. The chapter ends with a brief overview of the current Government's recently published strategy. We conclude that while there are many promising aspects to this strategy and it has the potential to effect an even greater shift towards the comprehensive and high quality care in the community that could transform the lives of the most vulnerable, this will not happen as a matter of course. It will require a relentless focus on outcomes, the end of professional and budgetary silos, and a level of cross-departmental working in national and local governments that goes far beyond rhetoric and business as usual.

Members of the Working Group travelled to Northern Ireland to gather evidence of their approach to mental health services

While it is clear that there is much to be applauded in the UK's mental health system, indeed policymakers from other countries consider the UK to be a beacon of good practice in terms of the extent to which we have deinstitutionalised our services, the Review has concluded that the most disadvantaged fare badly. Care in the community too often means 'care in complete isolation', not least because money is disproportionately invested in buildings (mainly hospitals) rather than in the community itself. We heard that hospitals are rarely places where people become mentally well and regain their wellbeing and ability to function, whereas well-funded community-based services run by the public, voluntary and private sectors, that work together, have the potential to transform outcomes. Helping people cope with the full range of life's challenges – in other words, doing whatever that takes – at the same time as providing medication, therapy – whatever they need – would complete the revolution embarked upon half a decade ago.

Although the following quote comes from an American perspective and is several years old, it expresses well the goals of deinstitutionalisation and its downside when people's socio-economic and other needs go unattended.

> *'Deinstitutionalization was based on the principle that severe mental illness should be treated in the least restrictive setting…[and] this ideology rested on 'the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services.' This is a laudable goal and for many, perhaps for the majority of those who are deinstitutionalized, it has been at least partially realized.*
>
> *For a substantial minority, however, deinstitutionalization has been a psychiatric Titanic. Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The 'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies.'*[1]

1.2 Overview of key Government policy on mental health 1997–2010

The mental health and wellbeing of communities involve complex issues, and policy initiatives from a wide range of government departments and local agencies impact upon it. It is not an exaggeration to say that mental health influences everything, from the life chances of children and young people, to reoffending rates in the criminal justice system, to the ability of people to work and make a contribution to the economy.

This short overview of some of the key policies of the previous Government relating to mental health is therefore not intended to be an exhaustive list – there are few policy areas that do not relate to mental health and wellbeing in some way. In this section we outline the major initiatives relating to the NHS and selected wider cross government activity, and also consider changes to mental health legislation, using a timeline approach.

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1   Torrey EF, *Out of the Shadows: Confronting America's Mental Illness Crisis*, New York: John Wiley and Sons, 1997

1998: Reform of the Mental Health Act began with a Green Paper and Expert Committee report led by Professor Genevra Richardson. (The latter's recommendations were then countered in a White Paper and two draft Bills published in 2002 and 2004 for completely new legislation.) Eventually a 2006 Bill was published to amend the 1983 Act and this was passed in 2007 (as mentioned below) after an acrimonious and lengthy journey through Parliament where the Liberal Democrats and Conservatives joined with cross-benchers to defeat the Government in the Lords six times.[2]

1999: The DH produced the first two of the Government's National Service Frameworks, specifically for coronary heart disease and mental health, indicating the new, high priority they intended to place on the latter.

> *'Despite its prevalence and importance mental illness hasn't had the attention it deserves. That's why the Government is determined to give it a much higher priority.'*[3]

The National Service Framework for Mental Health (NSFMH) was a ten year strategy that focused on the needs of adults, aged 16 to 65. It was largely developed to address a perceived failure of adult mental health care in the community. The report entitled *Modernising Mental Health Services: safe, sound and supportive* which incorporated findings from the National Service Framework External Reference Group made the following observations:

> *'Taken overall, the policy of care in the community failed because it left some people vulnerable, others a threat to themselves or a nuisance to others, with a small minority a danger to the public. With the dedication of staff it did, though, bring many beneficial changes to the care and treatment of people with mental illness. Sheltered employment and rehabilitation programmes were developed, and new drugs were discovered. During the past thirty years, many people left the Victorian asylums for a better quality of life in their own neighbourhoods with support from community based staff.*
>
> *But the policy was always overly optimistic and it has become clear that care in the community is failing because:*
>
> ■ *a group of service users has begun to emerge with severe mental illnesses – typically schizophrenia – who are socially isolated, difficult to engage and obviously in need of care in the long term: care in the community has often failed to deliver the treatment and support they need;*
> ■ *families who contributed willingly to the care of people with mental illness, have found they are overburdened*

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2   House of Commons Library Social Policy Section, *The Mental Health Bill, research paper*, London: House of Commons Library, 2007 [accessed via: http://www.parliament.uk/documents/commons/lib/research/rp2007/rp07-033.pdf (28/09/11)]

3   Department of Health, *National service framework for mental health: modern standards and service models*, London: Department of Health, September 1999, p2

■ *inadequate systems, poor management of resources and underfunding have resulted in widespread and unacceptable variation in standards;*

■ *problems of recruitment, retention and poor staff morale are commonplace, particularly in the inner cities.'[4]*

Its overarching *values* of social inclusion, care in the least restrictive setting possible, user choice, carer support and consideration for the needs of minority ethnic groups were considered by many to be excellent. It also closely specified how these values would be delivered and performance measured. This resulted in considerable investment and a reduction in some of the variability in delivery of secondary mental health care across the country. It also, however, led to a rather prescriptive model of mental health service delivery which was very process-driven and target-oriented.

Its key feature was the creation of three new specialist service models for people with severe mental health problems, which have been copied abroad (as in Norway, visited by the Mental Health Review) and were designed to work as follows:

■ **Crisis resolution and home treatment teams**
Crisis resolution teams support people in their own homes through counselling, practical help, monitoring, and liaison with other services. The model is available 24/7. Home treatment teams were developed as an alternative to hospital admission with, ideally, a package of treatment and care (drug treatments and psychological therapies) delivered.

■ **Assertive outreach teams for community support**
A form of intensive case management that provides a clinically effective approach to managing the care of severely mentally ill people in the community. Staff visit them at home, act as an advocate, and liaise with other services such as the GP or social services. Help is usually needed to find housing, secure an adequate income, and sustain basic daily living – shopping, cooking and washing, for example.

■ **Early intervention teams for young people with first-time psychosis**
Specialist mental health services offering intensive, evidence-based support to individuals as young as 14, who are experiencing a first episode of a psychotic disorder.

That same year saw the establishment of the **National Institute for Health and Clinical Excellence (NICE)**, which increased the amount of guidance available on the most effective and cost-effective ways of delivering mental health care and ensured some consensus on what are evidence-based interventions.

It is essential that a modern health service has access to this kind of expertise which draws on systematic reviews, studies of randomised control trials, well designed intervention and

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4   Department of Health, *Modernising health services safe, sound and supportive,* London: Department of Health, January 1998, p15 [accessed via: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4046866.pdf (09/09/11)]

observational studies as well as expert opinion, including the opinion of service users and carers. However this is guidance, not prescription and NICE itself is at pains to point out that lack of evidence does not necessarily mean lack of effectiveness.

> ### Applying NICE guidance[5]
>
> Once NICE guidance is published, health professionals (and the organisations that employ them) are expected to take it fully into account when deciding what treatments to give people. However, NICE guidance does not replace the knowledge and skills of individual health professionals who treat patients; it is still up to them to make decisions about a particular patient in consultation with the patient and/or their guardian or carer when appropriate.

1.3 The era of targets – advantages and disadvantages

2000: **Spending Review PSA White Paper** published, establishing Public Service Agreements (PSAs), a series of cross governmental targets to reduce health inequalities, suicides and improve outcomes of people with mental health conditions.[6]

The NHS Plan was also published in the same year. This targeted eight care areas, one of which was mental health (it injected £300 million to fast-forward the NSFMH over four years and included a specific pledge to create and train 1,000 new graduate mental health staff to work in primary care, acknowledging the importance of the latter's role).[7]

At this point the three new teams mentioned in the NSFMH (tasked with assertive outreach, crisis resolution and early intervention for young people with first-time psychosis) were mandated in targets and funding ring-fenced for community mental health services and help for those in prison. Although this led to an overly prescriptive approach to mental health service delivery, it has been argued that this was the reason the teams became so firmly embedded as many of the other aspirations in the NSFMH were never translated into reality.

2001: **Changing the Outlook**, a joint policy between DH and the Home Office created the principle of 'equivalence' for prison health care, began the process of the NHS taking responsibility for this which was universal by April 2006 and led to creation of 'inreach' teams in all prisons in England.[8]

2002: DH set up the **National Institute for Mental Health** in England to guide implementation of NSF with network of regional offices. This was later absorbed into the Care Services Improvement Partnership abolished in 2008 shortly after which (2009) the National

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5   National Institute for Health and Clinical Excellence, NICE and the NHS [accessed via: http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp]

6   HM Treasury, Spending Review, Public Service agreements [accessed via: http://webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/pss_psa_index.htm (16/09/11)]

7   Department of Health, *The NHS Plan: a plan for investment, a plan for reform*, London: Department of Health, July 2000

8   Department of Health, *Changing the outlook: a strategy for developing and modernising mental health service in prisons*, London: Department of Health, December 2001

Mental Health Development Unit was created. This was also recently abolished leaving many wondering how the current Government's mental health strategy will be implemented.

2003: Personality Disorder: No longer a diagnosis of exclusion published by DH who, for the first time, said mental health services had to offer support to people with PD.

Criminal Justice Act creates Imprisonment for Public Protection with indeterminate sentences which have subsequently been used for many people with fairly serious mental health problems, and the new Community Order which includes a little-used Mental Health Treatment Requirement.

Scottish Mental Health Act passed: creates legal framework for mental health in Scotland along similar lines to the Expert Committee's rejected proposals for England

2005: Mental Capacity Act: Deprivation of liberty safeguards addressing 2004 European Convention on Human Rights 'Bournewood' judgement, requiring that people may only be deprived of their liberty through a process set out in law, with safeguards to prevent arbitrary detention and speedy access to a Court to review the detention.

Delivering Race Equality Programme: established in the wake of the Bennett Inquiry report, to tackle variations in the access to and experiences of mental health services by people from different ethnic groups. A five year review of the programme was published in December 2010.[9] It set ambitious targets for race equality in mental health services and measures including the creation of community development workers. Implementation has been mixed with no evidence of reduced inequalities in bed use. This is considered in more detail in Chapter Five.

2006: First demonstration sites set up for the **Improving Access to Psychological Therapies** programme, in Newham and Doncaster PCTs, to take forward the 2005 Labour manifesto commitment to improve access to psychological therapy for common mental disorders. Each of the ten pathfinder sites set up by the program in 2006/7 aimed to learn more about providing an IAPT type service to one of the following patient groups:

- BME groups;
- Young people;
- Offenders;
- Old people;
- People with medically unexplained symptoms;
- People with long term conditions; and
- Perinatal care.

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9   National Mental Health Development Unit and Equalities in Mental Health, *Race equality action plan: a five year review*, London: Department of Health, 2010 [accessed via: http://www.nmhdu.org.uk/silo/files/race-equality-action-plan-a-five-year-review.pdf (16/09/11)]

More recently, in March 2009, additional funding was announced to allow the roll-out of talking therapy services across the country throughout 2009 with services beginning to be available in every area by 2010. Crucially, the explicit aim was for employment support workers to be linked to every talking therapy service, providing job support for people with common mental health problems and help people back to work.

Again, while IAPT was an important step forward in making therapies more widely available. However, much more needs to be done to ensure that:

- People needing access to psychological therapy are given a real choice of effective treatments;
- Many forms of psychological therapy that may be able to achieve good outcomes have not yet had the opportunity to go through the research procedures necessary to achieve NICE approval. So people are potentially losing out on accessing a wider range of effective therapies through the NHS. NICE must take this into account when making recommendations on where new research should be targeted;
- Waiting times from referral to treatment reduce markedly and people receive sufficient sessions to make genuine progress; and
- Therapy is available to all those who may benefit from them, including people with severe mental health problems and members of BME communities.[10]

2007: Mental Health Act: Overhaul of legal framework controlling when and how a person can be detained for compulsory treatment of mental illness. It included the introduction of community treatment orders (CTOs), through which a person can be subject to compulsory treatment while living in the community. These are considered in more detail in Chapter Five on BME groups (who are disproportionately subject to these orders) and in the Chapter Seven on secondary care.

2008: The NHS Next Stage Review endorsed the proposal to include NHS funding within personal budgets.[11]

2009: National Dementia Strategy published which aimed to increase awareness of dementia, promote early diagnosis, and improve the quality of care provided.[12]

Children and Adolescent Mental Health Services (CAMHS) Review and 2010 Government Response.[13]

Bradley Review of mental health and learning disability in the criminal justice system and the Government's national delivery plan to reduce reoffending and improve

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10   We Need to Talk Coalition, *We need to talk: Getting the right therapy at the right time*, London: Mind, 2010
11   Department of Health, *NHS next stage review: our vision for primary and community care,* London: Department of Health, July 2008
12   Department of Health, *Living well with dementia- a National Dementia Strategy*, London: Department of Health, 2009
13   Department of Health, *Children and young people in mind: the final report of the National CAMHS Review*, London: Department of Health, 2008; Department of Health, *Keeping children and young people in mind: the Government's full response to the independent review of CAMHS*, London: Department of Health, 2010

(physical and mental) health, Improving Health, Supporting Justice.[14] Developed by the Health and Criminal Justice Programme Board, this built on Lord Bradley's review.

Work, recovery and inclusion and **Working our way to better mental health: a framework for action,** two cross-departmental strategies (particularly involving the DH, the Department for Work and Pensions (DWP) and the Department for Business, Innovation and Skills, to improve employment outcomes for those with common mental disorders and more serious mental illnesses.[15]

New Horizons: with the existing National Service Framework coming to an end in 2009 this set out the next phase of cross-government policy on mental health in England. It had an explicitly public health approach, aiming to improve the general mental health and wellbeing of the population, and the quality and accessibility of adult mental health services in England.[16]

1.4 The current Government's approach to mental health

In recent months, the Government has introduced a raft of legislation and policies with significant mental health implications.

- The **Health and Social Care Bill**, together with the White Paper **Equity and Excellence: Liberating the NHS, the Command paper Liberating the NHS: Legislative Framework and Next Steps** and the **Operating Framework for the NHS in England 2010/11**, set out the Coalition Government's plan for the NHS in England.[17, 18, 19, 20] They have also issued a response to the NHS Future Forum report commissioned to address concerns about these plans from across the health sectors. We look at this in more detail in Chapter Six on primary care.
- Children and young people's NHS services are covered in the companion document **Achieving Equity and Excellence for Children: how liberating the NHS will help us meet the needs of children and young people**.[21]
- **A Vision for Adult Social Care: Capable Communities and Active Citizens** sets out the agenda for social care reform.[22]

14 Department of Health, *Improving health, supporting justice: the national delivery plan of the Health and Criminal Justice Programme Board*, London: Department of Health, 2009

15 HM Government, *Work, Recovery and Inclusion: Employment support for people in contact with secondary care mental health services*, London: National Mental Health Development Unit, 2009; Cross-government Health, Work and Well-being Programme, *Working our way to better mental health: a framework for action*, Norwich: The Stationery Office, 2009

16 Department of Health Mental Health Division, *New Horizons: a shared vision for mental health*, London: Central Office of Information, 7 December 2009

17 Parliament UK, Health and Social Care Bill [accessed via: http://www.publications.parliament.uk/pa/bills/lbill/2010-2012/0092/lbill_2010-20120092_en_1.htm (29/9/11)]

18 Department of Health, *Equity and Excellence: Liberating the NHS*, Norwich: The Stationery Office, 2010

19 Department of Health, *Liberating the NHS: legislative framework and next steps*, Norwich: The Stationery Office, 2010

20 Department of Health, *Revision to the Operating Framework of the NHS in England 2010/11*, Norwich: The Stationery Office, 2010

21 Department of Health, *Achieving equity and excellence for children: How liberating the NHS will help us meet the needs of children and young people*, London: Department of Health, 2010

22 Department of Health, *A vision for adult social care: Capable communities and active citizens*, London: Central Office of Information, 2010

- **Healthy Lives, Healthy People: Our Strategy for Public Health in England** explains the Government's vision for public health, including the expanded role of local authorities in health and health improvement.[23] It emphasises the importance of mental health, which is reflected in **Healthy Lives, Healthy People: Transparency in Outcomes – Proposals for a Public Health Outcomes Framework**.[24]

- **No Health without Mental Health**, the new cross-government mental health outcomes strategy, outlines the Government's vision for improving the mental health of the population through high quality mental health services, early intervention when mental illness arises, prevention of mental illness and promotion of population mental wellbeing.[25]

1.5 Cross-government mental health strategy

Similar to New Horizons before it, the mental health outcomes strategy, **No Health without Mental Health**, has two key and interlinked aims:

- Improve *outcomes* for people with mental problems; and
- Build individual and community resilience and wellbeing in order to prevent ill health (the public health approach).

As such it is designed to work closely with the **Healthy Lives, Healthy People strategy for public health in England** and – as a cross-government, rather than DH strategy – expects input from all relevant government departments towards meeting these aims. The role of the cross-cutting Social Justice Cabinet Committee will therefore be crucial in ensuring that policies are implemented to benefit those who are subject to the inverse care law (who typically receive the poorest health care yet are most in need of it).

The strategy is structured around six shared, cross-government and multi-agency mental health objectives, consistent with those set out in the NHS, social care and public health frameworks. The objectives are designed to support delivery of the two aims:

(i) **More people will have good mental health:** More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

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

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23 Department of Health, *Healthy lives, healthy people: our strategy for public health in England*, Norwich: The Stationery Office, 2010

24 Department of Health Public Health Development Unit, *Healthy Lives, Healthy People: transparency in outcomes, proposals for a public health outcomes framework*, London: Department of Health, 2010

25 HM Government and Department of Health, *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*, London: HM Government, 2010

(iii) **More people with mental health problems will have good physical health:** Fewer people with mental health problems will die prematurely and more people with physical ill health will have better mental health.

(iv) **More people will have a positive experience of care and support:** Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

(v) **Fewer people will suffer avoidable harm:** People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

(vi) **Fewer people will experience stigma and discrimination:** Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.[26]

The Joint Commissioning Panel for Mental Health identify the key policy imperatives driving mental health since the change of government as follows:

- 'Improving population mental health and wellbeing and shifting the locus of power and responsibility to individuals, communities and local government;
- Increasing people's choice and control over services through personalisation of assessment processes and service provision; and
- System reform to support innovation and free up resources to follow people's choices through personalisation, Payment by Results and related developments.'

Importantly, they say, these aims and the emphasis on achieving improved outcomes for people with a range of mental health needs, regardless of their age and background, 'broaden the focus of intervention beyond the traditional arena of medical and social care'. Addressing the wider determinants of mental health and wellbeing, such as employment, education, housing, relational networks and the environment will be essential.

This will require services to be 'person-centred, cost-effective, clinically effective and safe. They have to work upstream, at the preventive and promotion end of the spectrum, as well as downstream with people experiencing severe mental illness'. Some services fitting this bill work outside of the usual categories of mental health provision and commissioners (who buy in services at the local level) will have to work with and in partnerships of organisations from the public, private, voluntary and community sectors.[27]

26   Department of Health, *No Health Without Mental Health, a cross government mental health outcomes strategy for people of all ages*, London: Department of Health, 2011, p6
27   National Mental Health Development Unit, Practical Mental Health Commissioning: A framework for local authority and NHS commissioners of mental health and wellbeing services, London: Joint Commissioning Panel for Mental Health, 2011, pp6 and 8 [accessed via: http://www.nmhdu.org.uk/silo/files/practical-mental-health-commissioning.pdf (28/09/11)]

1.6 Conclusion

In many ways, the new mental health strategy has good foundations on which to build:

- The last Government's *New Horizons* acknowledged the need to take a cross-governmental and public health approach;[28]
- There are now significantly better community services for many people with severe mental illness, and even though the current, more explicit, focus on outcomes is sorely needed, the NSF targets did make a big difference to many people's lives;
- There are the beginnings of investment in psychological therapies and much-needed support for people with depression – support for those at the mild to moderate/common mental illnesses end of the spectrum;
- The transfer of prison health care to the NHS is also an improvement although it is still under-funded and the implementation of the Bradley Report remains a priority. A key aspiration which this Review endorses is that no one with serious mental illness should be inside a prison, especially given the high number of unoccupied secure beds available in the private sector.[29]
- There is a much more pervasive recognition that employment is important to people with mental health problems; the new 'fit note' should become increasingly useful over time in this regard;
- The last decade has also seen investment in new buildings and facilities for inpatient services: many old Victorian hospitals have been refurbished or rebuilt; and
- A number of new roles have also been introduced to mental health, including primary care mental health workers, Support, Time and Recovery workers and community development workers (who are particularly focused on minority ethnic communities). Peer support services are also gaining some prominence, highlighting the contribution people with experience of using services (personally, or as a carer) can bring to improving outcomes.

However, as we describe in more detail in the following chapters, the strategy has its work cut out to ensure significant progress is made on the ground in the following areas:

- The Delivering Race Equality agenda had raised the profile of unmet need in BME groups without sufficiently improving major indicators such as detention rates and admissions.
- Chapter Seven on secondary care explores the extent to which inpatient services remain unreformed: limited in terms of providing therapeutic interventions and poorly linked into community services. In-patient services are still the most costly part of the mental health system.
- In primary mental health care, most GPs are still under-skilled in mental health issues, and rates of anti-depressant prescriptions have increased. (Prisons especially lack primary mental health care.) Clinical Commissioning Groups (CCGs) will have to compensate for this lack of expertise in how they are constituted and ensure that sufficient attention is given to a public mental health agenda.

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28   Cross-government strategy: mental health division, *New Horizons: a shared vision for mental health*, London: HM Government, 2009
29   This was a recommendation made in Centre for Social Justice, *Locked up Potential: a strategy for reforming prisons and rehabilitating prisoners*, London: Centre for Social Justice, 2009

- CAMHS has seen some recent improvements but these have not kept pace with levels of need and children's mental health care is still very patchy. As we describe in Chapter Four, there are some recent and promising initiatives in schools but much progress remains to be made.

- Mental health legislation arguably still needs to be properly reformed; we support the Future Vision Coalition's call to carry out a major review of the use and impact of the Mental Health Act (2007) after a sensible waiting period.[30] England now has a very different system to Scotland and the latter looks far more modern.

- Although great strides have been made in public health (for example with the smoking ban in public places) as yet there has been too little investment in prevention and promotion of mental health despite steep inequalities and clear links to social exclusion.

To reiterate, given the need to ensure that the most vulnerable do not continue to be bypassed by improvements in mental health care enjoyed by the rest of the population, there is a particularly important role for cross-cutting bodies such as the Social Justice Cabinet Committee and local health and wellbeing boards, to make sure mental health is at the heart of a preventive public health agenda. It is to this subject we now turn.

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30   The Future Vision Coalition, *A future vision for mental health*, London: The Future Vision Coalition, 2009 [accessed via: http://www.newvisionformentalhealth.org.uk/A_future_vision_for_mental_health.pdf (28/09/11)]

chapter two

Tackling mental ill-health and stigma through a public health approach

2.1 Introduction

The contribution a public health approach could make to improving mental health at a population, community, family and individual level is potentially enormous. In this chapter we look across a full range of implications of making this shift towards designing and delivering national and local services from a public health perspective. We note from the outset this Government's frequently expressed commitment that, on their watch, the nation's health will be considered through this lens. We start by explaining the importance of tackling stigma through a multi-faceted and society-wide strategy that is achievable by making mental health a key aspect of public health.

2.2 Stigma

For many centuries, people with mental health problems were literally 'out of sight and out of mind'. The phrase 'round the bend' is derived from the days when the asylums, built in Victorian times, had a bend in the entrance drive so that they couldn't be seen from a distance. It was only in the 1950s, when the Government started the closure programme of the asylums, that there began to be increased openness about mental health. In general, understanding about mental health and poor mental health remains lacking, with public polls over many years confirming low levels of knowledge, and unhelpful attitudes and behaviours. This Review's interim briefing described how human beings' deeply-rooted antipathy to mental illness may be based in bio-neurology as well as in misunderstanding. There may be something fundamental about mental illness that frightens us more than any physical disease and forces us to turn away from it.[1]

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1   Centre for Social Justice, *Mental Health: Poverty, Ethnicity and Family Breakdown, Interim Policy Briefing*, London: Centre for Social Justice, 2011, p14

Yet anyone can experience a mental health problem – one in four will develop a mental health problem in a year. Formal and informal stigma associated with it persists, despite the inclusion of mental illness in the 2010 Equality Act.[2]

Members of the Mental Health Review visited Norway to look at a system which had made significant progress in vesting mental health with the same significance as physical health and in tackling stigma. We met with the former Prime Minister Kjell Magne Bondevik, who is considered to be the most senior politician globally to disclose mental health problems yet remain in office and be re-elected. Bondevik refers to stigma as being 'a main problem, maybe the main problem regarding our efforts to improve the mental health situation in our countries.'[3]

Yet research carried out on media coverage on mental health issues (in the UK and US) has found that:

'…when it came to directly addressing issues around stigma or discrimination...very few headlines or articles did so in either country...The question perhaps to be asked by any further research would be why is stigma not more extensively covered when it is such a big problem for people with mental illnesses and therefore a significant problem for our society?'.[4]

The mental health charity ok2b describes stigma as 'an attitude, based on ignorance, prejudice and fear of a particular group which leads to being treated unfairly or less favourably than others due to mental health problems'.[5] Stigma skews many individuals' life chances. A systematic review has found that stigma and discrimination related to mental illness has a range of financial impacts through effects on employment, income, public views about resource allocation and healthcare costs.[6] Discrimination due to disclosure of a mental illness typically continues long after the symptoms have been treated or managed effectively. It can lead to being refused employment or to substandard treatment for physical health needs as we explain in our chapters on primary and secondary care.

Research carried out among 3,000 service users and 660 carers in England found that discrimination stopped two-thirds of people with mental health problems from volunteering, taking part in activities, joining clubs, making friends and more actively engaging in community life.[7] In short, as one person expressed it, 'the fear of stigma and discrimination caused me to retreat from life'. Furthermore, as Link and Phelan have observed, if the impact of stigma is considered at all, it is usually only in relation to a

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2   NHS Information Centre, *Adult psychiatric morbidity in England, 2007: results of a household survey*, London: NHS Information Centre, 2009
3   Keynote address at EU High level conference Together for Mental Health and Well-being, 13 June 2008, Brussels
4   O'Hara M, *Press Coverage of Mental Health and Suicide*, Gresham College Lecture, 14 December 2010 [accessed via: http://www.gresham.ac.uk/print/2636]
5   Ok2b, *What is Stigma?* [accessed via: http://www.ok2b.org/page4.html (14/09/11)]
6   Sharac J et al, 'The economic impact of mental health stigma and discrimination: A systematic review', *Epidemiologia Psichiatria Sociale*, 19, 2010, pp223-32
7   Time to Change, *Stigma Shout*, London: Time to Change, 2008

particular circumstance at a particular time. However, if the cumulative effects of stigma arising from different situations in an individual's life are taken into account, the impact is much greater.[8]

The stigma surrounding mental illness affects people of all ages, but there is a strong case for developing anti-stigma initiatives targeting children and young people while their attitudes, identities and skills are developing. In its next phase, the anti-stigma campaign Time to Change will be looking at specific programmes for children and young people, and how children themselves could help to develop initiatives aimed at schools, sports clubs and libraries (see below for evidence to suggest that public anti-stigma campaigns such as Time to Change are shifting attitudes slowly).[9]

Addressing the causes and effects of stigma will be key to the success (or failure) of the recovery approach which undergirds the Government's mental health strategy and emphasises 'the equal importance of good relationships, education, employment and purpose alongside reduction in clinical symptoms'.[10]

Revoking existing discriminatory legislation is also a vital tool in tackling mental health discrimination, such as section 141 of the 1983 Mental Health Act, which stipulates that an MP who receives six months or more medical treatment for a serious mental health problem must be removed from his or her seat. The Government has committed to repealing this section by December 2012 and **we recommend that the Government also support Lord Stevenson's Private Members Bill, which seeks to repeal discriminatory legislation relating to jury service, school governance and company directors**.[11]

The Young Minds Children and Young People's manifesto says, 'don't ignore us when we are young – we are your future… we need help and support early on – not when it's too late'.[12]

The figure below illustrates how public education and anti-discrimination programmes, strong local initiatives and good quality services, can all work together to improve mental and physical health, and the negative effects when these are absent or disjointed.

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8   Link B and Phelan J, 'Stigma and its public health implications', *The Lancet*, 367, 2006, pp528-529
9   *Time to Change* is a national programme to end the discrimination faced by people with mental health problems and improve the nation's wellbeing
10 Department of Health, *No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, London: HM Government, 2011
11 The Juries Act 1974 bans those who are receiving treatment for mental health problems from sitting on a jury; the Companies Regulations 2008 provides that somebody who is 'mentally incapable' must cease to be a company director; and the School Governance Regulations 2007 exclude anybody who has been detained under the Mental Health Act from serving as a school governor
12 Young Minds, *Children and Young People's Manifesto*, London: Young Minds, 2010 [accessed via: http://www.youngminds.org.uk (12/09/11)]

Figure 1: Positive and negative cycles

Version 1: Positive Cycle

Public Attitude "Positive"

Improves

Seek help early, family, friends, third sector

Engage in society, work friends etc

Go to services for help

Primary care

Secondary care

Receive effective help

"Recover"

Version 2: Negative Cycle

Public Attitude

Negative impact

Slow to seek help, stigma, misunderstanding

Isolation, stigma, no job

Go to services for help

Poor quality referral

Primary care

Detention, Criminal Justice System

Secondary care

Receive effective help

"Maintain"

Source: Mind

2.3 The role of public health in tackling stigma

Although the effects of stigma and discrimination are felt and perpetuated at an individual level, tackling the problem requires a comprehensive and sustained approach locally and nationally across government. A successful public health approach will help to reduce misconceptions and stigma surrounding mental illness, as it will engage larger numbers of people when they are 'well' and not only deal with symptoms when they are 'ill'. Some people experience a one-off episode of mental ill-health but are, for the majority of their lives 'well'. Others have conditions which fluctuate over many years but even recurrent mental illnesses need not be a life sentence or a label that an individual must carry permanently.

2.3.1 Public health is the paradigm through which stigma can be addressed

By improving a person's *physical* health in a way which promotes mainstream social contact and engagement, this ethos has inspired many innovative programmes.

Case study: Mind

One especially energetic example is Boxercise, run by Mind in Croydon, where people with mental distress learn boxing techniques to help improve both their physical and mental wellbeing, and recover their confidence and self-belief. Although Boxercise is designed for both men and women, it has been shown to have particularly good outcomes for men.

Ecominds is a Mind programme funded by the Big Lottery Fund, comprising 130 varied environmental projects around the country, designed to promote better health through green activities. Projects range from an urban food growing project in London's Spitalfields to restoring a derelict orchard in Margate or creating art using recycled materials in Blackburn. One scheme in Bow, the People, Life, Landscape and Nature (PoLLeN) project, offers social and therapeutic horticultural activities and motivational coaching for people experiencing stress, anxiety, lack of confidence, or difficulty in coping with day-to-day life. Since joining, one of the members, Reg, has made friendships with other members, accessed the centre's welfare and benefits service, sought advice about his hearing problems and has been referred to a specialist. His GP has noticed a marked improvement in his mood. Reg's experience demonstrates the individual and wider benefits that relatively small-scale, imaginative projects can have.

2.3.2 Social contact and activism

Social contact theory states that positive social contact between people with or without experience of mental health problems is one of the most effective ways of changing negative attitudes. That is why community involvement is vital in order to transform outcomes for BME groups as we explain in more detail in Chapter Five.

The principles of social contact and public education are being effectively applied in country-wide initiatives, notably in New Zealand, Scotland and in England's Time to Change model (a Time to Change Wales programme has also recently been launched). This programme includes a variety of community events designed to bring people together, support for people with mental health problems to speak out in their communities and workplaces, and face-to-face and online forums to enable people with experiences of mental distress to share their experiences. It is backed up by a national social marketing campaign to raise public awareness.

Evidence suggests that Time to Change is having an impact. The 2010 National Attitudes to Mental Illness Survey showed a 2.2 per cent improvement in attitudes since the Time to Change programme began in 2008, with 1.3 per cent from 2009 to 2010, since its anti-stigma campaign launched.[13] The Viewpoint survey among people who experience a mental

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13   Unpublished data from King's College London Institute of Psychiatry, Health Service and Population Research Department

health problem, evaluated by the Institute of Psychiatry at King's College London, also shows reduced levels of discrimination overall and a significant reduction in discrimination among people looking for work and in employment.[14, 15]

2.3.3 Challenging fearful attitudes towards mental health and risk-aversion

In 2011, a startling 33 per cent of respondents to the national attitudes to mental illness survey, chose the statement 'someone prone to violence' to describe a person with mental illness.[16] Fear perpetuates misunderstanding, particularly in regard to mental health and dangerousness. Associations between mental health and violence are vastly exaggerated but persist in the public mind. This is due to a number of factors. Media reporting over-emphasises the connection between mental illness and crime, frequently using sensationalist language and reporting the same case several times. Research carried out by the Fulbright scholar and Guardian journalist Mary O'Hara found that in both the US and UK, murder by a person with a mental illness was a common topic in news headlines, suggesting that – in the UK at least – "murder is being used to 'sell' an article but may not in fact be a primary aspect of the full story".[17]

Homicide enquiries, which have been mandatory since 1994, also heighten the perceived links between mental disorder and violence. This affects not only public attitudes, but also professional practice as services become focused on risk rather than recovery. This can lead to various restrictions on an individual's liberty being in place for longer or at a higher level than may be necessary.

Research has shown, however, that people with serious mental illness are far more likely to be the victim of a violent crime than the perpetrator. Contrary to popular belief, since the 1970s, the number of homicides committed by people with mental illness has fallen to historically low levels. Although the rates may vary slightly from one year to another, the risk of being killed by someone with mental illness has actually declined. The vast majority of homicides are committed by people who have not been diagnosed with a mental health problem.[18] Where there are associations with mental illness, perhaps due to acute post-natal depression or psychosis, there has often been a breakdown in the provision of care and families' warnings have gone unheeded.

Violence in any form, including violence which may arise from mental illness, cannot be condoned and it is vital to do everything possible to prevent and address it. But this dissonance between perception and reality which in turn fuels unhelpful attitudes and

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14   Ibid

15   The overall level of discrimination reported by people who experience a mental health problem has dropped by four per cent in the last 12 months. The levels of discrimination people face when searching for a job dropped by nine per cent, with a 6 per cent reduction in the number of people who report losing their job due to a mental health problem

16   The NHS Information Centre, Mental Health and Community, *Attitudes to Mental Illness – 2011 survey report,* Leeds: NHS Information Centre for health and social care, 2011, p22

17   O'Hara M, *Press Coverage of Mental Health and Suicide,* Gresham College Lecture, 14 December 2010 [accessed via: http://www.gresham.ac.uk/print/2636]

18   Kings College London Institute of Psychiatry, *Risk of violence to other people,* London: King's College Institute of Psychiatry, 2006; 95 per cent of homicides are committed by people who have not been diagnosed with a mental health problem

behaviour must be addressed head on. It is essential to put the dangerousness which may be associated with mental illness in its appropriate and proportionate context. Fundamentally, this is about managing risk.

The recently published final report from the Munro Review on child protection makes some important observations about risk drawn from other fields where it is a highly salient issue (aviation and physical healthcare) which also challenge the current risk-aversion that characterises mental health:

'The ideal would be if risk management could eradicate risk but this is not possible; it can only try to reduce the probability of harm... Uncertainty pervades the work of child protection. Many of the imbalances in the current system arise from efforts to deal with that uncertainty by assessing and managing risk... The big problem for society (and consequently for professionals) is working out a realistic expectation of professionals' ability to predict the future and manage risk of harm to children and young people... Those involved in child protection must be 'risk sensible'. There is no option of being risk averse since there is no absolutely safe option. In reality, risk averse practice usually entails displacing the risk onto someone else'. [19]

Our concern with mental health is that the risk is displaced onto the vulnerable person themselves – it is their recovery and the quality of their life that are placed at risk by depriving them of liberty. (This can take the place of finding creative and flexible ways to provide social and other support in the community.) **Therefore we recommend that the Government calls for the same cultural change in mental health that Professor Munro is calling for in child protection**.

2.3.4 Reshaping services to meet needs

Improving access to services will help to address desperately high levels of unmet need, for example among the homeless, BME groups and people in the criminal justice system. Although additional investment in psychological therapies is welcome, a recent survey highlighted that one in five people wait over a year to receive treatment and one in ten wait over two years. [20] Access is particularly difficult for children, older people, men and those from BME groups.

This is just one illustration of the inverse care law first described by Julian Tudor Hart, that people who are in most need of services and support are least likely to receive them. [21] This expression may be over 40 years old, but it is as persistent as ever. In his Review Professor Marmot forcefully argues that in reshaping services, we should use these opportunities not merely to reinforce the existing status quo, but to achieve a fairer distribution of health. Sustained partnerships between different sectors and services will be necessary to tackle the causes of disadvantage that result from and contribute to

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19   Department for Education, *The Munro review of child protection: Final report – a child-centred system*, Norwich: The Stationery Office, 2011, pp 21-46

20   We Need to Talk Coalition, *We need to talk: getting the right therapy at the right time*, London: We Need to Talk Coalition, 2010 [accessed via: http://www.mind.org.uk (12/09/11)]

21   Hart JT, 'The Inverse Care Law', *The Lancet*, 297, 1971

mental illness, as we describe throughout this report. Community 'places-to-go' that are open to everyone at any time are particularly important for people with mental health challenges who may need to use a range of health and public health services periodically as their condition fluctuates.

> *'They must focus on prevention thus make support more accessible and available – whether debt, housing, relationship problems, problems at work or lack of work, parenting difficulties etc etc'.*[22]

Artwork by patients in a secure psychiatric hospital

2.3.5 Social and economic case

Mental health influences a wide range of outcomes on an individual, communal and even national scale. It has been shown by both national and international studies that the benefits of improved mental health are widespread and may prompt improvements in individuals' lifestyle, educational attainment, productivity, family relationships, social cohesion and overall quality of life.

Mental health is already the largest single category for NHS expenditure and the prevalence of mental health conditions is rising.[23, 24] Costs rose from £77.4 billion in 2003 to £105.2 billion in 2009/10, while a third of all GP visits relate to mental health.[25, 26] Common mental disorders are extremely costly, for example depression in England accounts for about £9 billion per year, mainly in lost productivity. The evidence shows diverse policies beyond

22   Participant in a Mind Focus Group on the Department of Health consultation on *Healthy Lives, Healthy People: Transparency in Outcomes,* March 2011
23   *Harker R, SN/SG/724 – NHS Funding and Expenditure,* London 2011, p7 [accessed via: www.parliament.uk/briefing-papers/SN00724.pdf (21/09/11)]
24   World Health Organisation, Mental Health Disorders Management – Depression [accessed via: http://www.who.int/mental_health/ management/depression/definition/en/ (13/09/11)]
25   Centre for Mental Health, *Economic and social costs of mental health problems in 2009/10*, London: Centre for Mental Health, 2010
26   Mental Health Foundation, *How To Look After Your Mental Health,* London: Mental Health Foundation, 2008

the realm of health – such as employment and the economy, housing, welfare and criminal justice, are critical to our mental health.[27]

As the mental health bill swells, a stronger focus on prevention, earlier intervention and broader approaches which help a greater number of people at a lower cost, makes financial sense. Economic modelling has shown savings from interventions which aim to tackle social determinants and consequences of mental ill-health. For example, the Marmot Review presents a strong case for a substantial increased investment in ill-health prevention and health promotion to 0.5 per cent of GDP over 20 years.[28] Investing here, even in a demanding economic climate, should lead to far less need for secondary services which are much more expensive, particularly those based in hospitals.

A public health approach to mental health will require challenging traditional spending patterns. This is not about knee-jerk reactions, abruptly closing one service in order to pay for another, but about carefully considering how existing resources can be used in different ways to improve outcomes.

2.4 Where it matters: the 'everyday' impact of public health on mental health

Public health cannot be achieved through piecemeal initiatives. Changing the culture of services will require a set of interdependent measures as we make clear in Chapter Five on BME issues. The poorest and most vulnerable people in society are likely to be those with a range of overlapping and complex needs – such as a care leaver with a personality disorder, who self-medicates with alcohol and drugs, and is homeless after discharge from prison, or a single mother with schizophrenia who is keen to work, but struggles to maintain a healthy weight and improve her IT skills.

2.4.1 Employment

Both work and the lack of work have significant impacts on mental health and wellbeing. 'Good work' – including opportunities for meaningful employment, career progression and personal development – can positively impact mental health and contribute to long-term recovery.[29] Despite having the highest 'want to work' rate, only 21 per cent of people with mental health problems are in employment, compared to 74 per cent of the working age population and fewer than four in ten employers would consider taking on a person with a history of mental health problems. [30, 31, 32]

27   Foresight Mental Capital and Wellbeing Project, Final Report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century,* London: The Government Office for Science, 2008

28   Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England,* London: The Marmot Review, 2010

29   Parker L and Bevan S, *Good Work and Our Times: Report of the Good Work Commission,* London: The Work Foundation, 2011

30   Office for National Statistics, *Labour Force Survey*, Sept-Dec, Norwich: The Stationery Office, 2006

31   Office for National Statistics, *Labour Force Survey*, Jan-March 2009, Norwich: The Stationery Office, 2009

32   Social Exclusion Unit, *Action on Mental Health: A guide to promoting social inclusion,* London: Office of the Deputy Prime Minister, 2004

Work can also be 'bad' for mental health

Equally, the negative mental health impacts of 'bad work' are well documented, for example by the Work Foundation and London Health Commission.[33] Negative or bullying relationships, unrealistic expectations, unmanageable workloads, poor communication, a culture of long hours and no breaks can all take their toll on the wellbeing of employees. Over a third of those we polled who had experienced mental health problems or were a close friend or relative of someone who had said that employment was a major cause of poor mental health. The tough economic climate has increased pressure on workplaces, leading to higher levels of mental ill-health. Recent research from Mind shows work is now the most stressful thing in people's lives, above relationships, money worries or health issues.[34] One in five people in Mind's poll feared that speaking up about work-related stress or mental health issues would put them first in line for redundancy. Concerns about discrimination mean many people are unable to seek support. '*I feel like I am trapped in a vicious circle. I need to work to try to keep well, but can't access the services to help me keep well.*'[35]

Toxic workplaces and lack of mental health support for employees result in high individual, social and economic costs. The Centre for Mental Health has calculated that failure to address mental health, costs UK businesses £26 billion a year – around £1,035 per employee – due to sickness absence, staff turnover and, most of all, reduced productivity through 'presenteeism', where people come to work in spite of illness. Conversely, employers who are getting it right reap the benefits, saving up to 30 per cent of these costs.[36]

However, welfare reform policy has to be implemented with an awareness that people with mental health problems are particularly vulnerable to unintended injustices given the poor understanding of mental illness among benefit assessors and the already higher rates of unemployment. If the wrong people are excluded by a tougher disability test or find that their Employment and Support Allowance is cut arbitrarily after a year, GP surgeries, in-patient wards, Accident and Emergency, and homeless shelters are just some of the services that will come under further strain.

Many people with mental health problems already find applying for and retaining benefits very stressful due to the complexity of the system, the somewhat confrontational nature of assessments and the largely negative media coverage. This can have a negative impact on people's health even before the risk of being wrongly assessed as 'fit for work' is factored in, which entails a lower rate of benefit and more stringent levels of conditionality and sanctions. However, with the right support, often from community-based services working in partnership with GPs and other statutory services, many claimants could reach a point where they are sufficiently well to work, as many of them want to do.

Finally, our recent report on entry level employment highlights (and recommends solutions to tackle) the rising numbers of unemployed young people.[37] The impact of this is not just felt in terms of lost productivity and benefit dependency, but also in the correlation between

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33   Coats D and Max C, *Healthy work: productive workplaces*, London: The Work Foundation and London Health, 2005
34   Mind/Populus polling of 2,006 adults in employment in England England and Wales online between 25-28 February 2011, and 4-6 March 2011
35   Anonymous respondent to Mind survey on public health, London: Mind, 2011
36   Centre for Mental Health, *Mental health at work: developing the business case*, London: Centre for Mental Health, 2007
37   Centre for Social Justice, *Creating Opportunity, Rewarding Ambition: The value of entry level employment*, London: Centre for Social Justice, 2011

unemployment and developing or exacerbating mental health conditions and the longer-term effects on mental and physical health, potentially over a life-time.

The relationship between mental ill-health and debt

We welcome the Government's recognition of the value of debt advice in its mental health strategy. It estimates that debt advice could save around £30 million to the NHS, £50 million on legal costs and £220 million from productivity gains, aside from other benefits such as debt repayments to creditors and health and wellbeing gains to individuals.[38]

The Foresight Report suggests that the known association between poor mental health and low income is largely mediated by debt and that debt is a much stronger risk factor for mental disorder than low income.[39] Other evidence indicates that a quarter of people with a mental disorder are in debt, half of people in debt have a mental disorder and the more debts people have, the more likely they will have a mental disorder.[40, 41] Debt also erodes mental resilience and increases isolation as people are less able to socialise.

A study conducted before the recent recession by Mind into debt and mental health, brings into sharp focus the daily stress of living with debt. Of the 1,804 people surveyed, 70 per cent were unable to pay a bill on the final reminder. The distress of being unable to pay bills is compounded by insensitive treatment by creditors, so few people talk to them about it. Of the 37 per cent of survey respondents who did tell creditors, 83 per cent were still harassed about debt repayments despite informing the organisation.[42] As the rates of home repossessions rise, so too will the incidence of mental illness. Analysts fear that with job cuts, a stagnant economy and rising living costs, arrears and repossessions could peak by the end of 2012.

Aggression from bailiffs leads to increased levels of anxiety, depression and strain on the family. The CSJ's 2007 report on serious personal debt pointed out that methods used by various creditors and debt collection agencies can add tremendous pressure to a person caught in a debt spiral and that the debt collection systems of many companies and public agencies are significantly below best practice.[43] They fail to use customer segmentation and data analysis to develop less confrontational and more collaborative collection practices. One of our recommendations was the introduction of a code of practice for responsible debt collection. We also welcome the Government's commitment to consult on proposals to provide more protection for people by aggressive bailiffs.

2.4.2 Addictions

Smoking reduces life-expectancy by about ten years and people with mental health problems are more likely to smoke and to smoke more heavily. Smoking is credited as being responsible for the largest proportion of unequal health outcomes for this group.[44]

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38   Department of Health, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages,* London: HM Government, 2011

39   Foresight Mental Capital and Wellbeing Project, Final Report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century,* London: The Government Office for Science, 2008

40   Jenkins R et al, 'Debt, income and mental disorder in the general population', *Psychological Medicine,* 38, 2008, pp1485-1494 as cited by the Foresight Mental Capital and Wellbeing Project

41   For example Fitch C et al, *Debt and mental health. What do we know? What should we do?,* Royal College of Psychiatrists, London: Royal College Psychiatrists, 2009

42   Mind, *In the Red: debt and mental health,* London: Mind, 2008

43   Centre for Social Justice, *Breakthrough Britain: Debt,* London: Centre for Social Justice, 2007, p15

44   Department of Health, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages,* London: HM Government, 2011

Yet, despite being just as motivated to stop as the general population, smokers with mental health problems are less likely to be offered cessation support.[45] We look at the contribution primary care can make to this in Chapter Six.

Drug and alcohol use is also common among people experiencing mental distress, both of which exact heavy human and financial costs.[46] The DH estimates that treating the chronic and acute effects of alcohol misuse costs the NHS £2.7 billion a year.[47] In mental health terms, the damaging effects of alcohol are significant, particularly among heavy drinkers. Alcohol misuse can increase anxiety, accelerate or uncover a psychiatric disorder and is one of the highest risk factors for suicide. Associated physical problems are common, including hepatitis, liver disease, digestive problems and poor dental health, although access to the relevant services is difficult for this client group. Furthermore, the Marmot Review found that although people with a lower socio-economic status are more likely to abstain from alcohol altogether, if they do consume alcohol, they are more likely to have problematic drinking patterns and dependence than people higher up the socio-economic scale. Nearly half of those we polled who had experienced mental health problems or were a close friend or relative of someone who had, considered addictions to be a major cause of mental ill-health. The same proportion thought the direction of causal change pointed the other way i.e. that mental ill-health was a major contributor to addiction. (It is likely that some people thought addiction could be both cause and effect.)

Thus drug and alcohol misuse further marginalises already vulnerable people. The impact of alcohol misuse on the mental health of veterans is particularly concerning. The evidence received by this Review suggested that although in the Armed Forces there is generally a strong culture of using alcohol to switch off and relax with fellow servicemen and women, this environment is also more controlled. On discharge, however, these boundaries disappear. This subject is considered in more detail in the following chapter on trauma.

Clinicians working with the most vulnerable mental health patients strongly urged the Review to use minimum unit pricing as a driver both to improve both mental and public health more broadly. The CSJ's 2007 report on tackling addictions recommended using taxation policy, urged the Government to consider seriously the possibility of a treatment tax and stated that:

> *'The relationship between the affordability of alcohol and the level of consumption provides government with an effective tool for controlling levels of consumption within society through the levying of a tax on the product. This tax would in turn provide the funding needed to meet the social and economic costs of alcohol related harm, such as police enforcement measures resulting from binge drinking and violence, health service costs and treatment for addicts'.*[48]

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45   Brown C, *Tobacco and Mental health: a literature review,* Edinburgh: Ash Scotland, 2004 [accessed via: www.ashscotland.org.uk/ash/files/tobacco%20and%20mental%20health.pdf (21/09/11)]

46   For example: nearly half of patients treated within community mental health teams reported problem substance use in the past year, and up to three quarters of substance misuse patients had had recent psychiatric disorders. Weaver T et al, 'Comorbidity of substance misuse and mental illness in community mental health and substance misuse services.' *The British Journal of Psychiatry,* 183, 2003, pp 304-313

47   Department of Health and Home Office, *Safe. Sensible. Social. The next steps in the National Alcohol Strategy,* London: HM Government, 2007 as cited in Alcohol Concern, *Factsheet: The impact of alcohol on health,* London: Alcohol Concern, 2010, p2

48   Centre for Social Justice, *Breakthrough Britain: Addictions,* London: Centre for Social Justice, 2007, p13

A more recent investigation into the effects of pricing and promotion on alcohol consumption and related harm in the UK, commissioned by the DH, referred to a large number of studies that consistently suggest evidence for an association between increases in taxation or pricing of alcohol and reductions in harm.[49]

It also stated that 'there is very strong evidence for the effectiveness of alcohol taxes in targeting young people, heavy drinkers and the harmful effects of alcohol' and suggested a range of possible policies:

- Increase alcohol duty and link alcohol taxes to inflation;
- Link levels of taxation to alcohol strength, including introduction of tax incentives for low-alcohol alternatives;
- Minimum pricing; and
- Policies targeting price-based promotions.[50]

We welcome pledges made by the Coalition on this subject:

- 'We will ban the sale of alcohol below cost price.
- We will review alcohol taxation and pricing to ensure it tackles binge drinking without unfairly penalising responsible drinkers, pubs and important local industries'.[51]

Given the evidence of their own and our earlier reviews, we recommend that the Government makes the implementation of these pledges a public health priority.

Throughout this report we emphasise the need to tackle other physical health disorders that are comorbid with poor mental health. When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity also implies interactions between the illnesses that affect the course and prognosis of both.[52] Depression not only increases the risk of mortality by 50 per cent, it doubles the risk of coronary heart disease. We urgently need to ensure that the most vulnerable have access to a wide range of services – from smoking advice, cholesterol checks and cancer screening to debt counselling, dentistry and diet advice – to improve their overall health. A public health approach has the potential to bring physical and mental health more closely together.

2.4.3 Housing

Despite being top of the list for many people using mental health and other services, the impact of appropriate and stable housing is often overlooked. Environments in the early years

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49   School of Health and Related Research at the University of Sheffield, *Independent Review of the Effects of Alcohol Pricing and Promotion*, London: Department of Health, 2008 [accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_091366.pdf (21/09/11)]

50   Institute of Alcohol Studies, *Alcohol Alert,* London: Institute of Alcohol Studies, 2009, p17

51   HM Government, *The Coalition: our programme for government,* London: Cabinet Office, 2010, p13 [accessed via: http://www.cabinetoffice.gov.uk/sites/default/files/resources/coalition_programme_for_government.pdf

52   US Department of Health and Human Services National Institute on Drug Abuse, *Comorbidity: Addictions and Other Mental Illnesses,* Bethesda MD: National Institutes of Health, 2008
     [accessed via: http://drugabuse.gov/PDF/RRComorbidity.pdf (13/09/11)]

play a critical role in nurturing cognitive ability, with the home learning environment playing a larger role in determining future mental capital than socio-economic status or parental education.[53] Housing quality is also strongly associated with children's mental development, as children living in poorer quality housing have also been shown to have higher levels of stress hormones and behavioural problems. Housing continues to exert a strong influence, often at key transition points such as young people leaving care, servicemen leaving the Armed Forces, following discharge from hospital or after release from prison.

Housing is also a critical missing link when considering the treatment effectiveness of clinical and other services. For example, we know that a significant proportion of people with mental health problems also use drugs and alcohol. We also know that drug prevention and treatment are fundamental to reducing inequalities and social exclusion, but it is widespread homelessness which both contributes to initial use and prevents drug users from accessing and staying in treatment programmes.

The benefits of investing in good quality housing and providing housing related support are also significant. Extensive work by the National Housing Federation has shown that housing associations are key players in both reducing costs and health inequalities. They work in some of the most deprived areas of the country and can be valuable partners with organisations providing social and therapeutic support in delivering community-based health services. For example, in Peterborough where some residents have a life expectancy of up to ten years less than those in more affluent areas, *Keys to Health,* a partnership between Cross Keys Homes and Peterborough PCT, provides health trainers to work with people on various health issues.[54] Similarly, Ashram Housing Association in Small Heath in Birmingham works with My Time (Community Interest Company) to ensure that vulnerable people from many BME groups including refugees and asylum seekers, have access to wraparound care and support.[55]

2.4.4 The importance of families – early years, children and young people

There has been a welcome increased focus in Government on early and childhood years, notably to reduce poverty and increase investment in education. However, much more attention also needs to be placed on the mental wellbeing of children, vital to which is the quality both of their relationships with their parents and their parents' relationships with each other. Numerous studies concur with the Foresight Report that 'the quality of parental care has lifelong effects on mental wellbeing'.[56] According to Gregg et al, 'Holding constant other types of parental capital, income is strongly associated with types of maternal functioning that promote self esteem, positive behaviour and better physical health in children'.[57]

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53 Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England,* London: The Marmot Review, 2010

54 National Housing Federation, *Invest in housing, invest in health*, London: National Housing Federation, 2011; see also *Health and Housing: Worlds Apart*, 2010 and *Housing for Health: Worlds Aligned,* 2011

55 Evidence given to Mental Health Review

56 Foresight Mental Capital and Wellbeing Project, Final Report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*, London: The Government Office for Science, 2008

57 Gregg P, Propper C and Washbrook E, 'Understanding the relationship between parental income and multiple child outcomes: A decomposition analysis.' Working Paper 08/193 Bristol: Centre for Market and Public Organisation, University of Bristol, 2008, as cited in the Marmot Review

Family breakdown (whether due to divorce or separation, dysfunction or fatherlessness) can be both a cause and effect of poor mental health.[58] Our second wave of polling showed that 83 per cent of people thought family breakdown was a serious problem.[59] Conflict between parents has been associated with an array of adjustment problems in children, for instance: poor peer interaction, conduct problems, ill-health, depression and anxiety, low self esteem, eating disorders, substance misuse and poor attachment.[60] The Good Childhood Inquiry found that children with separated, single or step-parents are 50 per cent more likely to fail at school, have low esteem, struggle with peer relationships, and have behavioural difficulties, anxiety or depression. The report concluded that 'Child-rearing is one of the most challenging tasks in life and ideally it requires two people'.[61]

Given its effect on the mental health of children and adults, decreasing parental separation is an important public health outcome, and supporting families by strengthening the couple relationship should, therefore, be a key emphasis in public health. This is something Relate has been campaigning for over three parliamentary terms.[62] Health visitors' support for couples in the early stages of parenthood is seen as part of their distinctive contribution to public health and wellbeing.[63] Research indicates that the best predictor of each parent's adjustment to parenthood is the quality of the relationship between them.[64] Yet whereas the Government's public health strategy acknowledges the importance of good parent-child relationships, it neglects to mention the importance of the couple relationship.[65]

Half of lifetime mental illness (excluding dementia) starts by the age of 14 and 75 per cent by the mid-20s.[66] This emphasises the importance of preventing mental health problems from developing and equipping young people with what they need to foster long-term mental resilience, especially as various public and mental health factors tend to cluster together to intensify disadvantage. Obesity, depression, substance misuse and poverty are common features in the lives of many young people at a crucial time of transition into adulthood. We refer readers to Chapter Four which looks across a range of issues concerning families, children and young people in more depth.

Public mental health and screen time

The Royal College of Psychiatrists (RCPsych) has expressed concerns about the effect of excessive screen time on children and young people. The patron of this Review, Baroness Professor Susan Greenfield alerted us more specifically to their prolonged exposure to escapist cyber-scenarios. This could, she said, be skewing the natural dichotomy between escapism and living in the real world. Both of these are worrying, not least because of the changes occurring in the adolescent brain during key periods of development.

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58 Mooney A et al, *Impact of Family Breakdown on Children's Well-Being: Evidence Review*, DCSF-RR113, London: Institute of Education, 2009 [accessed via: https://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR113.pdf (26/10/11)]

59 CSJ/YouGov polling of 2,084 British adults, September 2011

60 Cummings E and Davies D, *Children and Marital Conflict: The Impact of Family Dispute and Resolution*, New York: Guilford Press, 2004

61 Layard R and Dunn J, *A Good Childhood: searching for values in a competitive age*, London: Penguin, 2009, p28

62 Relate, *Relationship Manifesto for Strong Couple and Family Relationships* [accessed via: http://www.relate.org.uk/manifesto/index.html (13/09/11)]

63 Unite and CPHVA Health Visitors' Forum, *The Distinctive Contribution of Health Visiting to Public Health and Wellbeing: A Guide for Commissioners,* London: Unite the Union, 2008

64 The Fatherhood Institute, *Father Facts: What Good are Dads?*, London: Fatherhood Institute, 2001 [accessed via: http://www.fatherhoodinstitute.org/2008/what-good-are-dads/ (12/09/11)]

65 Department of Health, *Healthy Lives, Healthy People: Our strategy for Public Health in England*, Norwich: The Stationery Office, 2010

66 Department of Health, *Our Health and Wellbeing Today,* London: HM Government, 2010

The UK average daily screen time is over five hours, which affects young people's ability to pay attention, levels of physical activity and the quality of their physical health and social interaction.[67] More controversially, we were alerted to evidence suggesting that population level 'mind change' might actually be taking place. The rationale behind the 'mind change' thesis is that 'the human brain will adapt to whatever environment impinges on it; the cyber-world of the 21st century is offering an unprecedented environment; therefore the brain may be adapting in unprecedented ways. We should try to foresee what these changes might be, both positive and negative: only then can we minimise the threats and harness the opportunities'.[68]

As well as exciting academic interest, Google's former CEO, Eric Schmidt has remarked: 'I worry that the level of interrupt, the sort of overwhelming rapidity of information... is in fact affecting cognition. It is affecting deeper thinking'.[69]

Backing up the assertion that prolonged immersion in the cyber-world could be leaving a long-term mark on the brain are recent reviews of possible links between this and violence, addiction, and attentional problems, evidence of a relationship between internet addiction and physical brain changes and the decline in empathy over the last 30 years which has accelerated in the last decade.[70] Empathy is harder to develop when relationships are increasingly conducted through a highly 'lean' medium of communication that excludes eye contact, voice tone or body language, and the opportunity to learn how and when to use physical touch.

At present these ideas are more theory than accepted fact and Greenfield identifies a refusal to debate the issue that she considers unscientific. She asserts that the 'mind change' thesis should be properly explored through the collective expertise of scientific disciplines, educationalists, media and policymakers given its potential harm or benefit. She highlights the need to involve the general public and recommends that, as a first step in opening up this debate more fruitfully, a proper survey of parents be carried out to identify if there are latent concerns and how prevalent these are.

2.4.5 Older people

Although not as high in the public and policy consciousness as Alzheimer's disease or dementia, depression is prevalent among older people and affects more than two million people in the UK aged over 65. It often co-exists alongside other physical health conditions, such as hearing loss, which can lead to high levels of isolation. A recent national study has found that hearing loss more than doubles the risk of depression in older people.[71]

67 Hancox RJ, Milne BJ and Poulton R, 'Association between child and adolescent television viewing and adult health: a longitudinal birth cohort study', *Lancet*, 364, 2004, pp257-262; Christakis DA, Zimmerman FJ and DiGiuseppe DL, 'Early television exposure and subsequent attentional problems in children', *Pediatrics*, 113, 2004, pp708-713; Ussher MH et al, 'The relationship between physical activity, sedentary behaviour and psychological wellbeing among adolescents', *Social Psychiatry and Psychiatric Epidemiology*, 42, 2007, pp851-856

68 The Independent, *Computers may be altering our brains,* 12 August 2011 [accessed via: http://www.independent.co.uk/opinion/commentators/susan-greenfield-computers-may-be-altering-our-brains-2336059.html (13/09/11)]

69 Charlie Rose Show, A Conversation with Eric Schmidt, CEO of Google, 6 March 2009 [accessed via: http://www.charlierose.com/view/interview/10131 (13/09/11)]

70 Bavelier D et al, 'Children, Wired: For Better and for Worse', *Neuron*, 67, 2010, 692-701; Yuan K et al, 'Microstructure abnormalities in adolescents with internet addiction disorder', *PloS one*, 6(6):e20708, 2011

71 Action on Hearing Loss (formerly RNID), *Hearing Matters*, London: Action on Hearing Loss, 2011

Once again, the solutions lie not with single interventions, but in joining-up public health and other service areas. For older people this should include addressing stigma, falls prevention, regular hearing checks, fuel poverty and accessible transport. As one lady in an Age UK report put it, 'If I couldn't get out of the house, I would go mad. I might as well give up on life'.[72] Studies show that access to public transport helps older people to stay socially connected and active, which in turn promote good mental health.[73]

Research consistently finds that contact with relatives and friends from different age groups are beneficial to the mental health of older people. There is a strong role for civil society in this area. Initiatives like Southwark Circle create a web of reciprocal relationships around the social and practical support of older people in the area, where people can be each others' solution with everyone in the Circle community contributing to the lives of others. Such initiatives enable a locality to 'mobilise public, private, voluntary and community resources to help all older people define and create quality of life and wellbeing for themselves'.[74]

Our two recent reports on older age emphasise the need for 'regenerated communities and dynamic neighbourhoods' and make a distinction between 'neighbouring' and 'neighbourliness'.[75] Neighbouring, they said,

> 'designates simply the practical informal interactions which occur in any given vicinity. Neighbourliness, by contrast, is a 'thicker' concept, defined by one sociologist as the more 'positive and committed relationship(s) constructed between neighbours'.[76]

At the centre of better treatment for older people there must be an improved social fabric, improved knowledge and skills in primary care, better access to specialist mental health services for older people and more effective collaboration across health, local authority and third sector services.

Older people with mental health problems suffer the effects of stigma, ageing discrimination and social economic disadvantage. Removing these problems will require a genuine change in the culture of delivery of health and social care in the UK, and is not merely a matter of improving the dignity and respect afforded to older people.

> 'There's a role for government. There's a role for charities. But there's no substitute for community.'[77]

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72 Age UK, *Pride of Place: how councillors can improve neighbourhoods for older people*, London: Age UK, 2011

73 Knight et al, *Understanding the Travel Needs, Behaviour and Aspirations of People in Later Life*, London: Department of Transport, 2007

74 Southwark Circle, *Our Story* [accessed via: http://www.southwarkcircle.org.uk/our_story.php (30/08/11)]

75 Centre for Social Justice, *The Forgotten Age: Understanding poverty and social exclusion in later life, London:* Centre for Social Justice, 2010, pp114-115; Centre for Social Justice, *Age of Opportunity: Transforming the lives of older people living in poverty*, London: Centre for Social Justice, 2011, p49

76 Bulmer M, *Neighbours: the work of Philip Abrams*, Cambridge: Cambridge University Press, 1986, p21 cited in Harris K, *Neighbouring and older people: an enfolding community?*, London: Age Concern, 2008, p3

77 Jim Diers, founder of the Seattle Department of Neighbourhoods, in the US, in evidence to the CSJ

A failure to provide older people with specialist services which are organised and staffed by people trained and skilled to meet their needs is unacceptable. There is recognition that children and adolescents require specialist services because they are not 'mini adults'. It is important that service commissioners and providers remember that although older people are clearly adults they can and do have specialist needs.[78]

As our two recent reports on older age make clear, millions of older people are active citizens, contributing greatly to the UK's economic and social wellbeing: they volunteer in many valuable roles in community groups, charities, schools and sports clubs nationwide and almost a million people over the age of 65 care for a relative or friend.[79] Older people have a significant impact on the economy. They have a spending power which amounts to over 100 billion pounds annually, but social and other healthcare costs associated with ageing are also increasing.[80] From many different perspectives, it is in everyone's interest that people in later life remain active, physically fit and mentally healthy for as long as possible.

2.5 How to ensure public health has a mental health perspective

The Government's major and concurrent reforms of the health, social care, welfare and public health systems are almost unprecedented in their scale and breadth. The proposed changes are a critical opportunity to deliver far reaching improvements. The human and financial gains to more closely integrating mental health, public health, social care and other areas are significant, but will only become apparent in the longer-term. The challenges faced by people with mental health problems of all ages and their families are multiple, persistent and compounded by poverty. These problems need not be insurmountable if policies are similarly multi-faceted and long-term in their scope and orientation. Leadership, sustained commitment, coherence and accountability are key elements to ensuring that public health has a mental health perspective. We suggest actions required nationally, locally and at the family/individual level and then turn to questions of commissioning and provision.

2.5.1 National government

Bringing a stronger mental health perspective to public health requires a mindset to do things differently and, although localism is a watchword of the Government and central to its recent White Paper on Public Health, this has to happen from the top down.

This document states that 'localism will be at the heart of this [public health] system, with responsibilities, freedoms and funding devolved where possible: enhanced central powers will be taken when absolutely necessary', (applying mainly to emergency preparedness and health protection).[81] A key challenge is to achieve an appropriate balance between localism and central direction. Localism brings many benefits: services can be better tailored to local

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78   Royal College of Psychiatry, *Consultation Response to the National Review on Age Discrimination in Health and Social Care,* London: Royal College of Psychiatrists, 2009, p9

79   Age UK, *Invisible but Invaluable,* London: Age UK, 2010

80   Office for National Statistics, *Family Spending 2010 edition,* Norwich: The Stationery Office, 2010

81   Department of Health, *Healthy Lives, Healthy People,* Norwich: The Stationery Office, 2010, p8

needs and co-created by the communities they are there for. There is strong potential for health and wellbeing boards to more closely integrate public and mental health if they are committed to doing things differently. We explain how this could happen in Chapter Six on primary care. Having set out an ambitious and welcome change of emphasis in public health, continued strong leadership from central government is indispensable, arguably needing more strategic direction and intervention than when 'absolutely necessary'.

> A key theme in the Marmot Review and other literature is that public health is not 'stand-alone', but must be integrated with other areas of health and social care; and that this could be achieved through joint working across government, cross-sector partnerships and with the participation of local people. In particular, more attention must be given to the follow-up funding and mainstreaming of successful pilot projects aimed at preventing ill-health, (which is why many models of good practice are included in this report).

As responsibilities, freedoms and funding to implement policies are devolved to local authorities, it is essential that mechanisms for accountability are robust, clear and transparent. Without robust commissioning outcomes, local decision making and funding would undermine a country-wide, consistent and coordinated public health approach, Strong leadership and long-term commitment from central government would help to bring about the coherent approach which a mental health perspective on public health so urgently requires.

We recommend that vision, priorities, provision and outcomes for public health and mental health must be more closely aligned to transform the outcomes for vulnerable people with a range of overlapping needs. It is essential that mental health is a higher priority for the cross-cutting Cabinet Committee on Social Justice, as they address issues of poverty, and inequality and justice.

2.5.2 Local authorities and other partners

The proposed Director of Public Health (DPH) role in local government will be critical in ensuring that public health is prominent in joint health and wellbeing strategies and in the Joint Strategic Needs Assessments. Pittam and Wright emphasise that this role must have sufficient authority among all partners to foster joint working in the locality, saying:

> *'...there are a wide variety of arrangements around the country and not all DPHs are formal members of Council Executives. DPHs with corporate responsibility are likely to have a greater impact'.*[82, 83]

82   Hunter DJ, *Perspectives on Joint Director of Public Health Appointment*, University of Durham: Improvement and Development Agency, 2008
83   Royal Society for Public Health, *Perspectives in Public Health*, London: SAGE Publications, 2011, p18
     [accessed via: http://www.sph.nhs.uk/sph-documents/the-role-of-the-director-of-public-health-in-england (14/09/11)]

Ultimately, the success or failure of implementing coherent policies will be felt most strongly at a local level. To quote the Future Forum's report, 'Health and wellbeing boards need to become the focal point for ensuring the health needs of local populations are met'.[84] Again, we emphasise this in Chapter Six on primary care.

Despite ambitious aspirations, local authorities will be hampered in fulfilling these new roles unless they are fully supported by health services in forming partnerships with other agencies that can make an enormous public health contribution, not least in services like Sure Start centres, to ensure that the most vulnerable families are being helped.

Councils also have an important public health role in town planning and in the ways they act on environmental factors.

2.5.3 Families and individuals

As in all areas of health, family support and self-management are indispensable in helping to prevent mental health problems from developing or escalating. While self-management is vital emphasis, it has to be complemented by high quality treatment and ongoing support where needed. This is particularly so when adversity has significantly undermined people's resilience and ability to cope. These two components often work best together; doing one's homework before cognitive behavioural therapy sessions is one such example. People with mental health problems need encouragement and support, for instance from a GP when enrolling on an exercise or prescription programme, or from their manager if starting or returning to work.

2.6 Commissioning and service provision

Changing commissioning behaviour across a broad spectrum of public and mental health areas is a huge challenge. As the Foresight Report observed, half of the then 30 departmental Public Service Agreements led by eight government departments had implications for mental health and mental wellbeing, but not all of them recognised this explicitly.[85] There is clearly a need for a consistent and comprehensive approach in the new structures.

There is also a need to plan budgets and allocate spending differently, as national and local departments who may derive most benefit from an intervention may not be the same as those paying for it. Local authorities are focused on budget cuts and preserving essential services. Although public health budgets will be ring-fenced, the CSJ report on outcome-based government emphasised the need for local decision-makers to 'spend to save' to achieve outcomes which are harder to measure and long term:

> 'Spending cuts have to be implemented across government: within departments, local authorities and service partners, in the right way. The impact of cuts can be minimised; with clear objectives and proper guidance, cuts will tend to fall where they will have

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84   NHS Future Forum, *Summary Report on the proposed changes to the NHS*, London: Department of Health, 2011, p22
85   Foresight Mental Capital and Wellbeing Project, Final Report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*, London: The Government Office for Science, 2008

least impact...with effective governance, cuts will be made that avoid burdening future taxpayers with the ongoing and increasing costs of social breakdown'.[86]

2.6.1 Clinical commissioning groups

CCGs will play a pivotal role in commissioning as we elaborate in Chapter Six on primary care. There is huge potential to refocus the mental health agenda towards public health and provide more integrated access to appropriate sources of help, such as social, psychological and occupational care. However, the Foresight report finds that although 'an estimated 30 per cent of GP consultations have an underlying mental health cause, many of which have a socio-economic basis e.g. debt, family breakdown, trauma, bullying at work' many GPs do not feel it is their job to help patients to seek appropriate support.[87]

A central aim of the Health and Social Care Bill is to give GPs freedom and budgets to commission more broadly. Potentially, in addition to traditional clinical services, GPs will be able to commission a range of public health services jointly with local health and wellbeing boards that tackle the root causes of health inequalities.

Given the greater health needs in deprived areas highlighted in the Marmot Review and the Public Health White Paper, **we recommend that the legislative framework i.e. the Health and Social Care Bill should address funding formulas and incentives so that more GPs work in deprived areas**.

Although there is some oversight from the NHS Commissioning Board, CCGs will have considerable freedom in how they group themselves and there may need to be some form of inducement to GPs to join those working in deprived areas. Higher vacancy rates in deprived areas mean that gaps are most likely to be filled either by locums, who don't know the local population or newly qualified doctors who are inexperienced.[88] According to the Social Market Foundation, survey evidence suggests that the single most important factor to a GP in choosing a job is deprivation in the practice community, and that the average GP would give up £4,222 of income to avoid serving deprived patients.[89]

An inner-city GP told the Review:

'Although there are still a number of GP trainees who are truly vocational, there has been a shift in expectations. They don't expect to work at night, they have been subject to the influences of the working time directive, marketisation and commodification. The rise of portfolio careers and part-time working because general practice is well paid have all changed the dynamic of their relationship with the job'.

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86   Centre for Social Justice, *Outcome-Based Government: How to improve spending decisions across government*, London: Centre for Social Justice, 2011, p127

87   Foresight Mental Capital and Wellbeing Project, Final Report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*, London: The Government Office for Science, 2008, p22

88   In 2008 Barking and Dagenham had half as many GPs per 100,000 weighted population as Northumberland; NHS Confederation, *Access all areas: Improving GP and primary care access*, London: NHS Confederation, 2008 [accessed via: http://www.nhsconfed.org/ Publications/Documents/Access%20all%20areas.pdf (21/09/11)]

89   Social Market Foundation, *Poverty pay: How public sector pay fails deprived areas*, London: Social Market Foundation, 2007, p8 [accessed via: http://www.smf.co.uk/assets/files/publications/Poverty%20Pay.pdf (21/09/11)]

Given these influences and the importance of ensuring primary care needs are met, we recommend that the Government investigates ways to encourage GPs to work in deprived areas. One possibility, if the survey quoted is correct, is a relatively modest enhancement of £5,000 that would, arguably, incentivise GPs to take up these vacancies.

A final caveat – CCGs consortia may bring together a range of public and mental health services within their locality, but there is a danger that too great an emphasis upon local services for local people may lead to blinkered commissioning behaviour. There must be scope and incentives to scale up proven models of good practice and to promote innovative practice beyond commissioning group boundaries.

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Creating an environment more conducive to mental and physical health

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The connection between town planning and mental health may seem tenuous but people are hugely influenced by the environment in which they live in. Many studies highlight the benefits of green space to physical and mental health and wellbeing. Just recently, the UK's first National Ecosystems Assessment showed that the health benefits of living with a view of a green space are worth up to £300 per person per year, in part by providing areas for people to exercise but also because looking at nature is shown to lift people's spirits.[90]

The way open spaces are used can create opportunities for community development. An asset-based community development approach involves many different types of people and interest groups within a locality in the design and build of innovative uses for public space like parks. Not only does this help to build relationships which can become sources of social support and involve people in open-air projects and exercise, but it also leads to greater ownership of the 'ends' of the project. In the case of a local park that might previously have been considered a no-go area for older people or those with young children because of its reputation as a hangout for disaffected young people or a place where drug deals were made, the participation of a range of local people in its redesign can make it a truly public place for social interaction.

Of course, the built environment is equally important, especially for the increasing numbers of older people. As the Foresight report observes, it can take decades to make substantial changes, so the needs of older people need to be at the heart of long-term plans being developed now. A range of scales to consider include: designs of homes and towns, improving access and accessibility to public places, better training for designers who influence the physical environment.[91]

2.7 Shape of provision

2.7.1 A continuum model

Taking a broader public health approach to mental health will involve blurring traditional distinctions between what is a mental health and what is a public health service, and aiming for more of a continuum model. This approach is particularly relevant to individuals who

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90   UK National Ecosystem Assessment, *The UK National Ecosystem Assessment: Synthesis of the Key Findings*, Cambridge: UNEP-WCMC, 2011 [accessed via http://uknea.unep-wcmc.org/Resources/tabid/82/Default.aspx (13/09/11)]

91   Foresight Mental Capital and Wellbeing Project, Final Report, *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*, London: The Government Office for Science, 2008

experience fluctuating periods of ill-health and go in and out of 'treatment' in clinical and non-clinical settings at different times.

From an individual's perspective, the boundaries between health, social care and public health services are largely irrelevant yet highly frustrating. Their overriding priority is to have appropriate care from a range of agencies, in the right place, at the right time with services organised in the most flexible and clear way possible. Services should also be geared towards individuals' ongoing improvement and recovery, and not be simply maintenance- or stability-oriented. The implications of this model for care planning and service design are significant.

In order to work well both for individuals using services and people working with them, care pathways should be broad. They should be integrated not only between specific mental health services and other health interventions such as substance misuse services, but must link with non-clinical agencies including housing and education providers. Care pathways should also be commissioned as a whole wherever possible.

However, a care pathway should not be fixed or rigid. People with long-term conditions or multiple needs will require a series of care pathways to reflect changes in their needs and circumstances. Clearly, the coordination of care is essential and we suggest that this is most effectively achieved through a named care coordinator. Such a role would also help to guard against people with complex needs falling through the gaps and ensure the most effective use of NHS and other resources. We explain the vital role the third sector could play in this in Chapter Seven on secondary care.

Another key facet of the design and commissioning of services is service user involvement and input from a range of professionals. We welcome the principle of 'no decision about me without me' but there is a long way to go before this becomes a reality in people's lives. In a survey of over 1,442 people with mental health problems conducted by Mind as part of the NHS Future Forum Listening exercise, 75 per cent of people with mental health problems had never been asked for their views on mental health services, but 94 per cent would like to be involved in the design of local services.[92] Robust user involvement is critical to ensuring services are locally appropriate and effective.

Multi-professional involvement and closer joint working are also essential and achievable even where integration is neither feasible nor necessary. As The NHS Future Forum observes, 'it doesn't always need a merger of services to deliver better care' but it does require providers working together, for example, in networks to coordinate around the needs of patients.[93]

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92   The survey was carried out between 21 April-13 May 2011 in response to the listening exercise on the Health and Social Care Bill; it received 1,442 responses; 1,301 (94 per cent) had experience of mental distress
93   NHS Future Forum, *Summary Report on the proposed changes to the NHS*, London: Department of Health, 2011, p20

2.8 Overarching public health recommendations

2.8.1 Outcomes and accountability

The Outcomes Frameworks across the NHS, public health and social care are critical drivers in reducing health inequalities, improving the health of the most vulnerable and ensuring that such aims are translated into reality. They are crucial to increasing the profile of mental health in public health activity and commissioning decisions, which historically has been low. However, the outcomes frameworks proposed for health, social care and public health need to be much more closely aligned. Instead of separate frameworks, we recommend a cross-government approach to outcomes, which builds on previous Public Service Agreements. The shared ownership of outcomes challenges tendencies towards silo-working and should drive innovative practice.

Increasing the synergy between mental and public health and promoting more fluid pathways between services does not mean adopting vague outcomes and blurred lines of accountability. Working within a collaborative framework, it is vital that different individuals and organisations deliver on their particular areas of expertise and take responsibility for weaknesses as well as successes.

2.8.2 The role of NICE

NICE plays a critical role in setting and influencing outcomes (for example, Quality Standards include recommended outcome measures). Their wide-ranging functions include producing Quality Standards on an increasing range of conditions as well as various types of guidance, spanning equally varied subjects which are relevant to public and mental health.

Whilst we understand the need for NICE guidance to be specific and have a defined scope, **we recommend that there be greater 'read across' between different topics addressing interrelated causes of adverse health outcomes**. For example, both depression and diabetes co-exist in many adults and **NICE is currently producing separate guidance on these two topics, however there appears to be little cross-referencing between the two**.

2.8.3 Workforce

Chief Executives, managers and frontline staff are key players in improving the nation's health and wellbeing. Yet knowledge and understanding about mental health among professionals in health and other sectors is poor. All too often, those in key roles such as social workers, police, GPs, council workers and staff from job centres and accident and emergency departments are ill-informed. Negative attitudes and lack of knowledge make it even more difficult for vulnerable people to access the help they need, particularly those from BME communities.

In several chapters throughout this report we describe the need for mandatory mental health awareness training for frontline health, public health and welfare professionals, as well as teaching staff. Apart from the human value, such training is cost-effective as it promotes appropriate and timely intervention, positive treatment outcomes and prevents problems

from escalating. People with direct experience of mental distress should be involved in delivering this wherever possible. Continuing professional development for practitioners and training for managers and commissioners is also integral to delivering high quality care. However, standards vary across the country and training programmes are being affected by budget cuts and organisational upheaval in the NHS, social care and numerous public services. Effective training must be prioritised and we await more information about the Government's proposals for Health Education England.

An ethos of working in partnership is equally important and is a theme we return to throughout this report. As the Future Forum report highlighted, if we are to achieve a coherent system-wide approach to improving and protecting the public's mental health, local authorities, health and social care bodies and a range of other partners must co-operate. This means ensuring that organisational structures actively encourage collaborative working across a range of agencies and recognising that strong partnerships cannot be built around informal networking alone, but require ongoing investment in time and resources. It also involves cultural change within many settings to challenge more or less unconscious assumptions that are disrespectful of the contributions made by professionals from different disciplines and other sectors.

2.9 Conclusion

In order to make a radical difference to mental health outcomes for the most vulnerable members of society, mental health must be addressed in areas that traditionally lie in the public health arena. There are strong moral, economic and social reasons for addressing the root causes of and contributors to poor mental health in our most vulnerable communities and for tackling stigma and discrimination about mental illness. This agenda is broad, ambitious and challenging, but it is also achievable and transformational. Progress is possible by learning from people with experience of mental distress, re-orienting our thinking and resources, and by better coordinating disparate services across different sectors and settings. The sweeping changes to the NHS, public health, social care and welfare are daunting for many, but they offer unprecedented opportunities to transform how services work together.

2.10 Summary of recommendations

2.10.1 Central government should lead in the following ways:

- Calling for the same cultural change to take place in mental health (around managing risk) that Professor Munro is calling for in child protection.

- Ensuring that vision, priorities, provision and outcomes for public health and mental health are more closely aligned to transform the outcomes for vulnerable people with a range of overlapping needs. It is essential that mental health is a higher priority for the cross-cutting Cabinet Committee on Social Justice, as they address the interlocking causes of poverty in which mental health is so heavily implicated.

- Revoking discriminatory legislation, either directly or through Lord Stevenson's Private Members Bill which seeks to repeal discriminatory legislation relating to jury service, school governance and company directors.

- Ensuring that Healthwatch's scrutiny role applies equally across local health, social care and public health services in the interests of joining up the public's experience, and that Healthwatch (both national and local) is adequately resourced to do so.

- Within Public Health England, there should be an explicit role for mental health, which carries the same seniority and responsibility as leading on other national programmes such as on obesity and anti-smoking.

- Making public health more prominent in the role of the NHS Commissioning Board.

- More explicitly addressing the interrelated causes of adverse health outcomes within NICE Quality Standards, with clearer cross referencing between different subjects covered by NICE guidance.

- Investigating ways to encourage GPs to work in deprived areas.

- Fulfilling Coalition pledges to tackle binge drinking by banning the sale of alcohol below cost price and reviewing alcohol taxation and pricing.

2.10.2 Local authorities:

- As per our first recommendation for central government, measures should be taken to encourage the same cultural change in mental health that Professor Munro is calling for in child protection.

- Health and wellbeing boards should ensure the public mental health of the community is addressed by commissioners locally and be accountable for this.

- Health and wellbeing boards should facilitate local partnerships that can deliver more comprehensive solutions to mental ill-health (see Chapter Six on primary care).

chapter three
Trauma, mental ill-health and military veterans

3.1 Introduction

As we said in the Introduction, it has long been known that psychiatric disorders can emerge in response to traumatic events such as war, assaults and disasters. Traumatic experiences in infancy and childhood establish corresponding, and often unconscious, expectations about life and especially about relationships and later traumas may activate and interact with these. Chapter Four explains how, more broadly, children's physical, social, intellectual and emotional development is heavily influenced by their early experiences. We described in an earlier report how the findings of a range of international research, such as the Adverse Childhood Experiences study, have:

> '…demonstrated the connection between childhood trauma and adult pathophysiology and are of direct importance to the everyday practice of medicine and psychiatry because they indicate that much of what is recognised as common in adult medicine and social behaviour has a dose-response relationship to what was not recognised in childhood'.[1]

In this chapter we look at other aspects of trauma and particularly their association with adverse mental health. Studies published in recent years show that in western societies around two-thirds of the population experience one or more traumatic events in their lifetimes.[2] Those who are the most socio-economically disadvantaged tend to be more at risk of being exposed to traumatic events and more vulnerable to the effects of such trauma.

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1 Felitti V et al, 'Relationship of childhood abuse and household dysfunction to many of the leading cause of deaths in adults. The adverse childhood experiences (ACE) study', *American Journal of Preventative Medicine*, 14, 1998, pp245-258 cited in Centre for Social Justice, *The Next Generation Report*, London: Centre for Social Justice and the Early Years Commission, 2008
2 Galea S, Nandi A and Vlahov D, 'The Epidemiology of Post-Traumatic Stress Disorder after Disasters', *Epidemiologic Reviews*, 27, 2005, pp78-91

Our attention was also drawn to military mental health which has been of significant public and political concern because of the British Armed Forces' involvement in a series of major military operations over the last 20 years. These include previous campaigns (such as the Falklands War), peacekeeping operations and sustained operations in Northern Ireland as well as more recent conflicts in Afghanistan and Iraq. Moreover, the military have traditionally recruited disproportionately from the poorest 20 per cent of society, who are of particular concern to this Review.

The recommendations focus mainly on ex-service personnel and, while we found some evidence of higher levels of mental health problems among this population, prevalence is to some extent distorted by those who leave the Forces prematurely (although alcohol misuse is a pervasive issue among troops who have deployed). Among this population higher levels of *pre-existing* risks and factors for adverse mental health outcomes are evident. Many would have exhibited problems in whatever walk of life they entered, indeed their exiting of the service early is further evidence of underlying pre-existing mental health risks.

3.2 Causes of and susceptibility to trauma

Traumatic events are those experiences that are highly unusual, unexpected or overwhelming. On experiencing them people may strongly believe that they, or others close to them, are going to die or have a deep sense of powerlessness. Such events include experiences such as:

- Being in a serious road traffic accident;
- Being involved in a traumatic birth;
- Succumbing to a sudden serious illness;
- Being mugged or raped;
- Involvement in battlefield conflict or war;
- Having a close friend, relative or colleague die suddenly; or
- Being seriously injured.[3]

While many people experience such events, the majority will suffer no adverse psychological or emotional consequences, except perhaps for a short period of distress or preoccupation with the experience; although when someone close dies in a traumatic event or circumstances, grief is obviously very common (though different to a trauma reaction).

How people cope with particular situations seems to be related to a number of factors including: what they made of the experience at the time and afterwards, the level of

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3   It may not be the obvious distressing experience that in time goes on to be the cause of psychological difficulties, but one or more events linked to it. For example, the trauma might not be due to a road traffic accident, but to the subsequent near death experience in accident and emergency, the moment a police officer calls to bring bad news or the visit to the mortuary to identify a family member or friend

support they received, whether they had other major life problems at the time and their overall resilience.

Following a traumatic experience some people (both adults and children) can develop one or more psychological disorders, such as depression, a panic disorder, general anxiety or post traumatic stress disorder (PTSD).[4] Sometimes people can have several such problems, and the longer people have a disorder such as PTSD, then the greater the likelihood they will develop other issues. An unsurprising example is that people suffering PTSD over a long period are often also depressed.

Furthermore, as a means of coping with the distress of these disorders, people may radically change their lifestyles. For instance, people can become very socially withdrawn, or increasingly dependent upon alcohol or other drugs (prescribed or illegal), which can turn into a secondary set of problems, leading to further family, social and work-related difficulties. Increasingly, evidence also links physical health problems and their associated difficulties, with PTSD and other disorders relating to trauma.

3.2.1 Traumatic events' importance to mental health policy

Some people are more at risk of having a traumatic experience which can, as stated above, lead to mental health problems. For example, young men are more at risk of traumatic events linked to street violence (see box below), and women to sexual violence and violence within relationships. Circumstances other than having had a traumatic experience seem to play some part in increasing the risk of acquiring PTSD or some other post trauma-related disorder, such as relationship problems, debt, previous illnesses or disabilities. Where people live can play a part, for example if that is in a particularly violent or unsafe neighbourhood, as can the work they do.[5] Accordingly, members of emergency services and the Armed Forces are at risk of greater exposure to certain types of traumatic events.

From a public health perspective, knowing about the risks associated with traumatic events can guide practice to reduce the likelihood of them happening to individuals (for example, by ensuring that women for whom English is a second language enter childbirth with adequate support and knowledge). It also emphasises the importance of identifying and helping people with problems arising as a consequence of such events; military procedures like Trauma Risk Management (TRiM), described later in the chapter, are transferrable to other work settings. In our polling two-thirds of people who had experienced mental health problems, or were a close friend or relative of someone who had, thought trauma was a major cause of poor mental health.[6]

4   Shalev AY and Yehuda R, 'Longitudinal Development of Traumatic Stress Disorders', in Yehuda R (ed.), *Psychological Trauma,* Washington DC: American Psychiatric Press; 1998, pp31-66
5   INCORE (University of Ulster and United Nations University), *The Cost of the Troubles Study: Report on the Northern Ireland Survey: the experience and impact of the Troubles,* Derry Londonderry: INCORE, 1999
6   CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010

Correlations between violence, gang membership and trauma

The CSJ's report *Dying to Belong* draws out the traumatic experiences many young people who are involved in gangs have experienced, and how these can be contributing factors to certain patterns of behaviour.[7]

Both academic research and anecdotal evidence point to the majority of gang-involved young people having experienced significant – and often extreme – family breakdown and/or dysfunction. A 2000 Office for National Statistics (ONS) report found that 42 per cent of female young offenders had experienced violence at home, nearly a quarter of males sentenced and remand young offenders had experienced violence at home and nearly one in three female young offenders had been sexually abused.[8] Although these statistics are not gang-specific, they do demonstrate a clear relationship between childhood abuse and future offending. Mark Johnson, author of *Wasted*, spoke to the CSJ's Gangs Working Group about the childhood abuse suffered by many of the gang members he had interviewed. He said that the anger and violence within many of the young people was the result of traumatic experiences such as rape and physical abuse.

Superintendent John Sutherland also talked of the prevalence of domestic violence in the homes of gang-involved young people: 'Much has been done [about domestic violence], but we still have an awful long way to go, and a huge proportion of our most troubled young people will have been victims or witnesses of abuse'. As one ex-young offender told the Working Group: 'Once you get used to living in that environment, of expecting violence, you recreate it when it's not there – because that's what you're used to'.[9]

3.3 PTSD

PTSD is of particular interest in understanding the impact of traumatic events on mental health and wellbeing. The term has been used since the 1970s for a range of psychological and physical problems that can sometimes follow particularly threatening or distressing events.[10] It was first classified as a disorder in the Diagnostic Statistical Manual of Mental Disorders, Third Edition (DSM-III), in 1980.[11] Its current profile is described in DSM-IV-TR (2000) and includes three clusters of commonly observed reactions to traumatic experiences, namely:

1. Re-experiencing of the event such as nightmares or flashbacks;
2. Avoidance of things that remind the person of the event and numbing of emotions and responsiveness; and
3. Hyper-vigilance symptoms such as jumpiness, irritability and sleep disturbance.[12]

Following the first classification of PTSD in 1980, a research literature emerged concerning trauma and trauma-related disorders and needs, with most early studies concentrating on

7   Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, 2009, p96
8   Lader D, Singleton N and Meltzer H, *Psychiatric Morbidity among Young Offenders in England and Wales*, London: Office for National Statistics, 2000, p89
9   Centre for Social Justice, *Dying to Belong: An in-depth review of street gangs in Britain*, London: Centre for Social Justice, 2009, p96
10 National Institute for Health and Clinical Excellence, *Clinical guidelines 26 Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*, London: Gaskell and the British Psychological Society, 2005
11 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (DSM III), Arlington VA: American Psychiatric Association, 1980
12 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV-TR), Arlington VA: American Psychiatric Association, 2000

small populations in the wake of specific traumas such as rape, combat and natural disasters.[13] While these studies are valuable in the understanding of PTSD, their applicability to the general population is limited. As the definition and criteria of PTSD have developed through numerous DSM editions, a body of research literature has developed. Of particular interest are the population (otherwise known as epidemiological) studies of trauma and PTSD. Evidence from these studies shows that PTSD is a common consequence of exposure to traumatic incidents and experiences.

How common is PTSD?

Prevalence estimates of PTSD experienced in the previous 12 months range from 0.5 per cent[14] to 3.6 per cent.[15] The amount of PTSD seems to depend on gender and other socio-demographic factors. For instance, the overall lifetime prevalence of PTSD has been estimated at 5.6 per cent with twice as many females developing PTSD as males,[16] although in a major US study Kessler and colleagues found that 51.2 per cent of women reported experiencing at least one traumatic event compared to 60.7 per cent of men.[17]

3.3.1 Treatments for PTSD

On the basis of currently available research NICE recommends two psychological therapy treatments of choice for PTSD in adults and children, namely, trauma focused cognitive behavioural therapy (CBT) or Eye Movement Desensitisation and Reprocessing. NICE recommends that drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy. However, there is evidence that drug treatment with anti-depressant medication can be effective in addition to trauma-focused CBT or if there is a failure to respond to a psychological therapy.[18]

Support is also very important in the care of people with trauma-related disorders whether at times of distress, while they are seeking help, specifically considering accessing therapy and while it is in progress, or helping an individual and their family readjust when they have recovered.

13   Breslau N, 'Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders', *Canadian Journal of Psychiatry-Revue Canadienne de Psychiatrie*, 47, 2002, pp923-929

14   Levinson D et al, 'Prevalence of Mood and Anxiety Disorders in the Community: Results from the Israel National Health Survey', *Israel Journal of Psychiatry*, 44, 2007, pp94-103

15   Kessler RC et al, 'Posttraumatic stress disorder in the National Comorbidity Survey', *Archives of General Psychiatry*, 52, 1995, pp1048-1060

16   Frans et al in Ferry F et al, *Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual*, The Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster, October 2008, p11 [accessed via: http://www.nictt.org/picture/reprint%201(3).pdf (12/10/11)])

17   Kessler and colleagues (1995) find in Ferry F et al, *Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual*, The Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster, October 2008, pp12-13 [accessed via: http://www.nictt.org/picture/reprint%201(3).pdf (12/10/11)]

18   National Institute for Clinical Excellence, *Post-traumatic stress disorder (PTSD): the treatment of PTSD in adults and children*, London: National Institute for Clinical Excellence, 2005 [accessed via: http://www.nice.org.uk/nicemedia/pdf/CG026publicinfo.pdf (14/09/11)]

Case study: Trauma and family breakdown – My Time, Birmingham

It is generally accepted that a child's mental health and development are affected by the mental and physical wellbeing of their parents, and parents who struggle to function because of mental health problems will need help across a wide range of different areas. The Review visited My Time, a Community Interest Company in Birmingham, which runs several related projects aimed at preventing family breakdown among migrant (often refugee) families who have been significantly traumatised. The risk of family breakdown was recognised in our polling with more than 60 per cent of people (who had experienced mental health problems or were a close friend or relative of someone who had) citing poor mental health as a major contributor. When parents lose care of their children because of their inability to cope after harrowing experiences, they and their children undergo further trauma, adding to their children's high risk of vulnerability.

Supporting fathers

One project is aimed at helping fathers to recover who have been left on their own with children. This requires:

- Working with all family members to help them understand negative behaviour and how to help each other practically;
- Mixed family support teams (based at Children's Centres, with whom My Time works in partnership) with father workers who are male and, ideally, the fathers themselves. People respond better to role models;
- Families with complex needs are able to access multi-skilled and intercultural community units that can manage complex and multiple issues, and sustain support for a significant period; and
- Training fathers as peer counsellors and support volunteers to enable the community to develop local support structures.

Mohammed's Story

The Review met Mohammed who originates from Somalia and in 2002 escaped a war zone with his wife and children. His wife and one child died, but he managed to get out with the remaining two, however they were separated. He arrived in the UK alone, not knowing whether or not his two remaining children were alive. After being diagnosed with chronic PTSD he became homeless. He made contact with the British Red Cross who eventually located the children in foster care in the UK, both of whom also had PTSD. In 2009, the family was reunited and Mohammed started a new life as a single father to two teenagers.
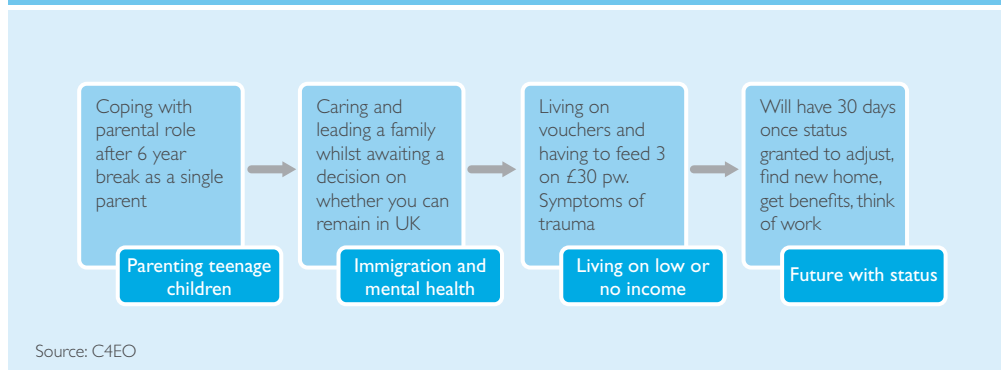
While waiting for a decision on their immigration claim and living with little income, the fear of deportation was very real; until they had the right to remain in the UK it was difficult to plan a future. Mohammed found it difficult to keep hope alive with his children and these years of destitution had a serious affect on his mental health. My Time provided a detailed psychological report to assist the family in their asylum claim, regular therapy including garden therapy (evidence shows that many men prefer this to talking therapies), socialisation and support on fathering teenagers – especially a teenage girl. Mohammed was mentored by Nigel, another father supported by My Time as part of their policy to encourage peer support.

He is now able to enrol on courses to achieve professional qualifications; 'supportive challenge' is a key aspect of My Time's work – they help people push themselves to rebuild their lives. They told us 'We recognise at a very early stage the causation of the trauma and try to act on it particularly when it comes to Asylum Seekers and BME ... Others (hospital staff) will tend to treat the symptoms not the causation which is a significant difference'.

Figure 2 below represents the challenges Mohammed faced while waiting to hear about his status – it is typical of the complex practical help and support needed which a 'community place-to-go' like My Time can provide. [19]

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19   C4EO, C4EO theme: *Families, Parents and Carers – further case studies* [accessed via: http://www.c4eo.org.uk/localpractice/files/403-fact-case-studies.pdf (10/10/11)]

Figure 2: Complexity of help needed by an asylum seeker with mental ill-health

Coping with parental role after 6 year break as a single parent	Caring and leading a family whilst awaiting a decision on whether you can remain in UK	Living on vouchers and having to feed 3 on £30 pw. Symptoms of trauma	Will have 30 days once status granted to adjust, find new home, get benefits, think of work
Parenting teenage children	**Immigration and mental health**	**Living on low or no income**	**Future with status**

Source: C4EO

3.3.2 PTSD and other mental health problems

As already noted, individuals can develop mental health problems other than PTSD, such as depression or panic disorder, following traumatic experiences, and some individuals can develop additional mental health problems concurrently with or subsequent to acquiring PTSD. A major survey found that respondents with PTSD were 9.3 times more likely than those without to suffer from one other comorbid disorder.[20] Data from the National Comorbidity Study (NCS) support these findings.[21] NCS figures show that 88.3 per cent of men and 79 per cent of women with PTSD also experienced at least one other lifetime disorder,[22] with substance abuse or dependence most prevalent in one US study.[23] Kessler et al found that 51.9 per cent of men with lifetime PTSD had comorbid alcohol abuse or dependence.[24]

There are several theories about the sequence of onset of different psychological disorders in relation to traumatic experiences.[25] Overall the evidence concludes that people who suffer from PTSD are more likely to have a range of mood, anxiety and substance-use disorders, and infers that an examination of the impact of trauma exposure should not be solely focused on PTSD, but on a range of possible psychological outcomes.

3.3.3 PTSD and other physical health problems

In recent years a growing body of evidence has pointed to the association between physical health problems and trauma related disorders including PTSD. Research has linked traumatic

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20   Davidson JRT et al, 'Post-traumatic stress disorder in the community: an epidemiological study', *Psychological Medicine*, 21, 1991, pp713-721

21   Kessler RC et al, 'Posttraumatic stress disorder in the National Comorbidity Survey', *Archives of General Psychiatry*, 52, 1995, pp1048-1060

22   Ibid

23   Breslau N et al, 'Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of Trauma', *Archives of General Psychiatry*, 55, 1998, 7, pp626-632

24   Kessler RC et al, 'Posttraumatic stress disorder in the National Comorbidity Survey', *Archives of General Psychiatry*, 52, 1995, pp1048-1060

25   First, there is a possibility that pre-existing psychological disorders, like substance abuse, may increase the risk of exposure to traumatic events that may result in PTSD. Second, PTSD may be a contributory risk factor for other psychiatric disorders. Third, there may be a non-causal relationship between PTSD and other disorders (Breslau N, 'Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders', *Canadian Journal of Psychiatry-Revue Canadienne de Psychiatrie*, 47, 2002, pp923-929); Finally traumatic events may themselves cause various disorders other than PTSD (Ferry F et al, *Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual*, The Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster, October 2008, p11 [accessed via: http://www.nictt.org/picture/reprint%201(3).pdf (12/10/11)])

stress exposure and PTSD to diabetes, chronic fatigue syndrome, gastrointestinal disease, cardiovascular disease, fibromyalgia, musculoskeletal disorders, and other diseases with significantly higher symptoms of cardiovascular, respiratory, musculoskeletal and neurological symptoms found amongst PTSD sufferers.[26, 27] Having a history of trauma has been linked with digestive disorders and cancer in women and with arthritis and diabetes in men.[28] A longitudinal study following older combat veterans over 30 years found an increased incidence of upper gastrointestinal disorders associated with greater combat exposure.[29] Those who met the criteria for PTSD face an increased risk for a wide range of chronic physical health conditions and more so than those with major depressive disorders.[30] Elsewhere in this report we describe the very poor quality of physical health care received by people with mental disorders and how this can be improved – not least through a preventive, public health approach.

3.4 The Armed Forces and mental health

As part of this Review, the Working Group heard from researchers who have investigated the impact of battle experience in recent wars and operations involving the British Army, as well as from a number of organisations involved in the care and support of ex-service personnel. This provided a broad set of observations and evidence which afforded a special opportunity to identify and explore strategies and service solutions.

Professor Simon Wessely giving evidence to the Review

26 Boscarino JA, 'Posttraumatic Stress Disorder and Physical Illness: Results from Clinical and Epidemiologic Studies', *Annals of the New York Academy of Science,* 1032, 2004, pp141-53

27 McFarlane AC et al, 'Physical symptoms in post-traumatic stress disorder', *Journal of Psychosomatic Research*, 38, 1994, pp715-726

28 Norman SB et al, 'Associations Between Psychological Trauma and Physical Illness in Primary Care', *Journal of Traumatic Stress*, 19(4), 2006, pp461-470

29 Schnurr PP et al, 'Physician-diagnosed medical disorders in relation to PTSD; symptoms in older male military veterans', *Health Psychology,* 19, 2000, pp91-97

30 Ferry F et al, *Trauma, Health and Conflict in Northern Ireland: A study of the epidemiology of trauma related disorders and qualitative investigation of the impact of trauma on the individual,* The Northern Ireland Centre for Trauma and Transformation and the Psychology Research Institute, University of Ulster, October 2008, p9 [accessed via: http://www.nictt.org/picture/reprint%201(3).pdf (12/10/11)]

Military mental health is an important area of consideration because of the involvement of the British Armed Forces in a series of major military operations over the last 20 years (two Iraq conflicts, Afghanistan, Sierra Leone and Libya). There are also significant numbers from previous campaigns such as the Falklands War, a number of peacekeeping operations and, the most enduring in recent times, Operation Banner in Northern Ireland, during which it is estimated 300,000 soldiers from Britain and Northern Ireland served. The health of serving and ex-service personnel has been a significant public and political concern in recent years and, from time to time, has been of great interest to the media.

The evidence that the CSJ Working Group received was varied. On one hand we heard from researchers engaged in major studies of large numbers of armed services personnel over lengthy periods of study. At the other end of the spectrum, we heard at first hand from those involved in small local groups aimed at providing support to ex-service men and women.

The most extensive scientific research was reported upon by Professor Simon Wessely who leads the Kings Centre for Military Health Research (KCMHR). This department has carried out extensive studies for both the British and US Governments on the military health of their respective armed services. The evidence from Professor Wessely suggested that with regard to the British forces, military service is not in itself associated with adverse mental health outcomes, and indeed may be beneficial for mental health.[31] The National Adult Psychiatric Morbidity Survey 2007 showed no association between adverse mental health outcomes and military service.[32] Furthermore the military has developed strategies to identify and manage trauma reactions that have been adopted by a variety of emergency services, the Foreign and Commonwealth Office (FCO), journalists, private security contractors and now some NHS bodies (including London Ambulance Service).[33, 34]

3.4.1 Prevention of PTSD in the Armed Forces

The Armed Forces have developed and implemented TRiM, an evidence-based peer-support system that helps organisations deal with the psychological aftermath of traumatic events.[35] TRiM was pioneered with the Royal Marines and subsequently used within some RAF and Army units, and numerous other non-military organisations including the FCO and the London Ambulance Service (because it fits with their culture).[36] Evidence of effectiveness suggests that TRiM could also be used by other organisations that 'predictably place their

31   Fear N et al, 'What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK Armed Forces? A cohort study', *The Lancet,* 375, 2010, pp1783-1797

32   National Centre for Social Research and University of Leicester Department of Health Sciences, *Adult psychiatric morbidity in England, 2007 Results of a household survey,* London: The NHS Information Centre for health and social care, 2007

33   Greenberg N, Langston V and Jones N, 'Trauma Risk Management (TRiM) In The UK Armed Forces', *Journal of the Royal Army Medical Corps,* 154(2), 2008, pp124-127

34   Personal correspondence with Professor Neil Greenberg

35   Greenberg N et al, 'A cluster randomised controlled trial to determine the efficacy of TRIM (Trauma Risk Management) in a military population', *Journal of Traumatic Stress,* 23, 2010, pp430-436

36   Personal correspondence with Professor Neil Greenberg

personnel in harm's way' to comply with NICE guidance on promoting mental wellbeing through productive and healthy working conditions.[37, 38]

The main aim of TRiM is not to prevent PTSD, which is likely impossible given the work undertaken by the Armed Forces, nor to treat it, which is within the remit of the Defence Medical Services. The TRiM system aims to provide an early indication of who may go on to develop formal illnesses and to enable unit leaders to implement management plans that aim to create the best possible conditions for psychological recovery to occur. Since it is known that exposure to excessive life stressors and a lack of social support are important factors which determine who may go on to develop illness, those that have been identified via the TRiM system as being at an increased risk of psychological injury can, wherever possible, have both attended to within their unit.

TRiM aims to avoid units adopting a medical model as the preferred route of intervention after traumatic events. This usually entails, for example, asking a mental health professional previously unknown to those involved to come into a unit and deliver a 'crisis intervention' that is likely to be ineffective. Such an approach might encourage the development of difficulties in some individuals, is likely to be met with resistance by others, and might pathologise a normal reaction which is part of the natural recovery following a major traumatic event. By giving units the means to carry out the immediate post incident psychological management 'in house', TRiM intends to avoid such problems.

TRiM practitioners are embedded within units and after traumatic events they ensure that the psychological needs of personnel involved in the event are assessed and managed. Practitioners are non-medical personnel in junior management positions who have been trained in the system. TRiM appears to be good practice; experts in the field of traumatic stress have stated their support in the scientific literature and a randomised control trial was completed before implementation in the Army.[39]

Well-respected TRiM practitioners can effectively become the 'eyes and ears' of the defence medical and mental health services because they are likely to be trusted by unit members who will confide in them. There is already evidence that personnel prefer to talk to colleagues who have deployed with them rather than to the chain of command or medical and welfare services.[40] Current experience from both Afghanistan and Iraq is that commanders highly value their unit TRiM practitioners.

Finally, by using peer TRiM practitioners rather than professionals with a health or welfare background, is hoped that over time there will be a cultural shift which will see a reduction

37   Greenberg N, 'Managing traumatic stress at work: An organisational approach to the management of potentially traumatic events', *Occupational Health [at Work]*, 7, 2010, pp22-26

38   National Institute for Health and Clinical Excellence, *Promoting mental wellbeing through productive and healthy working conditions: guidance for employers*, London: National Institute for Health and Clinical Excellence, 2009

39   Wessely S and Deahl M, 'Psychological debriefing is a waste of time', *The British Journal of Psychiatry*, 183, 2003, pp12-14; Alexander D and Klein S, 'Biochemical terrorism: too awful to contemplate, too serious to ignore', *The British Journal of Psychiatry*, 183, 2003, pp491-497; Greenberg N et al, 'A cluster randomised controlled trial to determine the efficacy of TRIM (Trauma Risk Management) in a military population', *Journal of Traumatic Stress*, 23, 2010, pp430-436

40   Greenberg N et al, 'Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment', *Journal of Mental Health*, 12, 2003, pp565-573

in the stigma surrounding traumatic stress and its associated problems.[41] Regular use of the TRiM system in units should also ensure that personnel are more aware of the effects of traumatic stress and what can be done about it.

3.4.2 Do veterans have poorer mental health?

As noted, evidence was also received from a variety of veterans' groups and organisations including Combat Stress and the Royal British Legion. These portrayed a more worrying picture suggesting that there is a large amount of unmet need, including many traumatised ex-service personnel who have untreated PTSD arising from combat operations, and a significant proportion of street homeless.

One explanation is that both views are correct, but it may be that the majority of ex-service personnel with unmet needs are not necessarily those who have suffered because of experience of combat, but those who were vulnerable because of pre-existing genetic and environmental factors. Some sections of the military have traditionally recruited largely from the poorest 20 per cent of society.

Working group taking evidence from veterans' organisations

There is evidence that military service provides a route to better social and mental health outcomes for some young people who might otherwise not have ready access to rewarding employment, training or higher education. We noted that the poorest outcomes are clustered in early service leavers and who faced multiple problems such as debt, antisocial behaviour, substance misuse, mental health problems, unemployment, marital problems and unstable housing (see below). For this group, the evidence points to pre-service circumstances rather than experiences during (relatively short) service careers as predictors of poor mental health and related outcomes. Also, those with mental health problems have difficulty accessing appropriate services and rarely obtain the best psychological therapies (although this is true for parts of the general public too).

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41   Greenberg et al, 'A cluster randomised controlled trial to determine the efficacy of TRIM (Trauma Risk Management) in a military population', *Journal of Traumatic Stress,* 23, 2010, pp430-436

Poor access to services is partly due to stigma. In a relatively recent legal case against the Ministry of Defence (MoD) by ex-service personnel (claiming to be have sustained psychological injuries through their military service), stigma was cited as a very real and significant issue.[42] Stigma, defined as something which sets the affected individual apart from others[43] can be both internal ('self stigma') and external. An example of internal stigma is the belief that asking for help for mental health problems will prematurely end a military career. External stigma includes the belief that people suffering from mental health problems are, by definition weak and unreliable.[44] Due to stigma, many military personnel who suffer mental health problems as a result of their military service will not readily seek help. This is concerning for the military because if personnel are effectively treated, a mental health problem is not at all career-limiting, but poor performance, whether secondary to untreated mental health problems or otherwise, will limit someone's progression.[45]

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The ex-service community

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The MoD defines a veteran as anyone who has served just one day in the armed services and estimate that there are 4.5 million veterans in the UK.[46] KCMHR undertook an early leavers study looking at those who left the service prematurely.[47] Half had a psychiatric diagnosis, often depression, with alcohol problems. Only half were seeking help and most often through their GP. Another study looking at 4,000 who had left the service between 1991 and 2001 (normal leavers) showed that 90 per cent had got a job.[48] Early leavers had poorer mental health and less chance of getting a job.

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3.4.3 Suicide and the Armed Forces

In a valuable study covering the period 1996 to 2005, Kapur et al compared the suicide patterns between ex-service personnel and the serving and the general populations.[49] Over the nine year period 233,803 individuals left the Armed Forces and 224 took their own lives. The overall rate of suicide did not exceed that in the general population, however suicide risk in men aged 24 years and younger with an Armed Forces history was approximately two to three times higher than the risk for men of the same age in the general and still-serving populations. Men aged 30-49 years were at lower risk of suicide than in the general population. Suicide risk was positively correlated with a short length of service, and holding lower rank. Those in age groups at greatest risk of suicide had the lowest rate of contact with specialist mental health services (14 per cent for those aged under 20 years, 20 per cent for those aged 20 to 24 years). The researchers concluded that the increased risk of suicide of

42   McGeorge T, Hacker Hughes J and Wessely S, 'The MOD PTSD Decision: A Psychiatric Perspective', *Occupational Health Review*, 122, 2006, pp21-28

43   Goffman E, *Stigma: Notes on the management of spoiled identity,* Englewood Cliffs NJ: Simon and Schuster, 1963

44   N Greenberg, V Langston and N Jones, 'Trauma Risk Management (TRiM) In The UK Armed Forces', *Journal of the Royal Army Medical Corps*, 154(2), 2008, pp124-127

45   Ibid

46   Ministry of Defence, Veterans World 'Who is a veteran?' [accessed via: http://www.veterans-uk.info/vets_world/Veterans_World_issue13/who_veteran.html (14/09/11)]

47   Iversen et al, 'Goodbye and Good Luck: the mental health needs and treatment experiences of British Veterans', *The British Journal of Psychiatry,* 186, 2005, pp480-6

48   Iversen et al, 'What happens to UK veterans when they leave the Armed Forces?', *European Journal of Public Health*, 15, 2005, pp175-184

49   Kapur N et al, 'Suicide after Leaving the UK Armed Forces – A Cohort Study', *PLoS Medicine*, 6, 2009

young men who leave the UK Armed Forces 'may reflect pre-service vulnerabilities rather than factors related to service experiences or discharge'.[50] This assessment accords with the evidence heard by the Working Group from contributors.

3.4.4 Homelessness and social exclusion among veterans

Studies on street homelessness have suggested that previous concerns of high numbers might be exaggerated. Recent work from the University of York suggested that six per cent of street homeless might be veterans which, given the large number of veterans due to the broad definition, might not be excessive.[51] A report for the Royal British Legion concluded that:

'The characteristics, profile and experiences of homeless veterans are largely the same as those of the wider homelessness population, although there are some notable differences. Homeless veterans have been found on average to be older, have slept rough for longer, be less likely to use drugs and more likely to have alcohol-related problems. Post Traumatic Stress Disorder (PTSD) has been found among a small number of homeless veterans although other non-military related mental health problems were more common'.[52]

3.4.5 Alcohol

Alcohol was identified as a major issue by many of those who gave evidence. Those under 35 years in the Armed Forces have twice the rate of alcohol misuse in both men and women compared to the UK population. (Coming from a junior rank, and social factors such as having a parent with a drink or drug problem also made excessive drinking more likely, again suggesting that those drawn from disadvantaged backgrounds are more at risk.) The Armed Forces not only drink more but in a different way: there is two to three times the rate of binge drinking compared with civilians.[53] The Working Group heard of particular concerns of excessive alcohol use by female service personnel. There is some evidence that operational deployment leads to increased drinking on the return home and this increase may be sustained.[54] Deployment also seems to increase the incidence of risk taking and accidental deaths from, for example, driving.[55]

3.4.6 Operational deployment and the impact of Iraq and Afghanistan

About 20 per cent of those returning from Iraq show some evidence of common mental health problems. However there is no overall increase in psychiatric problems (PTSD) and common mental health disorders in regular forces that have deployed to Iraq or Afghanistan compared to the rest of the Armed Forces. There is, however, an impact in terms of greater

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50   Ibid, p1
51   University of York Centre for Housing Policy, *The Experience of Homeless ex-service personnel in London*, York: Centre for Housing Policy, 2008, pix
52   The Royal British Legion, *The Literature review: UK veterans and homelessness*, London: The Royal British Legion, 2010
53   Fear et al, 'Patterns of drinking in the UK Armed Forces', *Addictions*, 102, 2007, pp1749-1759
54   Fear et al, 'What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK Armed Forces?', *The Lancet*, 375, 2010, pp1783-1797
55   Fear et al, 'Risky driving among regular armed forces personnel from the United Kingdom', *American Journal of Preventive Medicine,* 35, 2008, pp230-236

alcohol misuse among those who have deployed, and combat troops and deployed reservists do have an increased rate of probable PTSD. There is no substantial increase in mental health problems when personnel return home as in contrast to the US. Potential explanations could include different socio-demographic characteristics of the different armed forces (US troops tend to be younger), length of deployment (US troops deploy for 12 to 15 months in whereas average tour lengths in UK forces are six months), greater deployment of reserve forces within the US military and other factors including the financial benefits associated with mental health problems in the US military and veteran populations.[56]

3.5 Conclusions on military mental health and PTSD

According to the best evidence available, PTSD is not as great a problem in the Armed Forces as other mental health problems, which are as or more common than those found in the general population. Indeed, the objective evidence suggests that military service may actually enhance mental health, especially in those who have pre-existing vulnerability factors (who might be recruited from the poorest 20 per cent of the population).

However, early leavers (those who exit the services early in their careers before their intended retirement date) have poor outcomes associated with multiple pre-existing social disadvantages. Whilst there is some evidence of higher levels of mental health problems amongst ex-service personnel, further investigation shows that this is distorted by that group of joiners who leave prematurely, and amongst whom are higher levels of pre-existing risks and factors for adverse mental health outcomes. It seems that military service is not the only, perhaps not even the primary stimulus and that many of these young men (and they are mostly men) would have exhibited problems in whatever walk of life they entered and their exiting of the service early is further evidence of underlying pre-existing mental health risks. This population is of more concern to the Working Group not because of their military service, but because they are likely to come disproportionately from the high-risk group of the most socially disadvantaged with which this Review is chiefly concerned.

The evidence we gathered, alongside the current foremost academic research, affirms the view that many ex-service personnel value the solidarity of ex-service support. It is particularly attuned to the shared and uniquely challenging experiences of battle and all that is associated with it. That said, we also learnt of the specific risks and concerns of personnel suffering mental health problems, and of the tangible measures being taken by the MoD to prevent, detect and treat PTSD and related conditions, and of its concern about the high levels of alcohol use.

One of the subtexts, for which little evidence was presented, was concern that ex-service personnel would, after leaving the service, develop mental health problems disproportionately to others (e.g. of the same age) in wider society, and that they would be poorly served. The reasons given for this were that the MoD would be no longer responsible for their care

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56   All statistics and commentary drawn from Fear N et al, 'What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK Armed Forces?', *The Lancet*, 375, 2010, pp1783-1797

and that ex-service personnel would have difficulties asking for help, trusting and indeed respecting services, because the NHS was not perceived to be sufficiently attuned to the needs and culture of their community. On the other hand, we learnt of efforts to create pathways to improve veterans' access to NHS services, of joint appointments of ex-service NGO mental health practitioners to NHS departments and other special arrangements. Since our hearings (June 2010), the MoD announced other specific investments in this regard (October 2010) in response to the Fighting Fit report.[57] What is evident is that ex-service personnel find it hard to access appropriate treatment for mental health disorders because of stigma and low awareness of them, as well as poor signposting to services (a problem also faced by members of the general population).

Our attention was also drawn to the needs of families – parents, partners and children in particular – of serving members of the Armed Forces and ex-service personnel who have lived with enduring worry and anxiety and learned to one degree or another to function independently of their serving partner/parent, and have had to adjust after their return or discharge.

3.6 Summary of recommendations

We note the concern of ex-service organisations for members and their families, and recognise that their advocacy along with the practical care, services and solutions they offer for former service personnel and their families, are highly valued. To this we would add the importance of wider society and its key institutions in paying attention to the voice and views of ex-service organisations and their members. Besides representing the needs of vulnerable ex-service personnel, the organisations also expressed the benefits of service experience and how most members of the services have accomplished careers and leave the services to live fulfilled lives, bringing much experience and skills to civilian areas of life.

We also note the findings of recent research and recognise that there are occasionally differences between the assessment and conclusions of research, and the views and concerns of organisations representing ex-service personnel. Based on our conclusions from the range of evidence, we make the following observations and recommendations.

- **Preventive strategies should include practical and psychological preparation for discharge and encourage appropriate help-seeking behaviour once individuals have left the services.**

- **Military, ex-service and mainstream services should be attentive to the possibility of trauma-related needs, including PTSD, where they arise.**

- **All health and support services should be mindful of the unique experiences of deployment and war, and to the distinctive self-identity of ex-service personnel. Their needs should be understood within the context of the culture and community of the Armed Forces, and the challenge of adjustment and integration some face on leaving the services.**

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57   Veterans UK, 'Veterans issues' [accessed via: http://www.veterans-uk.info/mental_health/faq.html (22/09/11)]; also see Ministry of Defence, *Fighting Fit: A mental health plan for servicemen and veterans*, London, 2010 [accessed via: http://www.mod.uk/NR/rdonlyres/DF9DAC72-C196-4967-BBE9-4D8A6580E7F3/0/20101006_mental_health_Report.pdf (22/9/11)]

- Specific efforts must be made to ensure that health service (and other public service) organisations and staff recognise and positively respond to the specific cultural traditions, expectations and perspective of ex-service personnel.

- Efforts should be made to reduce the stigma and improve access to appropriate therapy for ex-service personnel with mental health problems. There may be more of a need for specific ways to signpost and facilitate ex-service personnel into mainstream therapy as opposed to particular treatment programmes for the ex-military.

- We can learn from the UK military in the steps they take to manage trauma risk without going down the screening route which other countries' Armed Forces have taken. We recommend that the benefits of TriM should be more widely distributed to other organisations where there is an increased risk of exposure to trauma.

- The Armed Forces should do more to reduce alcohol consumption in service personnel as part of a wider societal acknowledgement of the public health dangers of excessive alcohol consumption that is addressed, for example by a minimum unit pricing policy or an alcohol treatment tax.

- There should be more emphasis placed on dealing with multiple social disadvantages and life problems, particularly in the early leavers group rather than focusing on imagined high-prevalence PTSD in longer serving ex-servicemen. Many of our recommendations in other chapters take up this theme in the civilian population.

chapter four

The mental health of children and young people

4.1 Introduction

The numerous disadvantages associated with child poverty and the importance of its alleviation are particularly salient in public consciousness. Many people, however, are unaware of the high prevalence of childhood mental disorder in the UK. Nor are they aware of the close relationship that exists between these two complex social problems. Children (and adults) from the lowest quintile (20 per cent) of household income are three times more likely than those in the richest quintile to have common mental health problems.[1] They are also nine times as likely to have psychotic disorders.[2] The first onset of mental health problems is commonly in childhood or adolescence; half of all lifetime cases have started by the age of 14 years.[3]

One in ten children has a diagnosable mental health problem, learning disability or conduct disorder.[4] Furthermore, it is estimated that 55 per cent of children with autism and 57 per cent with Asperger's-levels of impairment or symptoms go undiagnosed and are not receiving any additional-needs support in education or health.[5] The high incidence of autism, ADHD, self-harm, depression and conduct disorder poses considerable challenges to parents, other family members, teachers and the youth justice system – and blights the childhoods of sufferers to an enormous extent.

1   Green H et al, *Mental Health of Children and Young People in Great Britain*, London: Office for National Statistics, 2005
2   Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010,* The Marmot Review, London, 2010 [accessed via: http://www.marmotreview.org/AssetLibrary/pdfs/chapters per cent of per cent20fshi/FairSocietyHealthyLivesChapter2.pdf]
3   Kim-Cohen J et al, 'Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort', *Archives of General Psychiatry*, 60, 2003, pp709-717
4   Meltzer H et al, *Mental Health of children and adolescents in Great Britain,* Norwich: The Stationery Office, 2000
5   Russell G et al, 'Identification of children with the same level of impairment as children on the autistic spectrum, and analysis of their service use', *Journal of Child Psychology and Pyschiatry,* 51(6), 2010, pp643-651

Despite the magnitude of this problem, mental health care has been called the neglected, or 'Cinderella', service. Even worse, children and adolescent mental health services have been referred to as 'the Cinderella of the Cinderella service'.[6] Compared with physical health, there is currently a disproportionately low investment in children's mental and emotional health.[7] This is despite the potential for early intervention in this area to transform children's future outcomes.[8] Moreover, we know what is required to build resilience: support from family and peers, good educational experiences, and the sense of agency and self-efficacy that comes, for example, through opportunities to contribute to family or community life by taking valued social roles.[9] A public health approach to children's mental health must act on this knowledge.

In this chapter we describe how and why mental health problems develop in childhood. We also explore the implications for children's lives of leaving these problems unaddressed. Children's future relationships, their ability to fulfil their potential both educationally and in the workplace as well as their basic enjoyment of life are all threatened by mental illness and unmet emotional needs.[10] Interventions need to be grounded in an understanding of mental health's continuity from conception to adulthood and a recognition that children's physical, social, intellectual and emotional development is heavily influenced by their early experiences.[11]

However, it is also vital to recognise that problems can emerge later in childhood as a result of difficult experiences. A recent ONS report on the prevalence of children's mental health problems found that children who experience three or more stressful life events, such as family bereavement, divorce or serious illness in the previous year, are significantly more likely to develop subsequent emotional and behavioural disorders.[12] A public health approach to childhood mental health anticipates and seeks to mitigate the potential damage that can be inflicted by such commonly occurring life events.

> Among those we polled who had experienced mental health problems or were a close friend or relative of someone who had: 92 per cent agreed we should do more to safeguard the mental health of adolescents, and 88 per cent agreed we should do more to safeguard the mental health of children.[13]

We then go on to lay out priority areas for change if mental health and related services are to address the needs of children and young people. Prevention where possible and integrated,

6   Hepburn H, 'Cinderella of the Cinderella Service' in *TES* 2010 [accessed via: http://www.tes.co.uk/article.aspx?storycode=6034529]

7   Kennedy I, *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs,* London: Central Office of Information, 2010

8   Collins PY et al, 'Grand challenges in global mental health', *Nature,* 475(7354), 2011, pp27-30

9   National Children's Home, *Literature Review: Resilience in Children and Young People,* London: National Children's Home, 2007

10   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission*, London: Centre for Social Justice, 2008

11   Ibid

12   Office for National Statistics, *Three years on: Survey of the development and emotional well-being of children and young people,* London: Office for National Statistics, 2008

13   CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010

early intervention where necessary are our key guiding principles. Consistent with our approach in the rest of this report, we emphasise the need to treat children in the context of their families and communities whenever possible. Instead of only treating problems in the individual, shortcomings in children's social contexts must also be overcome. While we do pay particular attention to the role played by CAMHS, we also look much more widely at the systems and approaches which need to change if the life chances of tomorrow's adults are to be transformed.

Our overriding concern is that there is an obligation built into services that they meet the needs of children and their families. They should be designed not for the convenience of professionals but be user-led to the greatest degree possible. Decision making should be shared and involve parents, children and clinicians so that an appropriate level of power rests with those whose lives are most affected. The necessary corollary to that is that it becomes second nature to evaluate services in terms of their long-term impact, wherever possible, given that much of mental illness is chronic and episodic (recurring) and families need help in the long term.

4.2 Risk factors for poor mental health

4.2.1 In the beginning

Over the last decade, research has established that an individual's brain structure and lifelong capabilities are influenced by the experiences and relationships of pre- and post-natal life, infancy and early childhood.[14] Early experiences that are mostly nurturing, structured and enriching increase the likelihood that a child will grow into a responsible, empathic and intelligent adult.[15] Conversely, a baby who is carried by and born to a depressed, resentful or mentally ill mother, or whose early childhood is spent in a neglectful, dysfunctional or perhaps violent family, is at risk of growing up with poor impulse control, of becoming aggressive and lacking in empathy, of being intellectually impoverished and, generally, of following a negative developmental trajectory.[16]

Research has also established that early childhood experiences affect not only brain development, mental health and behaviour, but also bodily development, growth and physical health.[17] That psychological and social wellbeing are inextricably linked with physical health, and that all forms of ill health are exacerbated by poverty, is increasingly recognised. The Audit Commission states:

'Children have a right to enjoy the best possible health, but there are significant differences in their experiences. Children under five years living in deprived areas are 8 per cent more likely to be obese; 9 per cent more likely to be of a low birth weight; and 12 per cent more likely to have an accident than those living in the rest of England. Evidence demonstrates that improving early years health contributes considerably to better health outcomes in later

14   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission*, London: Centre for Social Justice, 2008
15   Ibid
16   Ibid
17   Marmot M et al, Fair Society, *Healthy Lives: Strategic Review of Health Inequalities in England Post 2010*, The Marmot Review, London, 2010 [accessed via: http://www.marmotreview.org/AssetLibrary/pdfs/chapters per cent of per cent20fshi/FairSocietyHealthyLivesChapter2.pdf]

life, reducing levels of diabetes, coronary heart disease and hypertension, all of which have a significant impact on the NHS as well as wider society, the children and their families'.[18]

Ensuring that all infants have a positive start in life is a public health issue and is as important as focusing on physical health problems, such as infectious diseases, and chronic conditions, such as obesity. Many clinicians therefore see the integration of mental and physical healthcare as a policy priority. This is a point we return to several times throughout this report.

Dr Hilary Cass and Dr Ingrid Wolfe, from the National Collaborative for Children's Integrated Healthcare stated:

'We need to catch up with other countries, by integrating health services for children and by building strong community-based teams of children's healthcare professionals including family GP's, paediatricians, specialist children's nurses and other allied health professionals. Such integrated teams could provide the ideal balance between access and expertise, and help to raise UK children's healthcare to be among the best in the world'.[19]

New forms of service coordination are being suggested to cope with factors contributing to mental ill health and chronic disease. There is a particular focus on the perinatal (including the embryonic) period and first three years of a child and family's life. Early years interventions are likely to be effective because of the rapid and vital physical and biochemical changes taking place in young children.[20] Preventative measures may moderate individuals' biological, psychological and social vulnerabilities.[21]

4.2.2 Attachment

Human infants are born with the ability to seek out their parents or caregivers and to adapt to the relationships that are available to them. This process of attachment ensures that human infants will be cared for during their uniquely prolonged period of helplessness, and that each will adjust to the family into which he or she happens to be born.[22]

Many developmental theories contend that representations of relationships are established in infancy and then enacted in later development.[23] Shonkoff, for example, puts it like this:

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18   Audit Commission, *Giving children a healthy start,* London: Audit Commission, 2010, p4
19   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission,* London: Centre for Social Justice, 2008
20   Ibid
21   Ibid
22   Ibid
23   Bretherton I and Munholland K, 'Internal Working Models in Attachment Relationships: A construct revisited' in Cassidy J and Shaver PR, *Handbook of attachment: Theory, research, and clinical applications,* New York: Guildford Press, 1999; Crittenden PM, 'Peering into the black box: an exploratory treatise on the development of self in young children' in Cicchetti D and Toth S, 'Rochester Symposium on Developmental Psychopathology,' Vol 5, *Disorders and Dysfunctions of the Self,* Rochester, NY: University of Rochester Press, 1994; Fonagy P, *Attachment Theory and Psychoanalysis,* New York: Other Press, 2001; Stroufe LA et al, 'A prospective longitudinal study of psychological predictors of achievement', *Journal of School Psychology,* 34, 1996, pp285-306

'Human relationships, and the effects of relationships on relationships, are the building blocks of healthy development. From the moment of conception to the finality of death, intimate and caring relationships are the fundamental mediators of successful human adaptation'.[24]

Active, satisfying and reciprocal relationships with parents are the basis of an individual's sense of identity, self-esteem, appreciation of others and self-control.[25] Furthermore, the quality and content of the baby's relationship with their parents has an enduring physical effect on the neurobiological structure of his or her brain. Babies and infants, from birth to 36 months, who have been maltreated or neglected are at substantial risk of experiencing subsequent developmental problems.[26]

Infants need to feel safe and secure in the affection and emotional responsiveness of their parent or caregiver. They will panic and protest if they feel their attachment needs are not being met.[27] Traumatic experiences early in infancy establish corresponding expectations about relationships, and later traumas may activate and interact with these.[28] For example, continual conflict between parents may cause disruption to a child's attachment and undermine their sense of security.

Establishing a secure attachment requires the parent to be able to respond appropriately to the full range of the infant's states: joyful as well as painful. A distressed infant who is securely attached will turn to the parent for solace and will quickly be comforted.[29] As the infant grows up, his or her reaction to distress is to seek comfort from other people rather than through other, maladaptive strategies such as alcohol and drug use, self harm, or anti-social, promiscuous and self-destructive behaviours.[30]

In summary, secure attachment in the first few years of life is strongly associated with the capacity to have satisfying relationships in later life. It also protects against mental ill-health. By contrast, insecure attachment patterns in the early years have a role in mental disorders and are directly associated with troubled behaviours, unhappy or tormented relationships and a lack of emotional intelligence in later childhood.

> Research involving animals demonstrates clearly the ill-effects of disruption and trauma in early attachment relationships. Polan and Hofer, focusing on work with rats, note that attachment processes influence neurobiological development in ways that shape basic emotional regulation and adaptive strategies.[31] Specifically, high levels of maternal stimulation immediately after birth, including licking and grooming, lead to toned-down stress reactivity into adulthood, coupled with a proclivity toward exploration and learning. Conversely, low levels of stimulation and interaction (e.g., as associated with prolonged separations) are associated with high levels of fear, defensiveness, and avoidance, along with lower levels of exploratory activity.

24   Shonkoff J and Phillips D, *From neurons to neighbourhoods: The science of early childhood development*, Washington DC: National Academy Press, 2000
25   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission*, London: Centre for Social Justice, 2008
26   Ibid
27   Ibid
28   Sroufe LA et al, 'The development of the person: The Minnesota study of risk and adaptation from birth to adulthood', New York: The Guilford Press, 2005
29   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission*, London: Centre for Social Justice, 2008
30   Ibid
31   Polan HJ and Hofer MA, 'Psychobiological Origins of Infant Attachment and Its Role in Development' in Cassidy J and Shaver PR, *Handbook of Attachment Theory and Research*, Guildford, 2008

4.2.3 The developing brain

As we stated in our previous report from the Early Years Commission, over the last decade, the advent of new imaging techniques has helped transform our knowledge of how the brain develops and adapts.[32] The brain is at its most adaptable during the first two years after birth, at which time:

> *'[f]rom a basic biological perspective, the child's neuronal system – the structure and functioning of the developing brain – is shaped by the parent's more mature brain. This occurs within emotional communication'.*[33]

The older the child becomes, the more difficult (though not always impossible) it can be to modify the functioning of certain areas of the brain.[34] As the maturing brain becomes more specialised to assume more complex functions, it also becomes decreasingly capable of reorganising and adapting. For example, by the first year, the parts of the brain that differentiate vocal sounds are becoming specialised in the language to which the baby has been exposed; they are already starting to lose the ability to recognise important sound distinctions found in other languages.[35]

Differences in development appear very early. For example, differences in vocabulary growth between children in low socio-economic households and high socio-economic households begin to appear as early as 18 months.[36] As children grow toward school age, and enter school, the differences only get larger in the absence of intervention. Chronic neglect of very young children diminishes their 'brain power' well beyond the period when they were neglected. Put simply, if healthy brain architecture is the equivalent of a 100-watt bulb, serious neglect of children in their earliest years, can leave them with a 40-watt bulb.[37] For young children whose developing brains are incorporating experiences that are abusive or profoundly neglectful, the pruning process of brain development can cause enduring biases in the way they interpret the world around them. For example, children who were maltreated early in life interpret as angry certain facial expressions that non-maltreated children perceive as sad or frightened.[38] This may help explain the difficulties maltreated children have in establishing problem-free interpersonal relationships. Such interpretive biases can potentially last a lifetime.

4.2.4 The effect on mental health of child abuse and neglect

The main risk factor for poor mental health in any child's life and beyond the early years is neglect, especially emotional neglect; poverty and lack of education and support are

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32   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission,* London: Centre for Social Justice, 2008
33   Siegel DJ, *The Developing Mind,* New York: The Guildford Press, 1999
34   Centre for Social Justice, *The Next Generation: A policy report from the Early Years Commission,* London: Centre for Social Justice, 2008
35   Werker J and Tees R, 'Cross-language speech perception: Evidence for perceptual reorganization during the first year of life', *Infant Behavior and Development,* 7(1), 1984, pp49-63
36   Hart B and Risley T, *Meaningful differences in the every day experience of young American children,* Baltimore: Brookes Publishing Co, 1995
37   Marshall PJ and Fox NA, 'A Comparison of the Electroencephalogram between Institutionalised and Community Children in Romania', *Journal of Cognitive Neuroscience,* 16, 2004, pp1327-1338; Nelson CA and McCleery JP, 'Use of event-related potentials in the study of typical and atypical development', *Journal of the American Academy of Child and Adolescent Psychiatry,* 47(11), 2008, pp703-715
38   Pollack SD and Kistler DJ, 'Early Experience is associated with the development of categorical representations for facial expressions of emotion', *Proceedings of the National Academy of Sciences,* 99, 2002, pp9072-9076

important but only contributing factors.[39] The prevalence of depression at age 18 is almost four times greater in children of postnatally depressed mothers, who were unresponsive and emotionally unavailable to their children, than in children whose mothers were not depressed.[40] Moreover, longitudinal studies suggest that children who have been maltreated are at high risk of later psychopathology. One such study has shown that 80 per cent of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. Their problems included anxiety, depression, eating disorders and suicide attempts.[41] The effects of abuse are similar to those caused by poverty, but may be more severe.

Research has shown the importance of parents and carers respecting children's intentionality, of understanding the way they are motivated and what drives their behaviour. It is important not only to establish and consistently maintain boundaries, but also to give a degree of 'agency' to children (a sense of having responsibility for and control over their lives) that is appropriate to their age and developmental maturity.

Conversely, when children find themselves in situations where agency is absent or removed, they will react against the sense of helplessness induced and be adversely affected to an extent that can be easily underestimated. Children are exposed to a sense of powerlessness and vulnerability when they are subjected to violence, other maltreatment or simply have no control over what is happening in their lives and yet feel they should.[42] They have lower physical strength, no escape route or alternative place to live but all aspects of their survival appear to be bound up with the adults who have responsibility for them, however well or badly this responsibility is being discharged. The important point we wish to make is that adversity is not restricted to children who are subject to extremes of abuse.

The severity of adversity can lie in the accumulation of multiple stressors not just in the intensity of an isolated trauma. Risk factors (including neglect, physical abuse, sexual assault, psychological abuse, parental mental ill-health, caregiver substance abuse, low caregiver education, having a teen-aged caregiver, domestic violence, having four or more children in the home) are cumulative.[43] Although fewer than ten per cent of children with one or two risk factors show developmental delays, the proportion markedly increases with each additional risk factor: developmental delays are found in 40 per cent of children with four risk factors and in 75 per cent of children who experienced five risk factors.[44] Other conditions associated with abuse and neglect include panic disorders, ADHD, post-traumatic stress disorder and reactive attachment disorder.[45]

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39   Strathearn L et al, 'Childhood neglect and cognitive development in extremely low birth weight infants: a prospective study', *Pediatrics,* 108(1), 2001, pp142-151

40   Murray L et al, 'Maternal Postnatal Depression and the Development of Depression in Offspring Up to 16 Years of Age', *Journal of the American Academy of Child and Adolescent Psychiatry,* 50(5), 2011, pp460-470

41   Silverman AB, Reinherz HZ and Giaconia RM, 'The long-term sequalae of child and adolescent abuse: A longitudinal community study', *Child Abuse and Neglect,* 20, 1996, pp92-101

42   The effect of domestic violence on children is covered in more depth in the CSJ's forthcoming review on domestic abuse

43   Murray J, Farrington DP and Eisner MP, 'Drawing conclusions about causes from systematic reviews of risk factors', *The Cambridge Quality Checklists, Journal of Experimental Criminology,* 5(1) 2009, pp1-23

44   Barth R et al, *Developmental status and early intervention service needs of maltreated children,* Washington, DC: Department of Health and Human Services, Office of the Assistant, 2008, pp1-59

45   Teicher MH, 'Wounds that won't heal: the neurobiology of child abuse', *Cerebrum,* 2(4), 2000, pp50-62

Certain types of stressors carry particularly high risks. According to a report from the National Institute on Drug Abuse, as many as two-thirds of individuals in drug treatment programmes reported being abused as children.[46] Other studies have found that abused and neglected children are at least 25 per cent more likely to become involved in delinquency, to fall pregnant in their teenage years or to become drug users, as well as to suffer from mental health problems.[47]

Results from a recent study on the long term consequences of sexual abuse indicated that sexually abused females frequently showed deleterious outcomes across a host of biopsychosocial domains including: earlier onsets of puberty, cognitive deficits, depression, dissociative symptoms, maladaptive sexual development, asymmetrical stress responses, high rates of obesity, more major illnesses and greater healthcare utilisation, higher rates of dropping out of high school, persistent PTSD, self-mutilation, physical and sexual re-victimisation, premature deliveries, teen motherhood, drug and alcohol abuse, and domestic violence.[48] Children who have been abused are also among those at greatest risk for conduct disorders.

There is also an intergenerational cycle in which children who have suffered abuse and neglect may, in turn, become abusive or neglectful parents. Approximately one-third will find themselves recreating the only care-giving they knew and will repeat with their own children the kind of parenting they experienced.[49]

To understand the impact of maltreatment on children we have to understand the biology of stress. Stress is part of all our lives and learning how to cope with it must be a key part of preparing a child for the social world. Stress activates the hypothalamic-pituitary-adrenal axis which increases heart rate, blood pressure, serum glucose and stress hormones. In acutely threatening situations, inflammatory cytokines fuel the 'fight or flight response'. This is necessary and beneficial; cortisol, our stress hormone, is there for a reason. However, excessive or prolonged activation of stress response systems can lead to long-term disruptions in brain architecture, immune status, metabolic systems and cardiovascular function.[50]

When a young child experiences stress, an environment of supportive relationships with adults helps to buffer these physiological effects and bring them back down to baseline. The result is a healthy stress response system and the all-important development of resilience. For larger stressors — such as the death or serious illness of a loved one, a frightening injury, the divorce of one's parents or a natural disaster — these physiological responses

46   Swan N, 'Exploring the Role of Child Abuse in Later Drug Abuse', *NIDA Notes*, 13(2), 1998
47   Kelley BT, Thornberry TP and Smith CA, *In the wake of childhood maltreatment*, Washington DC: National Institute of Justice, 1997
48   Trickett P, Noll JG and Putnam FW, 'The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study', *Development and Psychopathology*, 23, 2011, pp435-476
49   Berlin L, Appleyard K and Dodge K, 'Intergenerational Continuity in Child Maltreatment: Mediating Mechanisms and Implications for Prevention', *Child Development* in Stith S et al, 'Risk factors in child maltreatment: A meta-analytic review of the literature', *Aggression and Violent Behaviour*, 14, 2009, pp13-29
50   Gunnar MR, *Early Experience, Toxic Stress and Neurobehavioral Development*, College of Education and Human Development, University of Minnesota [accessed via: www.cehd.umn.edu/fsos/ambit/.../Gunnar%20Presentation.pptx]

are sustained for a longer period of time. The buffering of supportive adult relationships can, however, allow the child's brain to recover from what might otherwise be damaging effects.[51]

It is when situations of extreme stress are prolonged and unrelenting, in the absence of supportive adults, that a child is affected by toxic levels of stress. These situations can include extreme poverty, physical or emotional abuse, chronic neglect, severe maternal depression, substance abuse and family violence.[52] Our inquiries for this report have found time and again that these adversities all too often occur together. Without the support of a caring network of adults, toxic stress can disrupt brain architecture and lead to stress management systems that respond at relatively lower thresholds, thereby increasing the risk of stress-related mental and physical illness.[53]

4.2.5 Adverse childhood experiences and later life

In other areas, the consequences of early risk factors for adult mental disorder are also cumulative and substantial. Another way of describing this is in terms of growing up experiencing any of the following adverse childhood experiences, in the household prior to age 18:

- Recurrent physical abuse;
- Recurrent emotional abuse;
- Contact sexual abuse;
- An alcohol and/or drug abuser in the household;
- A household member who is in prison;
- Living with someone who is chronically depressed, mentally ill or suicidal;
- Mother is treated violently;
- One or no parents; and
- Emotional or physical neglect.[54]

Researchers have found, for example, the rate of alcoholism amongst those who had four adverse childhood experiences is five times the rate in the normal population (three per cent).[55] Similar figures have been reported for illicit drug use.[56] The likelihood of heart disease is increased three-fold by multiple early adversities.[57]

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51 Masten A, Best K and Garmezy N, 'Resilience and development: Contributions from the study of children who overcome adversity', *Development and Psychopathology,* 2, 1990, pp425-444

52 Ibid

53 Gunnar MR, Fisher PA and The Early Experience, Stress and Prevention Network, 'Bringing basic research on early experience and stress neurobiology to bear on preventive interventions for neglected and maltreated children', *Development and Psychopathology,* 18, 2006, pp651-677

54 Dube SR et al, 'Adverse childhood experiences and personal alcohol abuse as an adult', *Addictive behaviours,* 27(5), 2002, pp713-725

55 Ibid

56 Dube SR et al , 'Long-Term Consequences of Childhood Sexual Abuse by Gender of Victim', *American Journal of Preventive Medicine,* 28(5), 2005, pp430-438

57 Dong M et al, 'Insights into causal pathways for ischemic heart disease: Adverse Childhood Experiences Study', *Circulation,* 110, 2004, pp1761-1766

Mental health problems can also co-exist with developmental disorders

People with disorders such as autism, ADHD, and Asperger's Syndrome are three times more likely to suffer mental health problems than their peers, largely because of the social isolation and misunderstanding they typically encounter.[58] There is currently a lack of accurate information on the aetiology of these disorders. This makes treating them – and preventing associated mental health problems – particularly difficult. For example, over the past 60 years, public and scientific opinion on the aetiology of autism has shifted between two extreme positions. One position holds that autism is caused by some specific genetic abnormality. This has generated a search for an 'autism gene'. The other position holds that autism is the result of some specific environmental factor or condition, including a 'lack of maternal warmth'. Although the cause has remained elusive, the evidence strongly counters both of these extreme positions.[59] Lane Strathearn, a neuroscientist from Texas's Baylor College of Medicine, has commented:

'Over the past decade, we have witnessed remarkable scientific advancements in our ability to explore the origins and manifestations of autism…Yet [we]…have failed to uncover a core psychobiological deficit for autism. Without such an understanding, treatment options are limited to various combinations of child directed therapy, with minimal data supporting effectiveness. With the dramatic rise in the number of children diagnosed with autism comes an escalating burden for schools, governments and society to provide intensive and costly services. Clearly, understanding the aetiology of autism is of paramount importance'.[60]

Again, it is important to reiterate that adversity in later childhood can also lead to poor mental health. This is true of physical as well as emotional adversity. In 2007, the ONS conducted a follow up study of children and young people who had no mental health problems in 2004. It found that those who had experienced a serious or chronic illness in the intervening years were twice as likely to develop emotional disorders.[61] This does not discount the importance of the early years in building resilience to adversity; rather, it highlights the need to take into account the effects of experiences later in the life course.

Identifying signs of abuse and neglect

Although few children growing up under conditions of chronic maltreatment or neglect show overall resilience in life adaptation, there is a great deal of variability in developmental outcomes.[62] This makes training in early recognition and timely intervention difficult. It is often the case that disturbances are only recognised with reference to normative behaviour; where normative behaviour varies widely, disturbances are hard to detect.

58   Green et al, *Mental health of children and young people in Great Britain,* London: Office for National Statistics, 2004

59   Bethea TC and Sikich L, 'Early Pharmacological Treatment of Autism: A Rationale for Developmental Treatment', *Biological Psychiatry,* 61(4), 2007, pp521-537

60   Strathearn L, 'The Elusive Etiology of Autism: Nature and Nurture?', *Frontiers in Behavioral Neuroscience,* 3(11), 2009, pp1-3

61   Office for National Statistics, *Three years on: Survey of the development and emotional well-being of children and young people,* London: Office for National Statistics, 2008, pp1-162

62   Haskett ME and Willougby M, 'Paths to child social adjustment: parenting quality and children's processing of social information', *Child: care, health and development,* 33(1), 2006, pp67-77

For example, most maltreated children have disturbed relationships with their peers, but the degree of withdrawal from or aggression towards other children that merits serious concern varies according to the child's age and stage. Friendships are still in the future for many three year olds, so lack of friendships at this age may not be cause for concern. Friends are central to the lives of normally functioning seven year olds, however, so friendlessness at this stage greatly matters.[63]

4.2.6 The effect of family breakdown on mental health

Children from 'broken homes' are twice as likely as those from 'intact' families to have behavioural problems.[64] They tend to become sexually active at a younger age, are more liable to suffer depression, to turn to drugs, smoking and heavy drinking, and to perform worse at school.[65] Children living in households where there are high levels of inter-parental conflict and hostility are also at risk for low academic attainment.[66] Harold et al found that the way children rationalise their parents' arguments, and specifically their tendency to blame themselves, is an important means by which inter-parental conflict adversely affects children's long-term academic attainment.[67] Children's aggressive behaviour can also be products of parental discord; both negative parenting (e.g. lack of encouragement and a harsh, authoritarian style) and children's appraisals of self-blame for parents' marital arguments have been linked to heightened behaviour problems.[68] Moreover, children who behave in a hostile and aggressive manner tend to underachieve academically.[69]

Dr Samantha Callan meeting staff and clients from Family Action who gave evidence to the Review

63   Thompson RA, 'Early attachment and later development: Familiar questions, new answers' In: Cassidy J and Shaver PR (eds.), *Handbook of Attachment Theory and Research* (2nd ed), New York: Guilford Publications, 2008

64   Meltzer H et al, *Mental Health of Children and Adolescents in Great Britain*, Norwich: The Stationery Office, 2000

65   Rodgers, B and Pryor J, 'Divorce and Separation: The Outcomes for Children', York: Joseph Rowntree Foundation, 1998

66   Harold GT, Aitken JJ and Shelton KH, 'Inter-parental conflict and children's academic attainment: a longitudinal analysis', *Journal of Child Psychology and Psychiatry*, 48(12), 2007, pp1223-1232

67   Ibid

68   Erel O and Burman B, 'Interrelatedness of marital relations and parent child-relations: A meta-analytical Review', *Psychological Bulletin*, 118(1), 1995, pp108-132; Grych JH et al, 'A prospective investigation of appraisals as mediators of the link between interparetnal conflict and child adjustment', *Child Development*, 74, 2003, pp1176-1193

69   Belsky J and Mckinnon C, 'Transition to school: Development trajectories and school experiences', *Early Education and Development*, 5, 1994, pp106-119; Hinshaw S P, 'Externalising behaviour problems and academic underachievement in childhood and adolescence: Causal relationships and underlying mechanisms', *Psychological Bulletin*, 111, 1992, pp127-155

Disrupted early family relationships are also a common precursor to addictions. Often, an intergenerational pattern comes into play: similar behavioural problems in a parent – a serious gambling,[70] drug or alcohol addiction for example – may have destroyed the quality of life for the other parent and children, and led to the breakdown of the family.[71] For example, because of the highly disruptive nature of their addiction, many gamblers steal from, and as a result lose contact with, their families, thus putting their children at greater risk.

Children who had a good start in life can be significantly affected by seeing their parents part. Lewis et al found that 89 per cent of young adults who were securely attached as babies showed insecure attachment if their parents parted. They concluded that, 'Secure attachment at one year does not buffer children from developing insecure attachments at 18 years if they are from divorced families'.[72]

Furthermore, the adverse effects of family breakdown are not confined to children: fathers may suffer without opportunities to look after their children; women may struggle to parent more or less alone; extended families are often drawn into the effects of conflict; and society may bear a heavy financial burden due to families becoming dependent on welfare.

4.2.7 Adolescence

One in five adolescents has significant mental health problems.[73] This figure varies by only one or two percent in association with geographical location, sampling methods and methods of defining cases.[74] Many of the most severe mental disorders (schizophrenia, severe depression, eating disorders and conduct problems) have a natural history that suggests a specific role for the onset of puberty.[75] There are some disorders that appear to have a particularly high prevalence in adolescence, such as self-harm. Although there are marked variations between rates in different countries across Europe, this is considered to be the most concerning adolescent problem.[76]

Adolescence is a period of increased vulnerability for every young person, even without experiences of overt maltreatment or of family breakdown, and the risks are far more acute

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70   Pathological addiction to gambling is increasingly recognised as a mental disorder, for example it will be in DSMV, the forthcoming *Diagnostic and Statistical Manual for Mental Disorders*.

71   Hagemann-White C et al, *Feasibility study to assess the possibilities, opportunities and needs to standardize national legislation on gender violence and violence against children*, Luxembourg: Publications Office of the European Union, 2010

72   Lewis M, Feiring C and Rosenthal S, 'Attachment over time', *Child Development*, 71(3), 2000, p713

73   British Medical Association, *Child and adolescent mental health: a guide for healthcare professionals*, London: British Medical Association, 2006, p9

74   Sawyer MG et al, 'The mental health of young people in Australia, Canberra', Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged and Care, 2000; Meltzer H, 'The Mental Health of Young People Looked After by Local Authorities in England', Report of a survey carried out in 2002 by the Survey Division of the Office for National Statistics on behalf of the Department of Health, Norwich: The Stationery Office, 2000; Frigerio A et al, 'Prevalence and correlates of mental disorders among adolescents in Italy: the PrISMA study', *European child and adolescent psychiatry*, 18, 2009, pp217-26

75   Moffit TE and Caspi A, 'Life-course persistent and adolescence limited antisocial males: longitudinal follow up to adulthood', in Stoff DM and Susman EJ (eds.), *Developmental Psychology of Aggression*, Cambridge: Cambridge University Press, 2005

76   Skegg K, 'Self-harm', *The Lancet*, 366, 2005, p1471

for those whose early relationships were not secure. As children grow older, disadvantages that were not overcome earlier tend to have accumulated and to be more pronounced in their effect.

The risk for mental disorder during adolescence arises due to vulnerability to problems involving the regulation of both affect and behaviour during this period. In early adolescence puberty heightens emotional arousability, sensation-seeking and reward orientation. The frontal lobes, which enable individuals to control their behaviour, do not mature until late adolescence. This makes middle adolescence a period of heightened vulnerability to risk-taking and problems in regulation of affect and behaviour.

Typical behavioural changes placing adolescents at risk include, unsurprisingly, their increased risk-taking behaviour, novelty seeking and increased prioritisation of social relationships. The vulnerability to substance abuse may be linked to decreased sensitivity to hangover sedation and motor impairment. Depression may entail hormonally mediated limbic effects that precede the maturation of a cognitive regulatory system. The increased incidence for the onset of depression correlates strongly with the mismatch between the development of the limbic system and the prefrontal cortex although vulnerability to depression remains evident throughout adulthood beyond the time at which prefrontal cortical maturation is complete.

'The developments of early adolescence may well create a situation where one is starting an engine without yet having a skilled driver at the wheel.'[77]

In summary, a growing body of research identifies puberty as the beginning of a life-stage characterised by heightened emotional arousal, sensation seeking, and reward orientation, and mid-adolescence as a period of increased vulnerability to risk taking and problems in behaviour, including drug and alcohol abuse and problem gambling and sometimes to mental illness.[78] As we said earlier, there is very high comorbidity between addictions and mental health problems. Arsenault et al conclude that cannabis use appears to be a component cause and part of a complex constellation of factors leading to psychosis (but not sufficient or necessary to do so in isolation) and cases of psychotic disorder could be prevented by discouraging cannabis use among vulnerable youths.[79]

4.3 Key principles for mental health policy solutions for children and young people

While all of the key principles we laid down at the beginning of this report are highly relevant to this age range, there are three in particular that need restating as they have guided us most powerfully in making our recommendations. They are summarised and then expanded below.

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77   Steinberg L, 'Cognitive and affective development in adolescence', *Trends in Cognitive Sciences*, 9, 2005, pp69-74
78   Ipsos MORI, *British Survey of Children, the National Lottery and Gambling 2008-09*, London: Ipsos MORI, 2009
79   Arseneault L et al, 'Causal association between cannabis and psychosis: examination of the evidence', *The British Journal of Psychiatry*, 184, 2004, pp110-117

- **The importance of services being joined up, integrated and co-located with other aspects of the lives of children and families:** this means they will take the whole family into account, provide continuity of care and be less fixated on boundaries of age (thus dealing better with transitions from adolescence to adulthood) and profession (i.e., creating joint solutions to replace silo working and the passing around of children and families from one service to another).
- **The need for early intervention policy** given the role that the early years of a child's life plays in the aetiology of mental illness and given our growing ability to identify those children and young people whose early symptoms, when combined with risk factors described above, are likely to lead to poor outcomes.
- **The public health perspective,** which prioritises the importance of building social capital through relationships and the development of supportive *communities*, for example in and through schools and children's centres.

4.3.1 The importance of services being integrated with children and families' lives

There is widespread concern about children in our society and the many plans and policies proposed to improve their wellbeing. We describe below the remarkable unanimity of the findings and recommendations of the various reviews published in the last ten years, and especially among those published shortly before and since the current Government took office. For example, all of these reports stress the need for the integration of services and for a commitment to working across professional boundaries to ensure that all children get services and support tailored to their needs.

Lord Laming stated in 2009 that 'much more needs to be done to ensure that the services are as effective as possible at working together to achieve positive outcomes for children'.[80] There is broad consensus that the most effective means for delivering the early intervention described later is a *multi-agency systems approach*. Frank Field MP says, 'Early years services for children and parents must be more effectively integrated and coordinated'.[81] Dame Claire Tickell advises that 'Only through professionals working together in this collaborative way can the full benefits of early intervention be achieved'.[82]

We were advised while conducting this Review that 'connectivity' was often the vital missing factor across a number of different dimensions considered below.

4.3.1.1 Across the age range
At a roundtable for CAMHS professionals hosted for the Review by the NHS Confederation Mental Health Network, the point was repeatedly made that "Working with the neediest families often means 'over the long haul' – achieving positive outcomes will take longer". We know which expectant parents are likely to need support during and shortly after pregnancy and of the importance of health visitors during this period. Infant mental health services identify where parents are struggling to bond with or nurture their babies. Early years services

80   Department for Education, *The Protection of Children in England: A Progress Report*, Norwich: The Stationery Office, 2009, pp1-98
81   Field F, *The Foundation Years: preventing poor children from becoming poor adults*, Norwich: The Stationery Office, 2010, p7
82   Tickell C, *The Early Years Foundations for life, health and learning*, Norwich: The Stationery Office, 2011, p25

have a role to play in working with parents to build children's emotional security and helping them achieve their developmental potential. Parents and children may need ongoing support throughout primary and secondary school. To prevent or minimise the risk of problems flaring up again, some contact with services may need to be maintained even when things are going well for the family. Such continuity is currently very rare.

Just at the point when many parents begin to see a lessening of dependency, those whose children have mental health or learning disabilities find that they have reached a cut-off point for children and adolescent services. Statements for children with special needs end when they reach 19. Adult services, however, may offer something very different – or nothing. These parents and their children therefore suffer from a lack of vital support.

The Review was continually told about the need for transition services at the age of 18. It is in many ways an artificial cut off point which does not correspond to either physiological changes or alterations in brain function, and can be very challenging for many of our most vulnerable young people (e.g. care leavers).[83] Age limits defining the transition from child to adult services should always be flexible, with bridging services available where possible.

We visited a special school in the South West of England and talked at length with many of the professionals based there as well as those working with the school from outside agencies. They drew our attention to the paucity of support (like daytime activities and other services) available to parents and carers of autistic children once they reach the cliff edge of age limits. Parents' employment opportunities can suddenly become extremely curtailed and the quality of life for autistic young adults (and their ability to become less dependent through work or other activities that give them some independence) can deteriorate considerably.

Children who have needs grow into adults who have needs, but society tends to be more mindful of the former. In its welfare reform agenda this Government has committed itself to supporting people who would otherwise be wholly dependent on benefits to enable them, wherever possible, to lead productive and fulfilling lives. **We recommend that central government gives a strong lead by setting outcomes for local commissioners to deliver against so that they find the best ways of supporting families and autistic young people make key transitions to adulthood in their area.**

One Consultant Clinical Psychologist told us: 'I run a clinic for severely self-harming girls and there is little to pass them onto in the adult sector once they reach 18, so I am currently seeking to set up a 18-24 transition service through a collaboration with adult services. Other services could benefit from a similar approach'.[84]

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83   Raznahan AB et al, 'How does your cortex grow?' *Journal of Neuroscience*, 31(19), 2011, pp7174-7177
84   Roundtable with CAMHS professionals hosted by NHS Confederation Mental Health Network, 3 September 2011

4.3.1.2 Across traditional service divides

Better managed transitions will therefore require better interagency working so that, for example, care pathways for young people can be developed into adult services – as for ADHD and substance abuse.[85] This challenges the tendency to work in 'silos' by requiring professionals to work across the usual boundaries. It will also require the development of imaginative protocols around the issues of confidentiality and consent.

Sometimes interagency working will be best achieved through co-location or by embedding mental health professionals into other settings, such as mainstream schools, the youth justice system and physical health settings. A nurse consultant told us that rather than criticising CAMHS, he preferred to say where he had seen it work best:

> 'If CAMHS professionals only provide a clinic for intensive, longer term therapeutic work and do not do this in conjunction with being well integrated with other agencies, there can be problems. However, where there are joint posts with other areas (such as education and youth offending) and where CAMHS is embedded in referral and assessment and involved very early on, this works better. Collaborative joint working earlier on leads to shared understanding among professionals as to the nature of the problems families face. It also means that families are not passed around between agencies but they work together towards a joint solution'.[86]

Finally, a recognition of and expertise in mental health issues in universal health services provides key opportunities to join up mental and physical health, given that they are so widely used. The same nurse consultant suggested that, for example, screening for emerging mental health problems could take place by nurse practitioners given that as many as 95 per cent of mothers take children for inoculations.

4.3.1.3 Across families

On many occasions, the Review was told that mental services urgently need to be based on a family-centred approach, not divided up between children and adolescents and adults. This is because the mental health of other members of the family is affected by one person's disorder. We were told, for example, that 'children are coping with adult personality disorders', and the adverse impact of parental mental health has been well-documented.[87, 88] Helping families with mental health needs in the context of their everyday lives and in their homes should also be a priority.

> 84 per cent of people polled thought it was fairly or very important to try and treat children with mental health difficulties at home where possible, rather than in hospitals.[89]

85 Roundtable with CAMHS professionals hosted by NHS Confederation Mental Health Network, 3 September 2011
86 Ibid
87 Ibid
88 Allen G and Smith ID, *Early Intervention: good parents, great kids, better citizens,* London: Centre for Social Justice and the Smith Institute, 2008, pp1-134
89 CSJ/YouGov polling of 2,084 British adults, September 2011

Hospitalisation of individuals will become even rarer when appropriate community-based responses are available. This may require involving more voluntary sector organisations in care pathways, which in turn will require the proper allocation of financial resources through commissioning. Later in this chapter we describe some of the key features of a family-centred mental health service.

4.3.2 The need for early intervention policy

Looking again at relevant recent policy reviews concerning children's wellbeing, there has been a welcome emphasis on the issue of prevention through early intervention. Examples include the CSJ's 2008 reports from the Early Years Commission, *Breakthrough Britain: the Next Generation*; *Early Intervention: Good Parents, Great Kids, Better Citizens*, a pamphlet jointly authored by the CSJ's then-Chairman Iain Duncan Smith MP and the Labour MP Graham Allen; and Action for Children's 2009 publication *Backing the Future: why investing in children is good for us all*.

During the past 18 months, there has been a steady stream of reports and studies taking up the theme of early intervention across a whole range of social problems, with mental health always high on the list of priorities.[90] These reports are usefully distilled in the CSJ's recent paper, *Making Sense of Early Intervention*.[91]

The Government has recently responded with its own plans for further reform, laying out 'how all those who work with young children and their families can work most effectively to give them the support they need at the earliest opportunity'.[92] As well as establishing its own early intervention intentions, the Government makes it clear in these published plans that children's mental health will be a priority.

An awareness of child development is an essential component of an early intervention approach. We have written elsewhere about how important it is that all adults involved with children, from family court judges to parents, know about how the infant brain develops and about the paramount importance of communication, relationships and nurture from the outset.[93] We welcome the Government's endorsement of a new programme of couple-focused antenatal support called Preparation for *Birth and Beyond*, which will help parents to understand child development in pregnancy and the first months of life, and the calls from Andrea Leadsom MP for basic neuroscience to be taught in schools.

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90   Government-sponsored reports include: Marmot M, *Fair Society, Healthy Lives: Strategic Review of health in equalities in England post-2010*, London: The Marmot Review, 2010, pp1-242; C4EO, *Grasping the Nettle: early intervention for children, families and communities*, London: C4EO, 2010; WAVE Trust, *International experience of early intervention for children, young people and their families*, Croydon: WAVE Trust, 2010, pp1-129; Field F, *The Foundation Years: preventing poor children from becoming poor adults*, Norwich: The Stationery Office, 2010; Allen G, *Early Intervention: The Next Steps*, London: Cabinet Office, 2011; The Scottish Parliament, *Finance Committee Report on preventative spending*, Edinburgh: The Scottish Government, 2011; Deacon S, *Joining the dots: A better start for Scotland's children*, Edinburgh: The Scottish Government, 2011; Tickell C, *The Early Years Foundations for life, health and learning*, Norwich: The Stationery Office, 2011; Allen G, *Early Intervention: Smart Investment, Massive Savings*, London: Cabinet Office, 2011
91   Centre for Social Justice, *Making Sense of Early Intervention: a framework for professionals*, London: Centre for Social Justice, 2011
92   Department for Education, *Supporting families in the foundation years*, London: Department for Education, 2011
93   Centre for Social Justice, *The Next Generation, A report from the Early Years Commission*, London: Centre for Social Justice, 2008

During the course of the Review we heard that one of the most successful areas of mental health policy over the last decade has been Early Intervention in Psychosis (EIP).[94] Resources were specifically directed towards adolescents showing symptoms of schizophrenia, enabling community mental health teams to provide far better support to patients and families (whereas previously psychosis services were only available in adult services). When she gave evidence to the Review the new President of the Royal College of Psychiatrists, Professor Sue Bailey told us that 'we have to see adolescent mental health services as prevention of adult issues'.

4.3.3 The public health perspective

This requires an awareness of the factors that promote emotional wellbeing and protect against the onset of (as well as help children recover from) emotional and behavioural disorders. Given what we know about the roots of mental illness, ensuring that preventative services are in place is essential if we are to provide a fence at the top of the cliff rather than an ambulance at the bottom. These services must be available during pregnancy, the early years, childhood and adolescence.

'Social capital' factors, such as networks of family and friends, participation in clubs and groups, and perceived safety in the neighbourhood, have been strongly linked with emotional wellbeing.[95] These point to the importance of strong communities, whether the communities are where children and families live or where they spend a lot of time (for example, in schools). Also to be considered are the quality and quantity of children and young people's access to the natural environment, the need for a built environment which is conducive to mental wellbeing (that goes beyond safety), and the impact of the media, in all its forms, on children's health. We welcome the final report from the recent Bailey Review on the Commercialisation of Childhood, which calls on businesses, broadcasters, advertisers and regulators to take a joined up approach to addressing parents' concerns about a 'sexualised culture' surrounding children.[96]

4.4 The need to transform children's mental health

As stated earlier, our aim has been to make policy recommendations that draw on these three key and interrelated principles. In this section, we look at important points across the age range where we think interventions can be improved to meet different levels of need and complexity. The necessary interventions require public health approaches as well as services for our most distressed children and families.

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94 For example, when the Review took evidence from a wide group of different professionals from Sussex Partnership NHS Foundation Trust in Hove, August 2011
95 Office for National Statistics, *Three years on: Survey of the development and emotional wellbeing of children and young people*, London: Office for National Statistics, 2008,
96 Bailey R, *Letting Children be Children – Report of an Independent Review of the Commercialisation and Sexualisation of Childhood*, London: Department for Education, 2011, pp1-104

4.4.1 The perinatal period – just before and shortly after birth

4.4.1.1 Premature babies

As described in the CSJ's previous report on the early years, a range of research has demonstrated the importance of relational experiences and of the quality of infant–carer interaction for the future mental health of premature babies.[97, 98] Although it has long been assumed that premature babies do not need human interaction, these studies established that contact through appropriate levels of touch has specific benefits of for these babies:

- Babies experiencing appropriate (e.g. very gentle) touch were less fussy, cried less, had lower stress levels, were more easily soothed, and were calmer with better muscle tone and less agitated movements;
- Mothers who were able to hold their babies, rather than leaving them in the incubator, were less depressed and were more able to respond to their babies during the hospitalisation period;
- Parents who held their babies, rather than leaving them in the incubator, were more sensitive, adaptive, warm and resourceful during social interactions at six months;
- Infants who had received physical holding were more socially alert than the incubator premature babies and their Bayley developmental scores at six months were higher in the cognitive and motor domains; and
- Early maternal touch had an impact on psychomotor skills six months later.[99]

Unfortunately, the resources for premature and ill newborn babies and their parents are scarce; for instance there are insufficient trained staff to provide the one-to-one care the DH say is needed for babies in intensive neonatal care.[100] For example, in order to facilitate bonding and, eventually, a secure attachment, babies in Special Care Baby Units (SCBUs) require as much contact with their parents as their physical condition allows.[101]

However, although DH guidance recommends that parents of babies in SCBUs be provided with nearby accommodation, one survey found that 60 per cent of such parents currently do not have access to the necessary facilities.[102] The report estimated that a further 250 rooms are needed. The scarcity of such resources is recognised by the Health Minister for maternity services, Anne Milton MP. She admits that that there are big challenges to overcome, but states that the Government is 'determined that people and their babies get the high-quality, safe neonatal services they need'.[103]

97 Centre for Social Justice, *The Next Generation, A report from the Early Years Commission,* London: Centre for Social Justice, 2008

98 Vickers A et al ,'Massage for promoting growth and development of preterm and/or low birth-weight infants', *Cochrane Database of Systematic Reviews*, 2, 2000; Feijo L et al, 'Mothers' depressed mood and anxiety levels are reduced after massaging their preterm infants', *Infant Behavior and Development*, 29, 2006, pp476-80; Feldman R et al, 'Comparison of skin-to-skin (kangaroo) and traditional care: parenting outcomes and preterm infant development', 110, 2002, pp16-26

99 Bayley Developmental Scales measure the mental and motor development and test the behaviour of infants from one to forty-two months of age. The Scales may be used to describe the current developmental functioning of infants and to assist in diagnosis and treatment planning for infants with developmental delays or disabilities

100 Department of Health, *Toolkit for High Quality Neonatal Services,* London: Department of Health, 2009

101 Centre for Social Justice, *The Next Generation, A report from the Early Years Commission,* London: Centre for Social Justice, 2008

102 Department of Health, *Toolkit for High Quality Neonatal Services,* London: Department of Health, 2009

103 BBC News, 'Special baby care 'still failing' 2 November 2010 [accessed via: http://www.bbc.co.uk/news/health-11664666]

Any meaningful public health approach to mental health must not neglect particularly vulnerable groups. This is not least because, as DH guidance states, the 'impact of social deprivation is felt in many neonatal units. Teenage mothers and mothers who have significant mental or physical health problems are at higher risk for premature delivery, low birth weight and infant mortality'.[104]

Given premature babies' elevated risk of mental (and physical) disorder in later life, **we recommend commissioners ensure that provision for these babies (and their parents) is commensurate with the need, and take advantage of the opportunity to prevent the subsequent development of health problems**.

4.4.1.2 Maternal mental health

Mothers' mental health before conception, during pregnancy and after birth has an important bearing on infants' mental and physical health and development.[105] A mother's stress-level during pregnancy is likely to impact on the development of the nervous system of the foetus; the higher the stress the greater the likelihood of affect dysregulation in the child.[106]

Currently, there are no services to protect pregnant women from psychosocial stress. Figures from the North East London NHS Foundation Trust showed that in pregnant mothers the prevalence of mixed anxiety and depression, obsessive compulsive disorder and panic disorder was 20 per cent. It was also reported that in 0.2 per cent of deliveries mothers may require inpatient treatment for psychotic disorders; 0.2 per cent may need admission for treatment of non-psychotic depression; and 0.2 per cent of deliveries are to schizophrenic women requiring the help of a specialist perinatal mental health service.[107] In addition, significant numbers of women have mental health problems during the postnatal period. For example, it has been estimated that around ten per cent of women experience depression at eight weeks postnatal.[108] This rises to 22 per cent at 12 months.[109] During the first six postnatal weeks, around 15 per cent of women experience anxiety disorders, and between three per cent and six per cent develop post-traumatic stress disorder.[110, 111]

The last three National Confidential Enquiries into Maternal Deaths have all recommended that priority be given to maternal mental health.[112] This has been echoed by successive serious case reviews relating to child abuse and neglect.[113] Similar recommendations are embedded

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104   Department of Health, *Toolkit for High Quality Neonatal Services,* London: Department of Health, 2009

105   Centre for Social Justice, *The Next Generation, A report from the Early Years Commission,* London: Centre for Social Justice, 2008

106   Bergman K et al, 'In utero cortisol and testosterone exposure and fear reactivity in infancy', *Hormonal Behaviour*, 57(3), 2010, pp306-312; Bergman K et al, 'Maternal prenatal cortisol and infant cognitive development: moderation by infant-mother attachment', *Biological Psychiatry*, 67(11), 2010, pp1026-1032; Glover V, O'Connor TG and O'Donnell K, 'Prenatal stress and the programming of the HPA axis, *Neuroscience and Biobehavioural Review*, 35(1), 2010, pp17-22

107   Evidence submitted to the Mental Health Review from North East London NHS Foundation Trust

108   Evan J, Heron J and Francomb H, 'Cohort study of depressed mood during pregnancy and after childbirth', *British Medical Journal,* 323, 2001, pp257-260

109   Gavin NI et al, 'Perinatal depression: a systematic review of prevalence and incidence', *Obstetrics and Gynaecology,* 106, 2005, pp1071-1083

110   Heron J et al, 'Course of anxiety and depression through pregnancy and the puerperium in a community sample', *Journal of Affective Disorders*, 80, 2004, pp65-73

111   Olde E et al, 'Posttraumatic stress following childbirth: a review', *Clinical Psychology Review,* 26, 2006, pp1-16

112   Lewis G, 'Saving mothers' lives: reviewing maternal deaths to make motherhood safer – 2003 2005', The seventh report of the Confidential Enquiries into Maternal Deaths in the United Kingdom, London: *CEMACH* December, 266, 2007

113   Ofsted, *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*, London: Ofsted, 2008, pp1-49

in NICE guidelines, in National Service Frameworks for mental health and for children, young people and maternity services, and in major policy documents.[114]

In the light of all these recommendations, **we recommend that maternal mental health, including the mental health of pregnant women, be recognised as a priority, on a par with maternal physical health, and that health professionals be better trained to identify symptoms of depression**. This will require every single one of the Government's promised 4,200 extra health visitors and commissioners need to address current shortfalls in midwife numbers in many parts of the country.

Health and wellbeing boards have an important role to play in ensuring that adequate resources are provided by local commissioners of services, and in recognising the strong role to be played by the voluntary sector and harnessing the potential of the wider community to provide social support through the facilitation of local community programmes. Organisations like Family Action and Homestart can make a significant difference and, for example, local Community Mothers and Fathers initiatives are a vital resource to health visitors.[115] These and other similar organisations can act as a bridge to statutory services, for example by helping mothers with severe mental disorders to access psychiatric care.

4.4.1.3 Infant mental health

The mental health of infants receives even less attention than does that of their mothers. This is not least because many people find the idea of a new baby with mental health problems inconceivable. No more than 60 years ago sick babies requiring surgery were frequently operated on without anaesthetic (curare was used to immobilise them), such was the collective resistance to conceiving of infants as self-aware human beings. 'It is often painful and difficult', writes psychiatrist Robert Emde, 'to recognise and address mental health problems in infants [whether these arise from] pain and distress from trauma; abuse or loss of a caregiver; misery from neglect; suffering from cumulative stress; [or] suffering from lack of opportunity'.[116]

The field known as 'infant mental health' is somewhat inadequately named: in fact, the field focuses its interventions on the dynamics of parent–infant relationships. It is well established in America and continental Europe. In the UK, however, it has only recently gained wide recognition. The goal of infant mental health services is to ensure optimal child outcomes in terms of a sense of security; self-esteem; the ability to form satisfying relationships, engage with the world, learn, cope and solve problems; and continuing positive development throughout life. To achieve these outcomes, infant mental health services strive to promote stable and supportive families and communities.

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114 Department for Education and Skills, *Every Child Matters: change for children*, Norwich: The Stationery Office, 2004; Department for Education and Skills, Children's Workforce Strategy, Nottingham: Department for Education and Skills, 2005, Department of Health/ Partnerships for Children, Families and Maternity, *Maternity Matters: choice, access and continuity of care in a safe service,* London: Central Office of Information, 2007; Social Exclusion Unit, *Mental Health and Social Exclusion, Social Exclusion Unit Report 2004,* London: Office of the Deputy Prime Minister, 2004

115 Innovation Unit and NESTA, *Transforming Early Years – radical efficiency in practice: Community-owned services – Parents 1st and One Plus One,* London: Innovation Unit, 2001, pp13-15 [accessed via: http://innovationunit.org/sites/default/files/TEY%20interim%20case%20studies_0.pdf]

116 Emde RN, 'Infant mental health challenges for Early Head Start: Understanding context and overcoming avoidance', *Zero to Three,* 22(1), 2001, pp21-24

The main reasons for referral to infant mental health clinics are regulatory disturbances such as excessive crying, feeding or sleeping problems, as well as bonding and attachment problems.[117] Recent research has shown that many such infant problems are closely linked with the infant-caregiver relationship.[118] They are also associated with adverse effects on the child's later development. This underlines the importance of supporting the mental health of mothers and their infants during the postnatal period. One key finding from 24 reviews about what works to support parents, parenting and the parent-infant relationship was the need for specialist perinatal mental health services within every mental health trust.[119] These services employ specialist practitioners who have the necessary training and skills to deliver evidence-based, dyadic (parent-and-child-focused) interventions such as Video Interaction Guidance and Watch, Wait and Wonder.[120]

The Review had extensive contact with three different but highly effective services offering parent-infant psychotherapy. One is based in mainstream health services, while the other two are more community-based. The latter services work with children's centres and other agencies and are staffed partly by highly trained volunteers.

North East London NHS Foundation Trust's specialist perinatal parent–infant mental health service is hospital based, covering three maternity units with around 15,000 live births per year. This service is for highly vulnerable parents with pronounced, unmet emotional needs and their babies, who are, as a result considered to be at risk of developing mental (or physical) health problems.

The Secure Start team, visited by members of the Review, provides an infant mental health service to Children's Centres and other early-years settings in Cheltenham, Gloucester and the Forest of Dean. Having both a rural and urban 'catchment area' requires outreach and home visits. Without such services, the geographical inaccessibility of mental health services is an almost insurmountable barrier. We were told that 'for mothers with older children needing help, CAMHS is four bus-rides away.'

Oxford Parent Infant Project (OxPIP) is based at a Children's Centre in North Oxford where it provides therapy to young families as part of an integrated approach to early intervention. A related project will shortly be starting in Northampton (NORPIP). Eventually, the programme aims to establish a voluntary sector network of Parent Infant Projects throughout the country that are sustained by a range of public (health and early years) and private funds.

Given their potential to ensure that good foundations are laid for future development, **we recommend that the provision of infant mental health services be the next frontier for early intervention, and that they be provided in every locality according to identified need**.

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117 Keren M, Feldman R and Tyano S, 'Diagnoses and interactive patterns of infants referred to a community-based infant mental health clinic', *Journal of the American Academy of Child and Adolescent Psychiatry,* 40, 2001, pp27-35

118 Barlow J, 'Health-led Intervention in the early years to enhance infant and maternal mental health', *Child and Adolescent Mental Health,* 15(4), 2010, pp178-185

119 Barlow J H et al, 'The effectiveness of the Training and Support Program for parents of children with disabilities: A randomized controlled trial', *Journal of Psychosomatic Research*, 64(1), 2008, pp55-62

120 The Highland Council, *Video Interaction Guidance* [accessed via: http://www.highland.gov.uk/learninghere/psychologicalservice/projects/vig. htm]; Watch, Wait and Wonder [accessed via: http://watchwaitandwonder.com/]

4.4.2 Ensuring all parents receive the help they need

Throughout childhood, the importance of good parenting to children's mental health and wellbeing is universally acknowledged. As we have said in previous CSJ reports, it is important that parents feel supported in their role and able to access advice and guidance when needed.[121] The degree of support required varies from family to family. Some parents need intensive, therapeutic programmes. Others need advice that is more generic and can be delivered through much less expensive programmes with a small number of sessions.

As part of a public mental health approach **we recommend that all parents (regardless of the age and developmental stage of their children) have access to high quality support and parenting programmes through children's centres, family hubs, schools, GP surgeries or other community-based locations**. Key principles for the content and delivery of these programmes include the following:[122]

- New parenting skills should be actively rehearsed, for example using role play and rehearsal;
- Programmes should teach principles rather than techniques;
- Programmes should cover both the encouragement of positive behaviour through praise and the need to set boundaries with accompanying sanctions for negative behaviour;
- An understanding that the parental relationship has a direct impact on the development and wellbeing of the child;
- Solution-focused techniques should be used, encouraging parents to focus on present and future opportunities rather than problems; and
- The parent-practitioner relationship is of fundamental importance to the success of the intervention.

However, when the relationships within a family have markedly deteriorated and remediation rather than prevention of difficulties is the priority, more intensive methods are required. Direct support which takes a systemic approach, such as Functional Family Therapy, Multisystemic Therapy and Multi-Family Therapy, can get to the heart of the problems which have become deeply embedded in the family system.[123]

Working with couple relationships

Helping couples develop their relationship skills can be as vital as helping parents to nurture their children. As stated in Chapter Six on public health, strengthening the couple relationship should be a priority in the interest of preventing family breakdown. The Review visited a community-based project operating out of a Children's Centre in the London borough of Greenwich. The project delivered relationship counselling to some of the most disadvantaged members of the community. Because of mental health problems, these parents are typically considered hard to help and unsuitable for insight-

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121 Centre for Social Justice, *The Centre for Social Justice Green Paper on the Family,* London: Centre for Social Justice, 2010
122 See Sutton C, Utting D and Farrington D (ed), *Support From the Start: Working with young children and their families to reduce the risks of crime and anti-social behaviour,* London: Department for Education, 2004, pp1-120
123 Functional Family Therapy [accessed via: http://fftinc.com/]; MST Services [accessed via: http://mstservices.com (19/10/11)]; Association for Multiple Family Group Therapy and the Multiple Family Group Resource Centre [accessed via: http://www.multiplefamilygrouptherapy.com (19/10/11)]

oriented counselling. Practitioners trained by the Tavistock Centre for Couple Relationships (TCCR) offered short-term counselling to couples who scored highly on indices of depression, attachment insecurity and relationship risk. In some cases, couples were attempting to cope with a new baby while the mother suffered postnatal depression.

As our previous work has made clear, maternal postnatal depression is a key risk factor for the development of mental health problems in infants and children.[124] Evaluations of couples who underwent TCCR's counselling showed statistically significant improvements in scores for depression and relationship satisfaction.[125] The counsellors and project manager had good working relationships both with the Head of the Children's Centre and local GPs, and were, when we visited, developing strong links with adult mental health services. Honor Rhodes OBE, Director of Strategic Development and Projects at TCCR, told us that:

'The range of people the services are helping are definitely groups for whom this is an entirely new experience and who rate the work as helpful. We are using a range of clinical tools to measure outcomes, as you would expect. What is very pleasing is that people who would have laughed at the idea of therapy/counselling are finding themselves making excellent use of it and spreading take up of the service by talking about it to people they know'.

4.4.3 A family-centred mental health service

Services for families and children need to recognise and be designed around the complexity of family needs. This requires inter-agency cooperation. We have already described the need for better integration of mental and physical health care systems. We also need to work towards better integration of child and adult mental health services. Integrating services across stages of human development would be achievable through the establishment of a family-centred mental health service.

We have already seen that many mental disorders are present from childhood. We have discussed some of the ways these disorders develop and have pointed out how parents' mental illnesses can profoundly affect children. In the majority of instances, those with mental disorders are looked after by their family. Adults' mental disorders inevitably affect children who live in the family home. Some of these children are young carers who spend a large proportion of their time with their mentally ill parent. Aldridge and Becker have estimated that there are likely to be about 65,000 children and young people in England and Wales who are acknowledged to be acting as young carers for parents with mental illness. However, they also estimate that as many as one million children and young people in the UK may be significantly adversely affected by parental mental illness.[126] By shouldering this level of responsibility to meet their parents' needs, these children are themselves at risk of poor outcomes, including the development of mental health problems.[127] Preventing

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124 Centre for Social Justice, *The Next Generation, A report from the Early Years Commission*, London: Centre for Social Justice, 2008

125 The Tavistock Centre for Couple Relationships, *Parenting Support – A Project in Partnership with Greenwich Mind* [accessed via: http://www.tccr.ac.uk/index.php?option=com_content&view=article&id=72:parenting-support-a-project-in-partnership-with-greenwich-mind-&catid=60:research&Itemid=121]

126 Aldridge J and Becker S, *Children Caring for Parents with Mental Illness: Perspectives of Young Carers, Parents and Professionals*, Bristol: The Policy Press, 2003

127 Becker F and Becker S, *Young Adult Carers in the UK: Experiences, Needs and Services for Carers aged 16-24*, London: The Princess Royal Trust for Carers, 2008

developmental mental disorders should be the primary target of interventions. **In this context, there is great potential to make mental health services much more family-centred than they currently are and we recommend this becomes a key guiding principle.**

Parents with personality disorder (PD)

The integration of local authority and health service provision underlines the need to identify models in which social and mental health care collaborate closely to deal with the difficult and costly cases where severe PD places the child at risk. Social care provisions are ill-equipped to address the parents' mental health difficulties. Adult mental health services, even those focused on PD, are not geared up to address parenting problems or offer effective child protection. Family courts frequently make recommendations about parenting interventions but programmes they often recommend cannot address the profound psychological and relational difficulties of parents with severe PD.

Keeping child and adult mental health services administratively separate means that cross-referrals must be made between these agencies. These referrals are wasteful and ineffective. Given the interrelationship between the needs of adults and children within the same family, integrated family-based services are likely to reduce distress and save money.

40 per cent of child protection cases and 70 per cent of care proceedings involve parents with PD. These parents' specific difficulty with social cognition in attachment relationships creates risks of emotional abuse and neglect, and leads to frequent failure to engage with professionals and delays in decision making which leave vulnerable children unprotected. Specialist day treatment programmes for PD do not address parenting or offer childcare, and thus are inaccessible and inadequate for parents of preschool children.

Integrated health services for families would require that:[128]

- **Problems are defined interpersonally** (not as individual illnesses). If maladaptive behaviour was perceived as an interactive pattern between two or more people, this would allow for a more full understanding of the problem, and would generate more options for addressing what is driving the behaviour. This driver can often be the family system. If the problem is defined as being in one individual, particularly in the one exhibiting the most obvious symptoms, this can lead clinicians to treat symptom display without understanding the source of the distress. Such treatments engender little confidence that the underlying problems will not reappear in a new guise or that aggressive symptoms will not be repeated.
- **Families, rather than individuals, are assessed before a service plan is developed.** Significant family members also need to be seen in order to evaluate how information is processed within the family context, the strategies that are played out and the relationship dynamics. The problem can then be formulated properly and a mixture of individual, dyadic (couple-based), family and group services can be applied to address it.
- **Family members – particularly parents when their children are suffering from mental illness – should be drawn into the therapeutic framework whenever safe and possible,** rather than relying solely on professionals. Such a process is ideally one of respectful partnership: the therapist is explicit to the parent about the interpersonal method they

128 Crittenden PM, *Raising Parents: Attachment, Parenting and Child Safety,* Devon: Willan Publishing, 2008

are using with the child(ren) and both expects and enables the parent to do the same. This often means that parents learn more effective ways to communicate with and respond to their children. As a result, the work of the therapist is reinforced in everyday interaction, rather than undermined.[129]

■ **Effective family services, with the characteristics described above, are prioritised over out-of-home care** (e.g. for children and young people with eating disorders). Although current thresholds for qualifying for out-of-home care are very high, the full-range of family-based treatment possibilities is rarely exhausted before this option is taken. This often reinforces the notion that only the child or young person has the problem. Daily support services, family placements in protected communities, and fostering the family rather than the individual are all under-used options for preserving families.

In our polling we asked if people thought treatment for mental health problems should be focused on the patient themselves, or on the patient and their family and relationships.

Only quarter said mental health treatment should be focused mostly upon the individual patient themselves and two-thirds said mental health treatment should be focused on both the patient, and their family and relationships.[130]

4.4.4 Complex families

This Government estimates that there are 120,000 families living in 'chronic crisis' in the UK today, and it has pledged to try to improve the outcomes of every one of them.[131] Others calculate this figure as being closer to 150,000 families, and argue that a further three million people are living on the margins of such a category and only just coping, with factors like the recession threatening to tip them into even more difficult circumstances.[132]

Whatever the numbers, such families are often repeating a generational cycle; the founding family members typically have a psychosocial background that was also damaging and dysfunctional. Such backgrounds contain risk factors from both the family and wider social environment. Environmental risk factors include poverty, homelessness, lack of educational opportunities and poor housing. Familial risk factors include: neglect, abuse (sexual, physical and psychological), substance misuse, domestic violence, divorce and parental separation, illness (mental or physical) and disability. Various core needs in the children of such families cannot be met and the psychological and behavioural effects of these omissions may then be transferred to the next generation.

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129 Centre for Social Justice, *The Next Generation, A report from the Early Years Commission,* London: Centre for Social Justice, 2008
130 CSJ/YouGov polling of 2,084 British adults, September 2011
131 Speech by Prime Minister David Cameron, Families and relationships, to Relate, 10 December 2010 [accessed via: http://www.number10.gov.uk/news/speech-on-families-and-relationships/]
132 Participle, *Your Own LIFE: a plan for your locality,* 2011, p3

Such core needs include:

- Secure attachments to others (including safety, stability, nurturance and acceptance);
- Autonomy, competence and a sense of identity;
- Freedom to express valid needs and emotions;
- Spontaneity and play; and
- Realistic limits and self-control.[133]

Families with children who have conduct disorder require effective parenting interventions and Family Intervention Projects (as well as the many more recent schemes being developed locally to coordinate services around these families) must be able to draw upon approaches and programmes that tackle the mental health needs of both parents and their children.

Interventions which attempt to address this problem include the 'Helping Families Programme' (which has a manualised core practice module derived from the Family Partnership Model) and 'Parents under Pressure' (which, *inter alia*, helps parents learn how to better regulate their emotions and aims to extend families' social networks by reconnecting to their local communities).[134, 135, 136]

We recommend that multi-agency interventions involving complex families include mental health assessments of both parents and children; these are crucial to ensuring families receive the right help. They should also include evidence-based programmes or approaches that build on families' existing strengths to create a more nurturing environment, in which children's behaviour problems can be managed in a calm and non-punitive manner.

4.4.5 Children of parents involved in the criminal justice system

Children can suffer markedly whenever a parent is remanded in custody or sent to prison.[137] However, we heard from Action for Prisoners' Families that when parents – and especially mothers – are sent to prison, insufficient regard is paid to their responsibility for children and to children's immediate and long-term care. The Ministry of Justice acknowledged this in their report on Women Offenders saying that:

- Although over half of women offenders are estimated to be mothers, there are no definitive statistics on the number who are mothers, the number of children who have a parent in prison, or what happens to a woman's dependents once she is imprisoned.
- It is not routine procedure to record information regarding dependants either within the Prison Service or Children's Services.
- Only a quarter of children whose mothers were in prison were in the care of either their biological or current father and just five per cent of women prisoners' children live in their

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133 Young J, Klosko J and Weishaar M, *Schema Therapy*, New York: Guilford Press, 2003
134 Day C et al, 'The Helping Families Programme: a new parenting intervention for children with severe and persistent conduct problems', *Child and Adolescent Mental Health*, 16(3), 2010, pp167-171
135 Davis H and Day C, *Working in partnership with parents (2nd edition)*, Oxford: Pearson, 2010
136 Parents Under Pressure, PUP Program [accessed via: http://www.pupprogram.net.au (19/10/11)]
137 Cabinet Office Social Exclusion Task Force, *Short Study on Women Offenders, London:* Ministry of Justice, 2009 [accessed via: http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/209663/setf_shortstudy_womenoffenders.pdf]

own home after their mother has been sentenced. Not only do they lose contact with their mother but they are also required to move away from familiar surroundings.

■ 12 per cent of children of female prisoners were in local authority care or had been adopted compared with two per cent of children of male prisoners. Care arrangements for children of prisoners are often unstable.[138]

The Government's recently published document setting out its vision for parents, children and families specifically mentions the particular vulnerability of children whose parents are in prison.[139] It states that these children are "often 'invisible' to services and are at risk of emotional and monetary problems, as well as intergenerational criminality … approximately 160,000 children are affected each year by parental imprisonment".[140] Often, these children experience stigma, bullying and teasing and unstable care arrangements.[141] They have at least double the risk of mental health problems compared to their peers and are at much greater risk of other poor outcomes: 65 per cent of boys with a convicted parent go on to offend and children of prisoners have three times the risk of anti-social/delinquent behaviour.[142]

Given these acknowledged risks and its commitment to an early intervention approach, **we recommend that the Government requires local authorities to arrange for their social services departments to be informed as soon as a parent who is principal caregiver is confined, to make formal arrangements to check on the children's immediate and longer-term welfare and to collect data on the numbers of children involved**. This will require and therefore drive more joined-up adults' and children's services between community and custodial settings to ensure that agencies work together not only to build an accurate picture of what is happening in their area but also to ensure that planning and delivery provide effective support.

> Three quarters of those polled agreed that councils should have a duty to monitor children whose parents are in prison.[143]

Furthermore, while mothers are with their babies in prison (in mother and baby units) we believe this provides a vital opportunity to help both of them through programmes like New Beginnings. Run as a joint project between Anna Freud and New Bridge Prison Service this intervention aims to:

■ Increase mothers' knowledge base about infant development;
■ Facilitate more positive interactions between mothers and infants;

138 Ibid
139 Department for Education, *Supporting families in the foundation years*, London: Department for Education, 2011, p47
140 Ibid
141 Cabinet Office Social Exclusion Task Force, *Short Study on Women Offenders, London:* Ministry of Justice, 2009, p19 [accessed via: http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/209663/setf_shortstudy_womenoffenders.pdf]
142 Murray J and Farrington D, 'The effects of parental imprisonment on children', in Tonry M, (Ed.), *Crime and justice: A review of research*, 37, Chicago, 2008, pp133-206
143 CSJ/YouGov polling of 2,084 British adults, September 2011

- Enable the mother to better understand her own and her child's thoughts and feelings within their relationship;
- Contribute to qualitative shifts in mothers' representations of their babies and themselves as parents; and
- Support the mother in preparing to say goodbye to her baby, where that is the case.

Secondary anticipated outcomes are: improvement in mothers' state of mind (by enhancing their sense of efficacy as a mother); and improvements in the relationships between mothers in the unit (through the sharing of experiences within the group).

Although small numbers make assessment difficult and it is very hard to do follow up studies in prisons, the programme has proved successful enough for the prison service to commission the course to be run in their four larger units (Holloway, Eastwood Park, Bronzefield and Peterborough) between 2009 and 2011. Given what we know about the need to do all we can to ensure children have the best start in life possible, **we recommend that services to help these often highly vulnerable mothers and their babies are available in prison mother and baby units as standard**.

4.4.6 Accessing joined-up and well-informed services for children

Most of the funding available for children's mental health services goes into CAMHS. The Review heard, however, that CAMHS has not always been successful in making the best use of the wide range of professionals who should be concerned with children's mental health. Nor has it met the wide-ranging needs of children of all ages, from all backgrounds and in all settings. For example, one in ten children accessing CAMHS has autism; the National Autistic Society, however, expressed to us concern that many CAMHS professionals lacked adequate knowledge of the condition and of the specialist support that autistic children with comorbid mental health conditions tend to require.

As we noted earlier, CAMHS has had success in a number of areas. In particular, it became clear to the Review that CAMHS functions better where it is embedded in other services, and when it is able to be involved with children and young people shortly after they begin to experience difficulties. **We recommend that, wherever possible and appropriate, CAMHS workers should be integrated with other agencies as part of an interdisciplinary team**, (in what is often termed a Comprehensive CAMHS model).

The Review found that within the wider children's workforce, there is a lack of knowledge and understanding of child development, of the causes of mental ill health and of ways in which children of all ages can be supported so as to maximise their resilience. These should be central to any services involving children and should, wherever possible, be imparted to children's families. This could partially be accomplished by embedding CAMHS workers in the children's workforce where appropriate, but **we also recommend that infant and child development (including basic developmental neuroscience) be part of the training courses of all who work with children, as well as part of parenting courses**. As we have previously discussed, **joint training from the beginning of clinical**

and other professionals' careers aids understanding and integration; inter-professional education could involve mental health, nursing, midwifery, pharmacy, social work and medical students.[144]

Many comment that the therapeutic competencies of CAMHS workers is variable and, while there are some remarkably talented and exquisitely skilled practitioners, others offering therapeutic services to children and families have limited or little formal training. Full-training in evidence-based interventions for those offering therapy for children is essential. The therapeutic work of child mental health workers should be collaborative with children and families, and the extent to which they meet the needs of children and young people needs to be carefully and systematically monitored.

Research and evidence about risk and protective factors, and about interventions is not well understood by or easily accessible to busy professionals.[145] **We recommend that current knowledge in this area be part of professional development at all levels**. Care pathways from one service to another are often unclear. Furthermore, gaining access does not necessarily mean that the needed treatment, therapy or support will be received within a useful time frame. Children develop and change so rapidly that help is often needed within weeks rather than months. Even when children's mental health problems reach such thresholds of severity that they qualify for specialist services, there are usually long waiting lists.

Working Group visit to The Pears National Centre for Autism Education

Moreover, attendance at such clinics often requires travelling a significant distance and overcoming pronounced feelings of stigmatisation. Both of these present barriers to access that can mean children 'do not attend' (DNA). After two 'DNAs', busy CAMHS professionals often feel that it is permissible to drop the child – who will at this point be very 'high need' – from their caseload.

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144 Centre for Social Justice, *The Next Generation, A report from the Early Years Commission,* London: Centre for Social Justice, 2008
145 Department of Health, *Children and young people in mind: the final report of the National CAMHS Review,* London: Department of Health, 2008.

Children and young people who do access specialist services say that they do not have the opportunity to develop trusting, enduring relationships as a result of staff mobility. Furthermore, professionals' entrenched views and administrative/legal barriers often mean that children are 'pigeon-holed' into particular services, preventing their needs being met in holistic and flexible ways. For example, a child with sensory disabilities will have great difficulties in accessing mental health services.

'I am a school governor and you cannot take for granted that teachers will recognise Asperger's syndrome or depression. Also we know self-harm starts around 12 years so this would be another target area that schools could facilitate.'[146]

Child psychologist, in evidence to the Review

We recommend that urgent attention be paid to providing parents and children with more information about available services. There should also be quicker and simpler multi- rather than single- access points to services, and professionals should make full use of modern media (internet, smart-phones, tablets, etc) as parents across the socioeconomic spectrum are now much more sophisticated consumers of information. For example, in schools with high numbers of children with serious mental health and social problems, there should be a designated member of staff who is very well networked into social and mental health services. This person must be given space in their timetable to do the vital job of helping children and families receive the full range of support available. This would greatly facilitate the joining up of services where there are complex needs.

4.4.7 Children in schools

Better access to timely and non-stigmatising help for children over four years and their parents can partly be achieved by providing an integrated school-based mental health service. This service would be family-focused and designed to meet the emotional needs of pupils, parents and teachers, and spot dawning mental health needs. By being based in the school, the service becomes embedded in of school life and is therefore more likely to be accepted. A non-stigmatising approach to service delivery can be achieved by making a universal service available to the whole school population (which children can choose to access) alongside a targeted counselling service for children with higher levels of need (to which they are referred by teachers and other staff).

By identifying problems early this sort of accessible service is also able to intervene early and appropriately and provide a support response to teachers and other school-based staff. As the CSJ's report on educational exclusion makes clear, it is essential to understand the underlying causes of behavioural problems that can significantly disrupt schools and blight

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146 Roundtable with CAMHS professionals hosted by NHS Confederation Mental Health Network, 3 September 2011

the lives of all involved.[147] This would help facilitate an effective response so that learning and enjoyment of school and teaching are not impaired.

It needs to be more widely understood that many of the behavioural problems that beset schoolchildren, their families and their schools may have a basis in traumatic attachments during the first two years of life. These attachments may result in structural limitations in the brain. There may be differences between these and normally developing children in the way they process social and emotional information, they regulate bodily states, cope with emotional stress, understand the emotional states of others (empathy) and ultimately develop a sense of a bodily and emotional self.[148] Limitations in these capacities can be seen in many children with behavioural problems. Many of them are unable to regulate the intensity of their emotions in relation to stress. In some, high levels of anxiety are easily evoked, and even relatively minor alarming events produce uncontrollable fear. In addition, aggression is deregulated, resulting in feelings of intense rage and an increased risk of acting out.

When a child does act out (e.g. by misbehaving violently) or becomes withdrawn and unresponsive, teachers often feel – and are – ill-equipped to respond in a way that helps to deal with the cause of the problem. This cause may be deep-rooted and chronic (such as the neuroanatomical limitations mentioned above), or more immediate and short-lived (such as a bereavement, parental separation or other distressing experience).

We therefore recommend making more universal and targeted mental health services available in schools as a key component of a public mental health approach. Providing such community-based, easily accessible services can, in some cases, prevent escalation to the higher levels of need that will require the expertise of CAMHS professionals in specialist clinics.

It is important to acknowledge that some children with severe mental health problems will require and should receive such expert help and that sole reliance on schools-based services will be insufficient. For example, it is to be hoped that the availability of talking therapies for children and young people will continue to expand, building on the newly launched Children and Young People's Improving Access to Psychological Therapies Project. However good preventive services may be, there will always be some particular groups of children for whom higher tier services are vital. Doing all we can to prevent children's mental health problems from escalating is therefore an overriding priority; but so is ensuring adequate and accessible expert help for severe need.

Some charitable organisations are making a large contribution to such work, not only improving children's emotional wellbeing in schools but also to evaluating services in order to build evidence bases. For example, The Place2Be works in more than 150 primary schools to provide universally available 'emotional support and nurture to troubled children'.[149] It does this by means of lunchtime drop-in sessions and support to year-seven and year-eight

147 Centre for Social Justice, *No Excuses: A report on educational exclusion*, Centre for Social Justice: London, 2011
148 Fonagy P et al, *Affect Regulation, Mentalization and the Development of the Self,* New York: Other Press, 2002
149 Place2Be [accessed via: http://www.theplace2be.org.uk/default.aspx]

children moving into secondary school. It also provides more targeted one-to-one counselling to children and their parents. Outcomes are carefully monitored and satisfaction levels of commissioning schools are high.[150]

Universal and targeted services

At the evidence gathering roundtable hosted for the Review by the NHS Confederation Mental Health Network the point was made that as well as any universal approach there is also the need for a targeted set of interventions. Specific groups of children and families were mentioned: children going through care proceedings and those already in the care system, mothers going through access proceedings, adolescents in the youth offending system and children of British Forces overseas.[151]

Looking briefly at two of those categories, many Forces children will be affected by paternal or maternal absence, injury, trauma or death as a result of combat duties, yet there is often little or no acknowledgement that British children may need support to understand why a parent who has seen active service has changed, or why their relationship with the parent who remained at home has altered.

Our 2008 report on improving outcomes for children in care emphasised the importance of meeting their health needs and how Government – both locally and nationally – has failed in its duties as a corporate parent when it has not ensured these needs are met.[152] We recommended the removal of the practical and statutory limitations which stop children in care from taking legal action to enforce the obligations of their corporate parents and receiving compensation, saying 'Children in care should have rapid access to enforce the law if councils wilfully chose to ignore their responsibilities'.[153]

Other approaches include teacher-led interventions such as nurture groups. These seek to address the difficulties of children exhibiting a range of emotional and behavioural problems by helping them to form better relationships with adults and peers and to develop 'pro-social' behaviour (for example, by their decreasing levels of hyperactivity). Academic levels can also improve significantly as a result. One study has concluded that nurture groups are 'a promising teacher-led intervention for social and emotional difficulties' and recommends a randomised controlled study to further explore the routes by which these groups effect change.[154]

4.4.7.1 The importance of a 'whole-school approach'
A key review of the evidence base for what works in schools to promote the mental health of children has recently been published.[155] It found that what is required for optimal impact is a whole school, 'multi-modal' approach. This involves a wide range of people, agencies, methods and levels of intervention. It also includes parents and the wider community, for example by drawing in community groups, and mobilises the whole school as an

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150 CAMHS Outcome Research Consortium, *The Place2Be Service Level Outcomes 2009-2010*, 2011
151 Roundtable with CAMHS professionals hosted by NHS Confederation Mental Health Network, 3 September 2011
152 Centre for Social Justice, *Breakthrough Britain: Couldn't care less*, London: Centre for Social Justice, 2008
153 Ibid
154 Seth-Smith F et al, 'Do nurture groups improve the social, emotional and behavioural functioning of at risk children?', *Educational and Child Psychology*, 27(1), 2010, pp21-34 [quotation from p21]
155 Weare K and Nind M, *Promoting Mental Health of Children and Adolescents through Schools and School Based Interventions*, 2011 [accessed via: http://www.dataprevproject.net/files/final_reports/WP3%20-%20Final%20Report%20-%Promoting%20Mental%20Health%20of%20 Children%20and%20Adolescents.pdf]

organisation.[156] Several reviews commented on the importance of a positive school ethos that helps shape the attitudes and interactions of individuals within the school, particularly in relation to the way staff and students treat one another.[157] They also stressed the importance of increased opportunities and recognition for youth participation in positive social activities.[158] Another researcher concluded that the most effective interventions are sited within supporting communities.[159]

What are essential elements of a whole school approach? Other contributors to the Review emphasised that bullying is a major source of stress within schools and that anti-bullying policies and programmes will only be effective if they are properly implemented and follow an evidence-based protocol.[160] Anticipating and mitigating exam stress is also important.

4.4.8 Childhood to adolescence

The path from childhood to adolescence, and from primary to secondary school, is often troubled. Many young people are not only misunderstood by the adults who are important to them but are unable to understand themselves or each other. Given the extraordinarily rapid changes in neurodevelopment that take place during adolescence, and especially during early adolescence, this situation is not surprising.

Under the age of 13-14 years there is marked immaturity of the neural networks of frontal brain regions, which are implicated in planning, perspective taking, social understanding and evaluating future consequences.[161] Immaturity of this brain region means that young people tend to make decisions on impulse, looking for excitement and immediate rewards rather than considering long term consequences.[162] The capacities of a child of ten or 11 years are not comparable to an older adolescent or adult.[163] It is not surprising that pubertal children often fall into 'bad company' and engage in high-risk behaviours. During mid-adolescence, young people are still vulnerable to risk taking, to extremes of emotionality and therefore to uncontrolled and inappropriate behaviour.

Recent studies have shown that gradually, as adolescence continues, there is maturation of the limbic system (concerned with emotion regulation) and of the prefrontal cortex (responsible for planning and self-control), with grey matter thinning and white matter increasing.[164] Late

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156 Catlano RF et al, 'Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs', *The ANNALS of the American Academy of Political and Social Science*, 591, pp98-124

157 Adi Y et al, 'Systematic review of the effectiveness of interventions to promote mental wellbeing in children and primary education, Report 1: universal approaches (non-violence related outcomes)', London: National Institute for Health and Clinical Excellence; Farrington D and Ttofi M, *School-based programmes to reduce bullying and victimization*, Campbell Systematic Reviews, Oslo: Campbell Collaboration, 2009

158 Catlano RF et al, 'Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs', *The ANNALS of the American Academy of Political and Social Science*, 591, pp98-124

159 Diekstra R, 'Effectiveness of school-based social and emotional education programmes worldwide', *Social and emotional education: an International analysis,* Santander: Fundacion Marcelino Botin, 2008, pp255-284

160 Twemlow S and Sacco F, 'Bullying is everywhere: ten universal truths about bullying as a social process in schools and communities', in press, *Psychoanalytic Inquiry*, 2011

161 Farmer E, 'The age of criminal responsibility: developmental science and human rights perspectives, *Journal of Children's Services*, 6(2), 2011, pp86-95

162 Van Leijenhorst L et al, 'Adolescent risky decision-making: neurocognitive development of reward and control regions', *Neuroimage,* 51(1), 2010, pp345-355

163 Farmer E, 'The age of criminal responsibility: developmental science and human rights perspectives, *Journal of Children's Services*, 6(2), 2011, pp86-95

164 Steinberg L, 'Risk-taking in adolescence: New perspectives from brain and behavioural science', *Current Directions in Psychological Science,* 16, 2007, pp55-59

adolescence is a period in which the frontal lobes continue to mature, facilitating regulatory competence and executive functioning.[165]

This neurodevelopmental picture is not mirrored in training for, or provision of, universal and preventive services for older children and young people. Some measures are now taken to ease the transition of 11 year olds from Primary to Secondary schools, but once they are 'settled' they are treated like all the other students. All are expected to manage themselves, their peer relationships, their daily lives and school work in a manner which may be impossible for many 12 year olds, difficult at 15, and only beginning to be comfortably manageable at 17 or 18. This could explain why many schools report high rates of low-level classroom disruption, aggressive behaviour, persistent behaviour problems and of formally recognised conduct disorder, and why many parents despair of being able to 'talk sense into' their adolescent child. From a public mental health perspective, we recommend that education and training for parents and all those concerned with services for older children and young people, including youth workers, should cover adolescent development.[166]

4.4.8.1 Mental health services to reach our most vulnerable adolescents

Many teenagers with pronounced mental health needs are likely to experience vulnerabilities in other aspects of their lives (in terms of, for example, poverty and disengagement from education). These are compounded by a reluctance to access either mainstream health services (which are non-stigmatising because they also treat physical health), or agencies specifically associated with mental health. A GP's surgery offers anonymity from peers and teachers but many adolescents are anxious that family members could see them at the surgery or that GP's will share information with their parents.

4.4.8.2 An example of a teenage-specific, GP-based 'one-stop shop'

Using the learning from the Institute of Education's Teenage Health Demonstration Site programme (see case study below), one London-based GP, Dr Stephanie Lamb, has set up a Young People's Clinic at her Group Practice in Herne Hill.[167] Whether young people (aged 13-19) need to see a doctor, nurse or counsellor (provided by a youth worker from a third sector partner) for physical, sexual or mental health needs – and regardless of whether they are registered with another GP or not registered at all – they are able to access the clinic at the same time each week. No appointment is necessary, and the separate waiting area and private entrance to the premises provide anonymity.

The service was initiated after conducting a needs analysis of the local community which is socially mixed but has some areas of high deprivation. The GP is able to refer young people with more severe mental health needs to the nearby South London and Maudsley NHS Foundation Trust, but the third sector counsellor from the clinic provides the ongoing support that often makes the difference between a young person attending or not. This is one example of the voluntary sector acting as a much-needed bridge to statutory services.

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165 Farmer E, 'The age of criminal responsibility: developmental science and human rights perspectives', *Journal of Children's Services*, 6(2), 2011, pp86-95

166 Philip K, and Spratt J, 'Choosing your friends: Young people negotiating Supporting Relationships', *Advances in School Mental Health Promotion*, 3(1), 2010, pp42-51

167 The Review conducted a field visit to her practice in April 2011

The approach of projects evaluated by the Teenage Health Demonstration Site (THDS) programme was to either:

- Enhance or develop teenage-specific, holistic health services ('one-stop shops') in innovative health and non-health settings;
- Create or enhance health provision for teenagers in non-health settings; or
- Use a combination of these approaches.[168]

Different models of support for increasing young people's participation in health service development and delivery were used in the different sites and early success factors included:

- Making young people's sustained involvement central to the development and delivery of adolescent health provision from the outset;
- Ensuring that a wide range of different young people, including those using services from vulnerable groups, were involved in different projects/issues; and
- Employing someone whose central task was to ensure their participation.

The THDS programme evaluation found that, when such enhanced mental and physical health services were made available in the four demonstration sites:

- Generally more young people accessed services and a wider range of types of services were offered;
- Young people reported very high satisfaction with services in the sites: 94 per cent said they would recommend the service to a friend and 91 per cent found staff easy to talk to;
- Targets for reaching a certain number of the 30 per cent most vulnerable young people appear to be being met; and
- Better access for harder to reach groups is achieved by innovative approaches.[169]

4.4.8.3 An example of innovative health provision for teenagers in non-health settings
Another way in which the voluntary sector can act as a bridge to statutory mental health services is through outreach to disadvantaged youth. The organisation MAC-UK builds relationships with some of the most challenging and marginalised young people in the most deprived parts of London. Many young people who offend have complex mental health needs including depression, learning difficulties, behavioural problems, hyperactivity and substance abuse. There appears to be a gap between statutory mental health services and their uptake by these traditionally 'hard to reach' young people. This 'gap' in provision is the foundation for MAC-UK's work.[170]

MAC-UK's clinical psychologist and mental health outreach worker conduct one-to-one 'visits' with young people wherever the latter want to meet – therapy is routinely delivered on housing estate stairwells, for example. If a psychiatrist is needed then rather than referring the

168 Austerberry H et al, *Evaluation of the Teenage Health Demonstration Site Programme: 1st Annual Report 2007*, London: Social Science Research Unit, Institute of Education, University of London, 2008
169 Ibid
170 MAC-UK [accessed via: www.mac-uk.org (19/10/11)]

young person to their clinic, with the likely outcome that they will not attend, a psychiatrist will also meet them in their neighbourhood – wearing a Music and Change sweatshirt which engenders much-needed trust. This is genuine 'care in the community' delivered by specialists, who may actually be NHS/CAMHS professionals, but are seen as integral to a trusted youth service.

MAC-UK also facilitates mental health promotion workshops with young people, for young people, and runs 'Mini MAC' sessions in local schools and youth clubs. These sessions involve young people from the Music and Change project facilitating peer-to-peer DJ and MC sessions with younger children. MAC-UK also runs free mental health awareness training. This training is carried out by young people and is aimed at professionals and young people working in youth services. Through these workshops and sessions, MAC-UK is led by young people and their communities, challenging the convention of the more traditional 'expert' orientation.

Agencies that have received MAC-UK consultancy and training include Camden Council, the Metropolitan Police, Kilburn Youth Centre, Voluntary Action Camden and two Camden hostels for homeless young people. Their community-based work is evaluated by University College London.

There are advantages to both the GP-based 'one stop shop' and the community-based outreach models, but the priority should be to meet the needs of the local neighbourhood. Identifying what these are may require a needs assessment or broad-based consultation. **We recommend that in areas with high numbers of young people at risk of mental health conditions that are likely to go untreated by the current statutory offering, local commissioners should ensure that teenager-friendly services are available.** These should be non-stigmatising, integrated with other services, designed with the involvement of the young people in the target population and easily accessible.

4.5 Summary of recommendations

- Local health commissioners should ensure provision for premature babies (and their parents) is commensurate with the need and opportunity to prevent subsequent development of physical and mental health problems.

- Maternal mental health must be recognised as a priority, on a par with maternal physical health, and health professionals must be better trained to identify symptoms of depression. Health and wellbeing boards have an important role to play in ensuring that adequate resources are provided by local commissioners of services, and in recognising the strong role to be played by the voluntary sector and wider community.

- The provision of infant mental health services should be seen as the next frontier for early intervention in every locality where high levels of need are identified, given their potential to ensure that good foundations are laid for future development.

- All parents (regardless of the age and developmental stage of their children) should have access to high quality support and parenting programmes (and couple support) through children's centres, family hubs, schools, GP surgeries or other community-based locations.

- Establish a family-centred mental health service where parents are supported rather than blamed, and helped with their as well as their children's mental health needs with timeliness and sufficient resource.

- Multi-agency interventions involving complex families should include mental health assessments of both parents and children, and evidence-based programmes or approaches that build on families' existing strengths to create a more nurturing environment.

- The Government should require local authorities to collect data on children whose parents are in custody, not only to track their welfare, but also to ensure that planning and delivery of services provide effective support.

- Mother and baby units should, as standard, take the opportunity to help these often highly vulnerable mothers and their babies with evidence-based courses that can give infants a better relational start in life and provide a range of support to mothers.

- Wherever possible and appropriate, CAMHS workers should be integrated with other agencies as part of an interdisciplinary team.

- Infant and child development should be part of the training courses of all who work with children, as well as part of parenting courses.

- Joint training should be put in place from the beginning of clinical and other professionals' careers to aid understanding and integration.

- Current knowledge of risk and protective factors and effective interventions should be part of professional development at all levels.

- Prioritise providing parents and children with more information about the services that are available (using up-to-date dissemination methods) with quicker and simpler multi- rather than single- access points to services and professionals.

- More universal and targeted mental health services must be available in schools as a key component of a public mental health approach. A whole-school approach which promotes a positive school ethos and culture will more effectively promote the mental health of children than 'bolt on' programmes.

- Central government should give a strong lead by setting outcomes for local commissioners to deliver against so they find the best ways of supporting families and autistic young people make key transitions to adulthood in their area.

- Local commissioners should ensure authentic services, genuinely fit for purpose for the modern teenager are available, easily accessible, non-stigmatising, integrated with other services and designed with the involvement of the young people in the target population.

chapter five
Black and minority ethnic groups – a priority area for action

5.1 Introduction

This chapter will make clear that there are ethnic as well as socio-economic dimensions to the prevalence of mental ill-health and to problems in accessing appropriate mental health care. These seem to be amplified for ethnic groups, with the inverse care law applying. That is, those who are in most need of support are the least likely to access the services which provide this support. Public health approaches that anticipate and prevent problems from developing are particularly appropriate given what we know about risk factors and that:

'Failures to achieve more equal outcomes for BME groups in mental health occur through passive, insidious, cumulative and sometimes purely unfortunate alignments of gaps in protective measures'.[1]

A public health approach needs to co-exist with strong local and national leadership that inspires hope that improvement is achievable as well as being part of a package of proven, interdependent measures that together will make the difference. The last decade of policy and practice has taught us that genuine and lasting improvements for this population can only be achieved by making the subject central to organisational priorities. In reality,

'Race equality initiatives have, however, become fragmented. Sites are held up as examples of positive practice if they have some good initiatives that are only part of an essential package'.[2]

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1   Sewell H, 'Leading race equality in mental health', *The International Journal of Leadership in Public Services*, 5, 2009, p21
2   Ibid, p23

From the outset it is important to note that individuals from BME groups do not form a homogeneous group, for example in terms of prevalence or outcomes of mental health conditions. Weich and McManus correctly state 'the need to view ethnicity as a complex social, economic and cultural matrix'.[3] Therefore differing responses will be required in order to achieve equality of outcomes, making a one-size-fits-all service approach to BME groups inappropriate.[4] However there is much common ground due to the fact that disadvantage and discrimination significantly affect mental wellbeing and mental health, and BME communities in the UK are generally agreed to be exposed to higher levels of such experiences.[5] These are then further compounded by the stigma relating to the development of mental health problems.[6] Across all areas of this Review we have been struck by the accumulation of vulnerability that has to be overcome by many BME sufferers of mental ill-health, and the need to ensure that services and the wider community support them rather than adding to their burden.

Use of terms

RCPsych describe how race, culture and ethnicity are frequently, but inaccurately, used interchangeably.

'Race describes the physical appearance; culture refers to shared features that bind individuals together into a community. The definition and identification of ethnicity is difficult because it includes aspects of both race and culture, as well as other characteristics such as traditions, language, religion, spirituality, upbringing, nationality and ancestral place of origin. It is also a personal expression of identity influenced by life experience and place of habitation; it is dynamic and changes over time.' [7]

The working definition of ethnic minority individuals preferred by RCPsych is 'those with a cultural heritage distinct from the majority population'.[8]

This chapter will focus on issues that are of particular concern to BME communities and set the context for themes to which we shall return in following chapters. We have been struck by the fact that BME communities are not so much a special case, as that the problems they face in the health system and the community highlight the general failings of mental health care for the most vulnerable people throughout wider society. It is important to understand the policy background and the reasons why BME mental health has been the subject of so many reviews, official enquiries and policy initiatives – yet has seen little or no positive change in some of the most important indicators of progress. Care for BME patients is still widely seen as 'a major faultline in mental health' despite the sustained policy attention we describe below.[9]

3   Weich S and McManus S 'Common mental disorders' in Sproston K and Nazroo J (eds), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, Norwich: The Stationery Office, 2002, p26

4   Nazroo JY, Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health. The Sociology of Health Inequalities, (ed. Bartley M, Blane D, and Davey Smith G), Oxford: Blackwell, 1998, pp151-170

5   Singh SP and Burns T, 'Race and mental health: there is more to race than racism', *British Medical Journal,* 333, 2006, pp648-651

6   National Mental Health Development Unit, *BME Groups and Mental Health – Presentation and Evidence to the Centre for Social Justice Mental Health Review, 18 October 2010,* London: National Mental Health Development Unit, 2010

7   Royal College of Psychiatrists, *Psychiatric services for Black and minority ethnic older people,* London: Royal College of Psychiatrists, 2009, p9

8   Manthorpe J and Hettiaratchy P, 'Ethnic minority elders in Britain', *International Review of Psychiatry,* 5, 1993, pp173-180

9   Ethnicity and the Use of the Mental Health Act conference, 24 May 2010, London

5.2 Problems common to BME groups

In this section we give a brief overview of the challenges faced by service users and their carers in many BME groups, looking in more detail at different parts of the healthcare system and segments of the community later in the chapter. The very low baseline of service responsiveness, appropriateness of care and service user satisfaction characterising general BME experience was acknowledged by the last Government and prioritised for action in their five year plan described below. However, while some progress has been made as a result, significant ongoing improvements are still required to transform outcomes.[10]

BME groups have typically been characterised by high levels of dissatisfaction with mainstream services which they often perceive as misunderstanding and/or misrepresenting their situation, while voluntary and community sector organisations providing mental health services tended to score highly in satisfaction ratings.[11, 12] Problems of access to the primary care, mental health promotion and specialist community services which might prevent or lessen their mental health problems have also been reported, with people getting the mental health services they do not want but not the ones they do or might want.[13] For example, lower rates of referrals for IAPT services have been seen for BME groups than for White groups, despite community engagement research finding that talking therapies were most often cited as the preferred alternative to, or accompanying treatment with, medication (although some concerns were also expressed about confidentiality and the need for cultural competence).[14]

One voluntary sector organisation visited by the Working Group has a garden, which provides therapeutic and purposeful activity for people with mental health difficulties

Black people were 40 per cent more likely to be turned away than White people when they asked for help from mental health services.[15] A wide-ranging review of research and practice into mental health services for BME populations undertaken by the then National Institute for Mental Health found that the stigma associated with mental health problems can be made

10   Department of Health with the National Mental Health Development Unit, *Race Equality Action Plan: a five year review*, London: Department of Health, 2010 [accessed via: http://www.nmhdu.org.uk/silo/files/race-equality-action-plan-a-five-year-review.pdf (27/09/11)]

11   Keating F and Robertson D, 'Fear, black people and mental illness: a vicious circle?', *Health and Social Care in the Community*,12, 2004, pp439-447

12   University of Central Lancashire International School for Communities, Rights and Inclusion, *Delivering Race Equality in Mental Health Care: Report on the findings and outcomes of the community engagement programme 2005-2008*, Preston: University of Central Lancashire, 2010, p19

13   Sainsbury Centre for Mental Health, *Breaking the Circles of Fear*, London: Sainsbury Centre for Mental Health, 2002

14   University of Central Lancashire International School for Communities, Rights and Inclusion, *Delivering Race Equality in Mental Health Care: Report on the findings and outcomes of the community engagement programme 2005-2008*, Preston: University of Central Lancashire, 2010, p33

15   *Rethink, Behind Closed Doors, The Current State and Future Vision of Acute Mental Health care in the UK*, London: Rethink, 2006 [accessed via: http://www.mentalhealthshop.org/display_images/document_icons/pdf.gif (26/09/11)]

worse by discrimination faced by this patient group. Access to appropriate assessment and treatment may be hindered as a result.[16]

5.2.1 Problems specific to Black and African Caribbean groups

A body of evidence shows that out of all ethnic groups, Black and African Caribbean people are disproportionately represented in mental health services and experience poorer outcomes.[17] In 2005, the first Count Me In Census report showed that Black people are 44 per cent more likely than average to be detained within psychiatric settings under the Mental Health Act, and Black Caribbean men are 29 per cent more likely to be physically restrained.[18]

While there are higher detention rates for this group, it is argued that there is no conclusive evidence of a higher prevalence of mental illness among the UK's African Caribbean communities – either of common mental disorders or of psychosis.[19, 20] Rather, many argue that people from Black and African Caribbean groups are more likely to be wrongly diagnosed or over-diagnosed for psychotic illness like schizophrenia. Studies also show that ethnic differences in clinical presentation, racial stereotyping and language barriers are all likely to be causes that result in wrong diagnosis among Black patients.[21]

Although Singh and Burns state that 'the excess of psychosis in the African-Caribbean community in the UK is real and well-accepted by epidemiologists and researchers', this is not borne out by two major prevalence studies of rates *in the community* as opposed to rates *in treatment* – an important distinction described in the box below.[22] In other words, in contrast with findings from, for example, the key Harrison et al community study, and after controlling for other factors, Black Caribbeans (and indeed other BME groups) are not more likely to have psychosis than White people.[23]

This report particularly highlights the importance of family support either as a protective factor against the development of mental illness or as an aid to recovery when it has become established. Conversely, we emphasise that family breakdown is a risk factor for the onset of mental illness. Morgan and Fearon examined the relationship between long-term separation from, and loss of, a parent before the age of 16 in the landmark AESOP study.[24, 25] They found that, across the whole sample, those with psychosis were two to three times more likely to

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16   Department of Health, *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*, Leeds: Department of Health, 2003

17   Sainsbury Centre for Mental Health, *Breaking the Circles of Fear*, London: Sainsbury Centre for Mental Health, 2002

18   Commission for Healthcare Audit and Inspection, *Count me in Results of a national census of inpatients in mental health hospitals and facilities in England and Wales,* London: Commission for Healthcare Audit and Inspection, December 2005, pp19-23

19   Weich S and McManus S 'Common mental disorders' in Sproston K and Nazroo J (eds), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, Norwich: The Stationery Office, 2002, pp25-46

20   Nazroo J and King M, 'Pyschosis – symptoms and estimated rates' in Sproston K and Nazroo J (eds), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, Norwich: The Stationery Office, 2002, pp47-62

21   Littlewood R and Lipsedge M, *Aliens and Alienists: Ethnic Minorities and Psychiatry,* London: Penguin Publications, 1982

22   Singh SP and Burns T, 'Race and mental health: there is more to race than racism', *British Medical Journal* 333, 2006, pp649

23   Harrison G et al, 'Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom', *Psychological Medicine*, 27, 1997, pp799-806

24   The AESOP study, based at the Institute of Psychiatry considers Aetiology and Ethnicity in Schizophrenia and Other Psychoses.

25   Morgan C and Fearon P, 'Social experience and psychosis: insights from studies of migrant and ethnic minority groups', *Epidemiologia e Psichiatria Sociale,* 16, 2007, pp118-123

have been separated from a parent because of family breakdown or to have lost a parent before the age of 16. Moreover, the effect of separation on risk of adult psychosis was very similar in White and African-Caribbean subjects.

Prevalence – community rates versus treatment rates

Nazroo and King argue that:

'One of the weaknesses of most work on ethnicity and mental illness is a reliance on data based on contact with treatment services. Contact with services, even when access is universal, as in the NHS, reflects illness behaviour (i.e. the way that symptoms are perceived, evaluated and acted upon), rather than illness per se…These problems become particularly important for psychotic illnesses where contact with services might be against the patient's wishes. So, despite the consistency of research findings showing that Black Caribbean people have higher rates of treatment for psychosis, some commentators have not accepted the validity of the interpretation of this data and continue to suggest that a higher illness rate (rather than a higher treatment rate) remains unproven, because of the methodological flaws with the research that has been carried out'.[26]

In contrast to studies on rates of contact with services, the EMPIRIC national study of prevalence rates in the community and the *Fourth National Survey of Ethnic Minorities* (FNS) indicated that ethnic differences (between Black Caribbean and White people) were not significant at the level of estimated rates of psychosis.[27] Both studies also found that rates for Black Caribbean people were not particularly elevated among men, the young or 'non-migrant' people. This detail also contradicts some of the data from studies of treatment rates, which have suggested that the onset of psychotic illnesses is particularly high among young Black Caribbean men, and among those born in the UK.[28]

However, one finding that is consistent with EMPIRIC, the FNS and treatment based studies is that the rate of psychotic illness is, for the Black Caribbean (and White) group, related to socio-economic position. Those who were economically disadvantaged appeared to have a higher risk, as did those living in inner cities.[29]

In the study's control groups, African-Caribbean individuals were more likely to have been separated from a parent early in life than White British individuals. This tallies with what is known from much larger datasets such as the census, which show that lone parent families are more common among 'Other Black and Black Caribbeans' (see Figure 3 below). So the risk of separation from parents was higher for African-Caribbeans (37 per cent) than for White British (19 per cent), a finding which, they say, 'suggests early separation may have a greater impact on rates of psychosis in the African-Caribbean population'.[30] Other important risk factors drawn out throughout this report such as unemployment, living alone and limited social networks, also showed a basic association with an increased risk of psychosis and a greater prevalence in the African-Caribbean population.

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26 Nazroo J and King M, 'Psychosis- symptoms and estimated rates', in Sproston K and Nazroo J (eds), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, Norwich: The Stationery Office, 2002, pp47-62
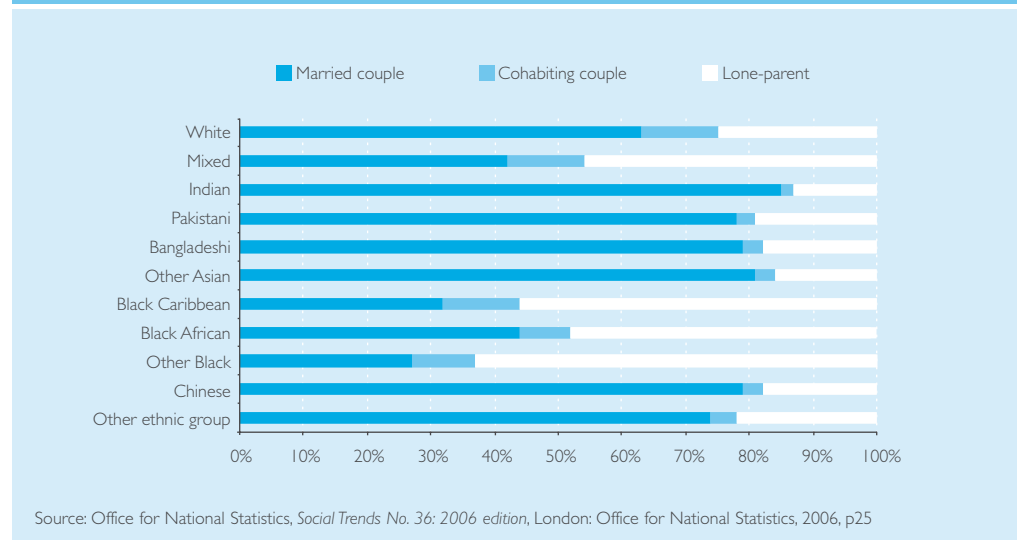
27 Smith P and Prior G, *The Fourth National Survey of Ethnic Minorities: technical report*, London: Social and Community Planning Research, 1996

28 Cochrane R and Bal SS, 'Mental hospital admission rates of immigrants to England: a comparison of 1971 and 1981', *Social Psychiatry and Psychiatric Epidemiology*, 24, 1989, pp 2-11

29 Nazroo J and King M, 'Psychosis – symptoms and estimated rates', in Sproston K and Nazroo J (eds), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, Norwich: The Stationery Office, 2002, pp47-62

30 Ibid, p121

Figure 3: Families with dependent children: by ethnic group and family type, 2001

Source: Office for National Statistics, *Social Trends No. 36: 2006 edition*, London: Office for National Statistics, 2006, p25

5.3 Policy responses to perceived injustices in mental health care

Given what is said above, the poorer outcomes Black Caribbeans (and other BME groups) tend to experience as a result of contact with mental health services cannot simply be ascribed to a greater susceptibility to severe mental illness (than the White population). The high level of fear associated with mental health treatment among Black populations is explained by:

■ Higher rates of admission to and compulsory detention in psychiatric inpatient units;
■ Violent incidents that are secondary to inadequate treatment of mental illness;
■ Inappropriate and poor treatment (excessive restraint, seclusion and medication);
■ Lower rates of recovery; and
■ Perceived and actual discrimination.[31]

Outcomes are occasionally catastrophic; deaths in mental health services following physical intervention are particularly feared, due to a number of incidents that have been the subject of high profile enquiries.[32]

The death in 1998 of David 'Rocky' Bennett, a 38 year old African Caribbean patient, in a medium secure psychiatric unit occurred after he was restrained by several members of staff for almost half an hour. It led to an independent inquiry which provided significant impetus to the Government's five year Delivering Race Equality (DRE) programme. The Bennett Inquiry brought to light many of the disparities and inequalities between BME groups and the majority White population in the rates of mental ill-health, service experience and service outcome, which have been the focus of much concern, debate and research for decades.[33]

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31   Sainsbury Centre for Mental Health, *Breaking the Circles of Fear*, London: Sainsbury Centre for Mental Health, 2002
32   Social Care Institute for Excellence, *Black and ethnic parents with mental health problems and their children*, London: Social Care Institute for Excellence, 2008, pp1-20
33   Department of Health, *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*, Leeds: Department of Health, 2003

Launched in 2005, the DRE action plan and DH recommendations in response to the Bennett Inquiry report together made up an extensive programme of work aimed at achieving equality of access, experience and outcomes for BME mental health service users. The combined programme aimed to change attitudes and behaviours as well as the way that mainstream mental health services were organised and provided in England so that the needs of an increasingly diverse population could be met.[34]

Key objectives of DRE included a reduction in the numbers of Black patients sectioned under the Mental Health Act, access to talking therapies for Black patients, and a reduction in the numbers of Black patients who are restrained and placed in seclusion.[35] However, there is little evidence of significant progress, either in terms of improvement in health status, a more benign service experience or positive outcomes for BME groups. If anything, the problems experienced by minority ethnic groups within mental health services have become consistently worse in almost every area earmarked for improvement.[36]

In order to monitor the progress of the five year DRE action plan, a series of six National Mental Health and Learning Disability Ethnicity censuses on inpatient care was conducted (the Count Me In Census referred to above). The 2010 Census, the last in the series, showed higher than average rates of admission into in-patient care for Black Caribbean groups, and a greater likelihood of being admitted through the criminal justice system than White British patients. They are also more likely to be placed in seclusion, have longer than average stays in hospital and be sectioned under the Mental Health Act than White people in a similar position. Detention rates are on average six times higher than the host population (in contrast, admission rates have consistently been lower than average among the Indian and Chinese groups, and are about average in Pakistani and Bangladeshi groups).[37] This final report concluded that ethnic differences in rates of admission, detention under the Mental Health Act and seclusion (three of DRE's 12 goals) have not altered materially since its inception in 2005.[38]

5.4 The Government's position

'When mental health services don't work, they can fail black and minority ethnic communities, young people who don't have stable family backgrounds and many others. But when they work well, and work well with local public, private and voluntary and community sector agencies, they help people to overcome disadvantage and fulfil their true potential. That is why this mental health strategy is both a public mental health strategy and a strategy for social justice.'[39]

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34   Department of Health, *Delivering Race Equality programme report: A review*, London: Department of Health, 2009
35   Department of Health, *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett*, London: Department of Health, 2005
36   Sewell H, 'Leading race equality in mental health', *The International Journal of Leadership in Public Services*, 5, 2009, p21
37   Care Quality Commission and National Mental Health Development Unit, *National Mental Health and Learning Disability Ethnicity Census: Count Me In 2010,* Quality Care Commission: London, 2010
38   Ibid
39   Department of Health, *No Health Without Mental Health: a cross government mental health outcomes strategy for people of all ages*, London: Department of Health, 2011, pp2-3

The Government's new No Health Without Mental Health Strategy acknowledges that equity in mental health care is as much about social justice as it is about health care. There are many other socio-economic factors affecting mental health and wellbeing for BME groups such as money, employment and housing and without these needs being addressed a significant number of people in the system are unlikely ever fully to recover. The strategy explicitly recognises that 'people from Black and minority ethnic (BME) groups are more likely to live in deprived areas and have negative experiences, both as a result of their ethnic identity and because of their socio-economic status and living environment'.[40]

Similarly, it is recognised that wider objectives for employment, education, training, safety and crime reduction, the reduction of drug and alcohol dependence, and homelessness cannot be achieved without improvements in mental health.

Among the shared objectives agreed by the DH and the many other partner organisations and government departments involved in designing the strategy (and already cited in Chapter One of this report), the following are particularly relevant for BME populations:

> (iv) *'More people will have a positive experience of care and support to improve mental health outcomes for individuals and the population as a whole.*
>
> *Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.*
>
> (v) *Fewer people will suffer avoidable harm.*
>
> *People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.*
>
> (vi) *Fewer people will experience stigma and discrimination.*
>
> *Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease'.*[41]

However, the actions attached to these (and the other three) objectives contain very little that will specifically help BME groups, apart from a broad commitment to implement the Equality Act 2010, although the overall emphasis on partnership working, improving the physical health of people with mental health problems and a recognition of the important role of religion are all welcome. As is the involvement of the Social Justice Cabinet Committee, 'which will ensure effective cross-government action to address the social causes and consequences of mental health problems', and the commitment to establish a Ministerial Advisory Group on Equalities.[42]

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40   Ibid, p56
41   Ibid, p6
42   Department of Health, *No Health Without Mental Health: a cross government mental health outcomes strategy for people of all ages*, London: Department of Health, 2011, p79

The strategy acknowledges that 'Tackling the inequalities for BME communities has been a central focus for a number of years however, the outcomes have in some ways been disappointing'.[43] We are concerned that the lack of clear actions to address the disadvantages BME groups face will not address this lack of progress. Our recommendations aim to build on previous learning from DRE and the many other studies in this area and to take on board the views and experiences of people with mental ill-health and those working with them, who are often in our most disadvantaged communities.
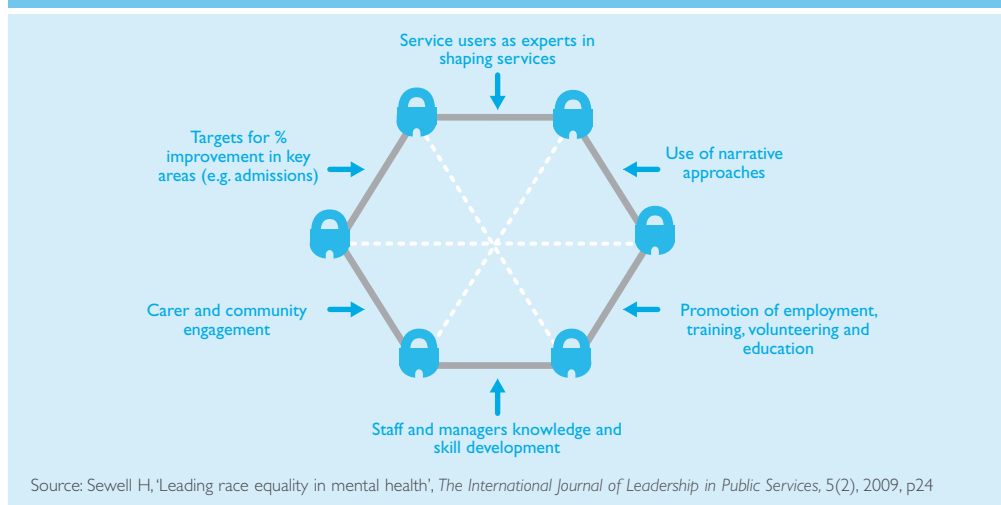
5.4.1 Learning from DRE – no magic bullet

Writing in 2009, when the Government's race equality programme in mental health was in its fifth and final year, DH consultant Hári Sewell concluded that:

'The headline figures demonstrate that society, public services and other providers have struggled to turn the tide on disparities in experience and outcomes for people from black and minority ethnic (BME) backgrounds…[and] represent a deterioration since the national censuses began in 2005'.[44]

Looking forward to what could be done to build on the learning of DRE (without simply doing more of the same as this was unlikely to be effective), Sewell identified six components of services from the associated research that could be considered interdependent and that should work together as a single package of measures if mental health services are to see evidence of improved outcomes. The absence of any one aspect has a disproportionately detrimental impact on the ability of services to make improvements in outcomes. He proposed a 'locked hexagon' model (reproduced below) representing these six interdependent elements, arguing that commitment to a consistent set of components in different sites across the country will enable evaluation of a model which, if it delivers improved outcomes, will legitimately be deemed as best practice.[45]

Figure 4: The locked hexagon model of essential unified components required to achieve improved outcomes for BME groups

Service users as experts in shaping services

Targets for % improvement in key areas (e.g. admissions)

Use of narrative approaches

Carer and community engagement

Promotion of employment, training, volunteering and education

Staff and managers knowledge and skill development

Source: Sewell H, 'Leading race equality in mental health', *The International Journal of Leadership in Public Services,* 5(2), 2009, p24

43   Ibid, p59

44   Sewell H, 'Leading race equality in mental health', *The International Journal of Leadership in Public Services*, 5, 2009, p19

45   Sewell, H, *Working with Ethnicity, Race and Culture in Mental health – a handbook for practitioners*, London: Jessica Kingsley Publishers, 2009

The six elements, as shown above, are: clear, locally set targets for improvement (ideally of outcomes rather than inputs); service users shaping services; use of narrative approaches and explanatory models (patients and clinicians working together to construct a story that makes sense of mental disorder for each individual); promotion of education, employment, training and volunteering; staff and manager knowledge and skill development; and carer and community engagement.

Throughout the course of the Review it became clear that there was very little evidence of this concerted approach, which is not unduly prescriptive as the implementation of each element will be locally determined. **Our first recommendation therefore is that the systemic, 'locked hexagon' approach suggested by the research to be effective is consistently implemented and evaluated.** Our other recommendations refer back to this framework as we want to build on what has been already learned – too much is at stake for a 'scorched earth' attitude in this area.

5.5 Specific policy challenges concerning BME groups

5.5.1 Routes into detention

The Review found that in many ways compulsion typifies the experience of mental health services for people from African-Caribbean communities; all the studies in this area have found that the African and African-Caribbean populations were disproportionately represented among patients who enter mental health services via Section 136 of the Mental Health Act.[46] Moreover, the Independent Police Complaints Commission found that Black people in particular were almost twice as likely as White people to be detained in police custody under Section 136 when rates of detention are compared to population data, and are 50 per cent more likely to be referred into the system via the criminal justice system or police.[47, 48]

If people are accessing the mental health system via Section 136, through whatever place of safety this entails, this generally means undergoing a traumatic experience that will itself be detrimental to their wellbeing. As described in the next section, it is known that Black people often fail to access appropriate mental health care from primary care, particularly from their GP, and that this can lead to long delays in accessing treatment until worsening conditions can cause a public crisis in which police and compulsory procedures are eventually involved.[49] This can set up a vicious circle whereby the often traumatic experience service users have when entering or using psychiatric services acts as a barrier to any further voluntary engagement with the services.[50]

46   Royal College of Psychiatry, *Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)*, London: Royal College of Psychiatry, 2011, p18

47   Independent Police Complaints Commission, *Police Custody as a 'Place of Safety': Examining the Use of Section 136 of the Mental Health Act 1983*, London: Independent Police Complaints Commission, 2008, p14 and p38

48   Care Quality Commission, *Count Me In Census 2009*, London: The Care Quality Commission, 2010, p21

49   Keating F and Francis E, *Breaking the Circles of Fear*, London: Sainsbury Centre for Mental Health, 2002

50   National Service User Network, *Dancing to our own tune. Reassessing black and minority ethnic mental health service user involvement*, London: Seagull Print Ltd, 2009

Removal to a place of safety' under the Mental Health Act 1983

Section 136 of the Mental Health Act 1983 states that:

1. 'If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of Section 136 above.

2. A person removed to a place of safety under this Section may be detained there for a period not exceeding 72 hours to enable him to be examined by a registered medical practitioner and interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care'.[51]

The 'place of safety' is defined in Section 136, subsection 6:

'In this section 'place of safety' means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948, a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient'.

In practice it is psychiatric units, police stations and emergency departments that are commonly used in England and Wales, although the Mental Health Act does allow other options.[52]

Many already fear that if they engage with mental health services they will be locked up for a long time, if not for life, and treated with medication which may eventually kill them.[53]

'I remember when I first went into hospital … I feared that I was going to die.'

Service User[54]

'I was restrained for not talking. They took my pants down and injected me...

What distresses me – for Black people – it sounds like we are paranoid, but when you hear about sexual assault, physical assault; it's not us being irrational. These are true facts and horror stories. A hospital is not always a 'place of safety' for us.'

Service User[55]

51 Mental Health Act 1983
52 Royal College of Psychiatry, *Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)*, London: Royal College of Psychiatry, 2011, p26
53 Keating F and Francis E, *Breaking the Circles of Fear*, London: Sainsbury Centre for Mental Health, 2002
54 Ibid
55 Royal College of Psychiatry, *Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)*, London: Royal College of Psychiatry, 2011, p22

We discuss wider problems with fears for safety and inpatient care in Chapter Seven on secondary care. However the experience of being taken to and held in a police station particularly amplifies fears; the more frequent use of police cells for Black people helps to explain why mental health services are closely associated with compulsion and coercion, rather than compassion and recovery for this client group.

A number of key organisations have stated clearly that using police custody as a place of safety should be avoided whenever possible. This is because it is felt to be the least appropriate environment to hold people and may exacerbate their mental disorder.[56] The Independent Police Complaints Commission (IPCC) has also stated that police cells are not a suitable environment for detaining people under the Mental Health Act. It has set out recommendations to sharply reduce the use of cells as places of safety to address the following concerns, with the aim of getting to the stage where police cells are very rarely if ever used.

- **Frequency:** There is widespread consensus that only in exceptional cases should police custody be used as a place of safety. Despite this, figures from the IPCC show that during 2005/6 over 11,500 people had been detained in this manner. During the same period, it is estimated that 5,900 people were detained in hospital for the same purpose. Therefore, in practice, police custody is used as the main place of safety.
- **Effect on the patient:** the environment can be frightening, it may worsen their mental state and, in the most tragic cases, can lead to deaths in custody. The IPCC's research shows that almost half the deaths of people in police custody are mental health service users. Police officers themselves admit they often do not have the training necessary to keep people safe: '…we as custody sergeants don't have…the training and insight [into] mental health problems… [compared to] doctors and nurses, so [what] we're looking for [when risk assessing individuals is] perhaps very different to what maybe we should be looking for'.
- **Criminalises what is essentially a health need:** this process of detention can be very stigmatising, particularly if it is done in a very visible way within a tight-knit community. 'If you are arrested, you are handcuffed, Black Maria, criminalised in front of your neighbours.'[57]

The RCPsych emphasises that some of these concerns are related to specific BME issues, particularly the lack of trust that exists between some members of BME communities and such institutions as the police. There is a significant history with ramifications beyond mental healthcare alone: their research indicated that Section 136 is identified with the old 'Sus Law'. Based on the Vagrancy Law of 1824, the 'Sus Law', was the informal name for police officers' ability to stop and search on the basis or suspicion or 'sus' alone. Its use was identified with police harassment and dropped following Lord Scarman's Inquiry into the Brixton Riots in 1981.

One service user in their study said 'Many Black people feel that Sus Laws were replaced by 136' and there is a view that Black people with mental health problems are especially vulnerable to police harassment:

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56   Independent Police Complaints Commission, *Police Custody as a 'Place of Safety': Examining the Use of Section 136 of the Mental Health Act 1983*, London: Independent Police Complaints Commission, 2008
57   Ibid

'Police can invite you outside the house and then use s.136 on the street. This was our experience'.

One carer described how:

'My son is very distinctive. If he just goes to the shop, they stop him on s136. He is 27, it's not appropriate for me to go with him all the time. He has a right to go up the street when he comes home from hospital. One time police stopped him and they wanted to take him to place of safety when he was home from the ward for the weekend. I had to get a lot of help to keep him home. I know the police well and I tell them. It was like Sus Law'.[58]

5.5.2 Deaths in custody

Figures published by the Independent Advisory Panel on Death in state custody show that between 1 January 1999 and 30 September 2010, there were 6,496 recorded deaths (whether in prisons, police custody, immigration detention, approved premises or in-patient mental health settings). This is an average of 541 deaths per year.[59] The deaths of those detained under the Mental Health Act account for 62 per cent of all deaths in state custody.[60]

5.5.2.1 Deaths in police custody

According to the Equality and Human Rights Commission Triennial Review, 'people with mental health conditions are more likely than those without to die during or following police custody'.[61] This is confirmed by the Joint Committee on Human Rights report into deaths in police custody, which found that just over half of those who died following contact with the police had shown signs of mental health conditions.[62]

In addition, in terms of total deaths in police custody since 2004 in England and Wales, a disproportionate number were of Black people (20 per cent of deaths in 2008/9[63] who comprise around two per cent of the population[64]).

The recent high profile case of Mark Duggan, whose death in August 2011 involving the police triggered civil unrest across the country, has again highlighted the issue of deaths in custody, the disproportionate way this impacts on ethnic minorities and in particular on the UK's African Caribbean communities – not least in terms of fears over personal safety.

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58   Ibid, p24

59   Independent Advisory Panel on Deaths in Custody, *Mid Term Progress Report on the work of the IAP and Future Priorities for the Work of the Panel,* London: Independent Advisory Panel, February 2011, p9

60   Ibid

61   Equality and Human Right Commission, *How Fair is Britain? Equality, Human Rights and Good Relations in 2010 The First Triennial Review,* Manchester: Equality and Human Rights Commission, 2010, p70

62   House of Lords and House of Commons Joint Committee on Human Rights, *Deaths in Custody: Third Report of Session 2004-5,* Norwich: The Stationery Office, 2004

63   Ministry of Justice, *United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment Fifth Report by the United Kingdom of Great Britain and Northern Ireland,* London: Ministry of Justice, 2011, p73 [accessed via: http://www.parliament.uk/deposits/depositedpapers/2011/DEP2011-1420.pdf, 26/09/11)]

64   Equality and Human Right Commission, *How Fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial Review,* Manchester: Equality Human Rights Commission, 2010

There is a growing body of research that has raised particular concern about deaths involving ethnic minority men following police restraint. Cases involving Black people and those of mixed ethnicity form a greater proportion of those restrained.[65] The UK Parliament's Joint Committee for Human Rights notes that between 1998 and 2003, 18 per cent of those who died in police custody overall were from ethnic minorities, and restraint was involved in a higher proportion of the deaths of people from ethnic minorities coming into contact with the police (22 per cent) than of White people (12 per cent).[66]

Over one-third of cases in which a Black detainee had died occurred in circumstances in which police actions may have been a factor (the proportion rises to almost one-half if the cases of accidental death where the police were present are added); this is compared with only four per cent of cases where the detainee was White.[67]

Reducing deaths in custody

Given these high figures and concerns over the greater risks BME groups face of dying in custody, a commitment needs to be made to see figures reduced. We recommend four specific measures to this end, two of which are further expanded in this chapter.

1. Acting to ensure that no people with severe mental health problems are in prison
The CSJ's 2009 review on prison reform, *Locked Up Potential,* recommended that there be:

> *'Early and appropriate diversion*
> *Prisons should not be used as dumping grounds for the mentally ill, as many currently are. The best way to prevent this is by the earliest possible interventions at police stations and at preliminary court hearings which result in the diversion of those with severe mental health problems into high quality medical treatment and where appropriate, into NHS accommodation'.*[68]

In *Locked Up Potential* we described the importance of drawing on the (unused) capacity of independent sector providers[69] and reiterate here the need for diversion. However when considering if and why shortages in NHS and other secure services are delaying admissions from prison to hospital, it is important to acknowledge and address bed blocking. Capacity within secure services is used not only by patients serving time after committing crimes but also by non-forensic patients deemed to be dangerous or very unstable. However patients can stay at a high level of security longer than necessary because of a) risk aversion and b) lack of suitable provision both at lower levels of security and in the community.[70]

65   Independent Police Complaints Commission, *Deaths in or following police custody: An examination of the cases 1998/99-2008/09,* London: Independent Police Complaints Commission, 2010

66   House of Lords and House of Commons Joint Committee on Human Rights, *Deaths in Custody: Third Report of Session 2004-5,* Norwich: The Stationery Office, 2004

67   Independent Police Complaints Commission, *Deaths in or following police custody: An examination of the cases 1998/99-2008/09,* London: Independent Police Complaints Commission, 2010

68   Centre for Social Justice, *Locked Up Potential: a strategy for reforming prisons and rehabilitating prisoners,* London: Centre for Social Justice, 2009, p113

69   Renshaw J, 'Waiting on the Wings: a review on the costs and benefit of secure psychiatric hospital care for people in the criminal justice system with severe mental health problems', [accessed via: http://www.laingbuisson.co.uk/portals/1/media_packs/Fact_Sheets/Waiting_on_the_Wings_2010.pdf (19/10/11)]

70   Centre for Mental Health, *Pathways to unlocking secure mental health care,* London: Centre for Mental Health , 2011

2. Independent investigations into preventable deaths

An independent investigation needs to be conducted whenever deaths of patients detained under the Mental Health Act occur that are not due to natural causes. A commitment also needs to be made to see a reduction in the numbers of such death nationally, with health providers publishing this data in their annual reports.

3. Alternatives to use of police cells as places of safety under Section 136

Alternatives to police-based places of safety need to be readily available for mental health patients who are sectioned by the police under the Mental Health Act. Resourcing to ensure sufficient staffing of such places must be prioritised. These facilities should adhere to the RCPsych 20011 standards on places of safety. Health-based places of safety within psychiatric hospitals and in the community need to be established. It is highly likely that the initial cost incurred to establish these settings will be saved in the reduction in resources currently spent on police man hours and investigations into fatal incidences that occur in custodial settings.

4. Right to advocacy before detention

The immediate appointment of an advocate trained to understand the needs of BME clients would prevent the distress and misunderstandings which can result in tragic outcomes for this group when members are taken into custody under Section 136 of the Mental Health Act.

Advocates would also broker discussions between the police, doctor or allied mental health professional which may prevent entry into the system and provide the necessary support for diversion to community-based support services.

5.5.3 Health- and community-based places of safety

Given that police cells are widely perceived to be inappropriate places of safety and their use is strongly identified with the perpetuation of inequalities in the care of mentally ill people from Black communities, we agree with the IPCC and the RCPsych that there should be sufficient health-based places of safety to meet foreseeable local need. Referring back to the 'locked hexagon', this is an example of an important target area for improvement. Recourse to police stations as a convenient local option to psychiatric alternatives or because the health-based place of safety is regularly full, should be phased out with police cells only used on a genuinely exceptional basis. Both infrastructure and staffing will require prioritising by CCGs who should also set up monitoring arrangements to ensure that facilities adhere to RCPsychs' standards on places of safety.[71] We support related recommendations from both the RCPsych and IPCC reports but would also urge commissioners to explore the possibilities in their area for *community-based* places of safety.

We spoke to voluntary sector organisations over the course of this Review which work in a highly personalised way with some of our most vulnerable mental health patients and who may be the last port of call when statutory services feel they can make no more progress. Staffed by clinicians and others who are highly trained, they often have an established relationship with the individual and the expertise to provide the necessary care while an assessment is carried out. Codes of Practice in both England and Wales both say that local

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71   Royal College of Psychiatry, *Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)*, London: Royal College of Psychiatry, 2011

policy should identify the most appropriate places of safety for individual cases and, as mentioned above, RCPsych standards have been established, are regularly reviewed and could guide practice in these settings.

5.5.4 Advocacy

The immediate appointment of an advocate trained to understand the needs of BME clients when members are taken to a place of safety under Section 136 of the Mental Health Act, would prevent the distress and misunderstandings which can result in tragic outcomes for this group (including deaths in custody). Advocates would also broker discussions between the police, doctor or allied mental health professional which may prevent entry into the mental health (or criminal justice) system, and provide the necessary support required to achieve effective diversion to community-based support services.

Statutory access to an Independent Mental Health Advocate (IMHA) has been offered to patients who are subject to certain aspects of the Mental Health Act 1983 since April 2009. IMHAs have been established to help and support patients to gain a better understanding of their legal rights and how to exercise them. Among other categories they are available to most detained patients and patients on community treatment orders or subject to guardianship.

However this Review's evidence gathering showed that independent support and advice needs to be available *before* detention (as well as when patients attend tribunal hearings) and when individuals are being discharged in order to help them access aftercare services. There also needs to be advocacy support at the earliest point possible for carers who are often ill-equipped to navigate the healthcare system or mental health law. We heard distressing stories of mothers' counsel based on their longstanding knowledge of their sons being completely disregarded. Where this is due to language barriers or unfamiliarity with medical terms, an advocate could help to mediate between relatives and clinicians so that both sides were better understood.

We took evidence from voluntary sector organisations providing independent support and advice at a point where detention could still be prevented. The African-Caribbean Community Initiative plays a vital role in negotiating with the police or clinicians when a person known to them appears to be in need of admission to hospital, typically against their will. Where it is appropriate and by offering to provide the necessary support within the community, this can avoid unnecessary detention with all of its implications for stigma, and possible over-medication and restraint.

The Care Quality Commission reported a record number of detentions in the year 2009/10 suggestive of 'defensive' practice, which is, they say, 'increasingly apparent in mental health services driven by concepts of risk rather than just treatment'.[72] The Government's commitment to patient choice and to the concept of 'no decision about me, without me' could hardly stand in starker contrast to this trend (and to the very high use of Community Treatment Orders among BME groups discussed in the next section).[73] We recommend that

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72   Care Quality Commission, *Mental Health Act Annual Report 2009/10 – A view on the report* [accessed via: http://www.cqc.org.uk/
mentalhealthactannualreport2009-10/aviewonthereport.cfm 14/10/11]

73   Department of Health, *Equity and Excellence: Liberating the NHS*, Norwich: The stationery Office, 2010

creative and innovative ways are found to increase sharply the number of advocates available. This may be done by developing a community advocate role which is wholly voluntary, draws on membership of community-based organisations (including churches and mosques) and depends on obtaining a more streamlined qualification. This would be appropriate if the community advocate role did not extend into detention and require the advocate representing the patient at Mental Health Tribunals, but did allow them to help reintegrate the patient back into the community after discharge.

It is possible that many people who had completed the more streamlined community advocacy training might go on to become full-fledged IMHAs as they are currently constituted. This would be aided by them obtaining credits through their community role which is entirely consistent with the National Advocacy Qualification's status as a competency-based qualification that is reliant on practical experience.[74]

A significant increase in the number of 'lay' citizens in BME communities who have a good working knowledge of medical and legal aspects of mental health has the potential to shift and improve attitudes towards the authorities and health services. Another likely impact is that an influx of BME service providers into the mental health system, albeit on a part-time and voluntary basis, could change perceptions and the culture there, helping to bridge what often appears to be a chasm of suspicion and misunderstanding.

Training could also be delivered through the Black Voluntary Community Sector (BVCS) where 'lay' citizens already have the skills to work with local communities to build capacity so they are able to identify and meet their own mental health needs and promote better mental health within the local BME population.[75] Referring back to the locked hexagon of Figure 4, this recommendation promotes carer and community engagement as well as education, employment, training and volunteering.

5.5.5 Community Treatment Orders (CTOs)

Although we discuss CTOs in more detail in Chapter Seven on secondary care, they are also particularly relevant here. CTOs were designed and introduced in law for what are known as 'revolving door' patients, who do not comply with their treatment or engage with community mental health services following their discharge from hospital. The order allows for them to be recalled to hospital if necessary. Black or Black British patients are subject to these new restrictions in greater numbers than any other group. This raises serious concern because of their coercive nature and the limited international evidence for positive effects. Although they can work well in certain circumstances it must be acknowledged that this is a provision that extends compulsion and increases stigma, which hinders recovery and reintegration back into the community.

In its first annual report into the use of the Mental Health Act, the Care Quality Commission states potential causes for concern:

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74   National Institute for Mental Health in England, *Independent Mental Health Advocacy: Guidance for Commissioners*, London: National Institute for Mental Health in England, 2008

75   Mayor of London, *Towards a Blueprint for Action: Building Capacity in the Black and Minority Ethnic Voluntary Community Sector Providing Mental Health Services*, London: Greater London Authority, 2005

- The high number: 4,107 CTOs were made in 2009/10, the first full year of their introduction; at least ten times the number anticipated when the legislation was introduced;
- CTOs do not appear to have reduced hospital-based detention: over the same period a record number of patients were detained;
- Although CTOs were particularly intended for 'revolving door' patients, the CQC found, in a sample of over 200 patients, that 30 per cent did not have a history of non-compliance or disengagement from services after they left hospital. This could partly account for the high number of CTOs, and suggests hospitals are making their judgements on the basis of defensive practice when applying them;
- Variations in the quality of patient involvement while treatment is being planned and a lack of understanding by some patients of what is expected of them; and
- The disproportionate number of patients from some BME groups placed on CTOs.[76]

If the Care Quality Commission continues to find that numbers remain high, **we recommend that CTOs are a priority area for parliamentary scrutiny in advance or as part of an overarching review of mental health legislation** (the Review enters into more detail in Chapter Seven).

5.5.6 The role of GPs and pathways into care

The BME Health Forum highlights significant barriers to BME communities' access to all GP services, not just those for mental health, and cites national and local reports, such as the 2007 national GP patient survey and the recent DH report *No Patient Left Behind* which also identified primary care access as a major issue of concern.[77] In its research in London boroughs it found a substantial minority group of BME communities were very dissatisfied with the process of registering with a GP and making appointments, a large number of patients were discontented with their relationship with their GP and practice staff, and communication problems, caused by language and cultural barriers, impinged on the doctor-patient relationship. They concluded that there was a need for GP practices to become aware of these barriers and more flexible in responding to different patient groups' needs.

Despite this, evidence shows that there are no significant differences in registration with GPs, or in overall consultation rates between minority ethnic groups and the population at large, but GPs have, certainly historically, appeared to be less able to recognise psychiatric disorder in BME patients than in others.[78] At the same time, Black African Caribbean and South Asian patients are also likely to have the nature of their presenting condition (underlying which may be social, economic, housing and other problems) wrongly attributed to mental illness.[79] Finally, BME service users asking for help from mental health services are 40 per cent more likely than White service users to be turned away.[80]

76 Care Quality Commission, *Monitoring the use of the Mental Health Act in 2009/10*, London: Care Quality Commission, 2010
77 BME Health Forum, *Primary Concern – Access to GP practices for BME communities in Kensington, Chelsea and Westminster*. London: BME Health Forum, 2008 [accessed via: http://www.bmehf.org.uk/media/publications/research/bme_Primary_Concern.pdf (26/09/11)]
78 Shaw CM et al 'Prevalence of anxiety and depressive illness and help seeking behaviour in African Caribbeans and white Europeans: two phase general population survey', *British Medical Journal* 318, 1999, pp302-306
79 Wilson M, *Mental Health and Britain's Black Communities*, London: King's Fund, 1993
80 Sainsbury Centre for Mental Health, *Removing Barriers. Achieving Change*, London: Sainsbury Centre for Mental Health, 2004, p3

Members of the Mental Health and Community Cohesion Working Groups meeting with the British Ambassador Jane Owen in Norway

GPs admitted feeling less involved in the care of BME patients with severe mental illness and evidence suggests that GPs' decisions concerning referrals of patients with mental health problems to specialist services are moderated by the patient's ethnicity;[81] rates of referral from GPs (and community mental health teams) are recorded as being lower than average among some Black and White/Black groups, and rates of referral from the criminal justice system were higher (as stated above).[82]

Economic benefits to avoiding hospital admissions

A notable feature of the patterns of service use extensively covered in literature on mental health and ethnicity is the disproportionate number of Black people in high-cost services, particularly hospital inpatient care. Greatest costs are incurred by medium secure and intensive care units where research shows outcomes are often poorest.

Research indicates that the total spending on inpatient care for Black people is 2.4 times higher than their White counterparts.[83] The scale of over spend is particularly pronounced in regard to medium secure and psychiatric intensive care units.[84]

Research published by the Institute of Psychiatry in association with the World Health Authority shows that 40 per cent of Black men currently detained in high security hospitals do not require that level of security and should be in less secure and more therapeutic environments.[85]

Chapter Six on primary care describes how GPs usually see people with mental health problems first and are well-placed to intervene early, if they have the necessary expertise and awareness. Timely (and preferably early) intervention is important given that delay in accessing

81 Sashidharan S, for the National Institute of Mental Health in England, *Inside Outside: Improving mental health services for black and minority ethnic communities in England*, London: National Institute of Mental Health in England, 2003
82 Care Quality Commission, *Count Me In 2008. Results of the 2008 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*, London: Care Quality Commission, 2009, p6
83 The Sainsbury Centre for Mental Health, *Policy Paper 6: The cost of race inequality*, London: Sainsbury Centre for Mental Health, 2006
84 Ibid
85 Thornicroft G, *Ethnicity of inpatients in high security psychiatric hospitals in England: Delivering Race Equality in Mental Health Care*; London: IOP, Kings College London, World Health Organisation Collaborating Centre, 2006

support is one of the reasons for higher rates of hospital admission and more complex and intrusive interventions, including compulsory detention and seclusion.[86] Police involvement and compulsory admissions for BME groups are strongly associated with the absence of GP involvement that flows from the perceived and actual barriers to care identified by research.[87]

Removing these barriers in order to improve access to mental health care for ethnic minorities is not simply about making GPs more aware of BME communities' needs, appointment procedures more simple or services more flexible. Moffatt et al draw attention to the need for a broader definition of 'pathways to care' that includes the ways people seek help in the community *before* making any contact with statutory services.[88] Such an approach expands existing pathways models to include the voluntary sector, traditional healers and specialist services. A 'pathway' is defined by them as 'the *flow* of patients, service users or help seekers with mental distress *into* services or *between* services or professionals'.[89]

We describe elsewhere in this report the need to make 'broader pathways' a focus of improvement in mental health care, including routes into, through and out of care across statutory and non-statutory sectors. The BVCS cannot be overlooked in this context. It has a vital role to play in acting as a bridge between mentally unwell people and GPs/other statutory services and also in advocacy, particularly in deprived areas where a disproportionate number of BME people use mental health services.

The BVCS also has a strong track record of providing culturally appropriate, easily accessible care based in the heart of the community often at a fraction of the cost of mainstream services, which enables it to play an irreplaceable role in health and social care delivery. It actively works to prevent admissions and readmission into the system and to provide early treatment, mainly in the community. The work of the BVCS is not only economically sound, but potentially saves lives.

We recommend that GPs work more closely and respectfully in partnership with the BVCS (given their bridging role) and that CCGs explore how they can, jointly with local authorities, commission effective BVCS services that provide the necessary guarantees of public safety and meet agreed standards. Consulting with minority ethnic groups on the planning and commissioning is also essential if service users are to shape services and there is to be better carer and community engagement. Innovative projects based around statutory services that have a component of outreach should also be explored, piloted and commissioned as the evidence base of their effectiveness grows. Referring again to the locked hexagon approach, this will build staff and manager skill development. We explore how statutory services could work more effectively in the community and the characteristics of successful BVCS projects in more depth in the next section.

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86 Keating F et al, *Breaking the Circles of Fear: A Review of the Relationship between Mental Health Services and African and Caribbean communities*, London: Sainsbury Centre for Mental Health, 2002; Office of the Deputy Prime Minister, *Mental Health and Social Exclusion: Social Exclusion Unit Report 126*, London: Office of the Deputy Prime Minister, 2004

87 Chirico S et al, *The Toolbox: Culturally Competent Organisations, Services and Pathways*, Bedford: Bedfordshire Health Promotion Agency and De Montfort University, 2001; Royal College of Psychiatrists, *Report of the Ethnic Issues Project Group London, Council Report CR92*, London: Royal College of Psychiatrists, 2001

88 Moffat J et al, 'Improving Pathways into Mental Health Care for Black and Ethnic Minority Groups: A Systematic Review of the Grey Literature', *International Review of Psychiatry*, 21, 2009, pp439-449

89 Ibid, p439

5.6 Caring in the community for 'hard to reach groups'

Case study: 'Cares of Life'

Evidence given at the CSJ hearing on mental health and ethnicity by consultant psychiatrist at South London and Maudsley NHS Trust, Dr Dele Oladije, illustrated how statutory services can work innovatively with what are considered to be 'hard to reach' groups, particularly among African-Caribbean communities, who do not voluntarily seek out services due to reasons outlined earlier in this chapter.

The 'Cares of Life' Project was a new service designed to encourage Black people to seek help for mental health problems. This group was identified as having higher unmet mental health needs compared to White majority groups, and adverse experiences of specialist mental health services meant they were less likely to remain in contact with services.[90]

Dr Oladije led a team of six, mostly Black, psychology graduates who were recruited as community health workers, providing a range of services. They attended local events and promoted the project with a red double-decker Health Bus, regularly parked in the same spot in Peckham, south London, and offering simple physical health checks as well as the chance to talk about any possible emotional or psychological problems. By talking about the 'cares of life' rather than mental health problems per se this significantly reduced any stigma that might be associated with accessing the service.

They worked directly with people and only referred those with complex mental health problems for specialist help. They were based in a building used by voluntary organisations and advertised their services by visiting churches, barbershops and local voluntary groups.

The Cares of Life project worked to break down many of the barriers which exist to accessing culturally competent community based services. This project made mental health services user-friendly and accessible. They also trained 13 barbers to certificate-level in counselling/listening skills, thus embedding skills in the community and making people less dependent on professionals. A randomised control trial conducted on this project showed that early detection of illness and provision of acceptable treatments are likely to lead to higher levels of satisfaction with services and decrease mistrust.[91]

'This project proved very effective in showing that culturally acceptable psychosocial interventions can be delivered in the community to individuals from BME groups with anxiety and depression in the spaces where they feel comfortable. This overcomes much of the stigma and also fear associated with mental health services, with no significant cost implications.'

Dr Dele Oladeji, consultant psychiatrist and Director, Cares of Life

Evidence given to the Review by Alicia Spence, Services Director of the African Caribbean Community Initiative (ACCI) in Wolverhampton, highlights that many voluntary services are capable of delivering services that:

■ Satisfy the requirements of safety and security, both for the individual service-user and the wider community;

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90 Afuwape S et al, 'The Cares of Life Project (CoLP): An exploratory randomised controlled trial of a community-based intervention for black people with common mental disorder', *Journal of Affective Disorders*, 127, 2010, pp370-374

91 Ibid

- Enjoy a high level of service user satisfaction and engagement; and
- Cost a fraction of what it takes to run statutory inpatient services.

The West Midlands NHS Regional Development Centre promotes ACCI saying:

> 'Since 1987, [it] has aimed to provide a range of person centred and culturally appropriate services to meet the needs of the African Caribbean individuals and families experiencing or recovering from mental ill-health. ACCI has also been instrumental in influencing local, regional and national mental health policy development and service delivery'.[92]

Research published by the Mayor of London also highlights the valuable contribution that Black voluntary organisations make to service provision at a fraction of the cost.[93]

Lessons need to be learnt from the achievements of agencies such as the ACCI, particularly when evaluating how risk is managed in the community. They have an excellent track record of managing instances that other agencies have considered 'beyond help', as illustrated in the case study below.

Case study: St Jude's assertively managed community-based support service

St Jude's is a specialist service offering emotional support and assistance for people who have serious and enduring mental health and substance misuse problems. This service is five years old and has a strong track record in effectively managing what is considered to be one of the most challenging client groups, categorised by other third sector services as beyond help.

It has been set up for African Caribbean men who have enduring mental health problems and are engaged with forensic and other criminal justice-based services. It is one of the only services in the country (and may actually be one-of-a-kind) providing community-based care for this client group. It is staffed by support workers 24 hours a day, not least because the six clients resident at St Jude's are particularly vulnerable due to their substance misuse problems – drug dealers routinely target those in the community with mental health problems. This risk is addressed by having an assertive presence at this service.

Part of the support is the appointeeship scheme that has been agreed by the DWP where the management of clients' money is agreed with the staff. A budget is drawn up for food, clients are encouraged to save, and they then negotiate how the rest is spent. Unlike other services where people in this client group are just 'contained', ACCI build in a support plan that incorporates what they want to achieve and includes therapeutic intervention. They work with the YMCA, as well as with the police and probation service work, and the local community mental health team for those who need medication.

> 'It is a valued service, and cost a fraction of what would be paid out to keep these men in forensic care, where the evidence shows that they don't get any better. The through-put at St Jude's is not that great but we are working with a group that have such a high set of needs that keeping them stable and in the community is an achievement.'

Alicia Spence, Service Director, ACCI

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92   NHS West Midlands Regional Development Centre, *Briefing paper on Models of Mental Health Care for Black African Caribbean communities*, Birmingham: NHS West Midlands Regional Development Centre, 2009 [accessed via: http://www.wmrdc.org.uk/silo/files/moc-african-caribbean-final.pdf (26/09/11)]
93   Mayor of London, *Towards a Blueprint for Action: Building Capacity in the Black and Minority Ethnic Voluntary Community Sector Providing Mental Health Services*, London: Greater London Authority, 2005

In summary, the history of BVCS organisations has been that they were originally set up in order to plug a gap in statutory service provision. They effectively supplement services and offer choice. They can also be more responsive to client needs because they are not encumbered by as much bureaucracy as the statutory sector, and can therefore act more quickly, even in circumstances that required them to act outside their usual remit. Their willingness to work outside of conventional office hours and support clients and their families meets an ongoing need and they tend to be highly valued by those using them.[94, 95]

However, more needs to be done in terms of capacity development in the BVCS to enable organisations to play a greater role in both the delivering of services and the commissioning process, as the under resourcing of this sector has resulted in a number of agencies being forced to close, despite the need for their services remaining.

In conclusion, **we recommend a pervasive and explicit shift to a more community-based and culturally appropriate pattern of care for this group, whether through outreach by statutory services or the often pioneering work of BME voluntary and community organisations**. Ensuring that resources are appropriately allocated to meet mental health needs at a community level can prevent people reaching crisis point. This would improve outcomes but also save expenditure, by reducing the demand for high-cost services.[96]

5.7 Refugees and asylum seekers

Research into the mental health needs of asylum seekers and refugees has shown that they are likely to experience poorer mental health than native populations.[97] This group routinely faces isolation, poverty and destitution, which can have a debilitating impact on their mental health and wellbeing; they are amongst the most vulnerable and socially excluded people in our society.[98]

There were 17,790 applications for British asylum in 2010. The Home Office listed Iran, Sri Lanka, Pakistan, China including Taiwan, Zimbabwe, Nigeria, Eritrea, Sudan and India as the top ten asylum producing countries for Q4 2009 and 2010.[99]

Psychological distress such as anxiety and post-traumatic stress is common among refugees and asylum seekers. This can be exacerbated by the UK's complex asylum seeker process, detention centres and aspects of UK life.[100] A lack of support and resources for refugees

94   Ibid
95   University of Central Lancashire International School for Communities, Rights and Inclusion, *Delivering Race Equality in Mental Health Care: Report on the findings and outcomes of the community engagement programme 2005-2008*, Preston: University of Central Lancashire, 2010
96   Ibid
97   Tribe R, 'Mental health of refugees and asylum-seekers', *Advances in Psychiatric Treatment,* 8, 2002, pp240-247; Burnett A and Peel M, 'Asylum seekers and refugees in Britain. Health needs of asylum seekers and refugees' *British Medical Journal,* 322, 2001, pp544-547
98   Mind, *A civilised society: mental health provision for refugees and asylum seekers in England and Wales*, London: Mind, 2009
99   Refugee Council Statistics, *Asylum statistics,* London: Refugee Council Statistics, 2011
100   Bernardes, D et al, 'Asylum seekers' perspectives on their mental health and view on health and social services: Contributions for service provision using a mixed-methods approach', *International Journal of Migration,* 6, 2010, pp3-19

and asylum seekers can also worsen pre-existing mental health conditions and lead to the development of new issues.[101] The CSJ report on refugees and asylum seekers, *Asylum Matters*, stated that it is in the interests of public health to ensure this group is not excluded from accessing healthcare, and that more work needs to be done in collaboration with refugee community organisations to ensure more culturally appropriate services are developed for this group.[102] *Asylum Matters* also showed that:

■ The destitution often faced by this group has an impact on mental and physical health as 30-50 per cent of homeless people experience mental health problems. (Although there are no official figures on the extent of destitution among refugees and asylum-seekers in England and Wales, some estimates range from 300,000 to 500,000 people.[103])

■ Asylum seekers left with ongoing and prolonged uncertainty about their legal status have higher levels of anxiety, which can lead to mental health and behavioural concerns. This can affect decision making, ability to cope and function (see quotes in box below) and thus the return or resettlement process.[104]

■ 80 per cent of asylum seeking parents who were surveyed in January 2006 were found to have mental health problems.[105]

Anxieties due to an uncertain future – often preceded by a traumatic past

'I am feeling so uneasy and afraid because I haven't got a letter for my interview yet, and they don't allow me to work, nothing, I just stay at home, with my flashbacks.'

Asylum seeker[106]

'Very difficult time for me; I feel every time worry and thinking all the time; cannot stop thinking. I am worrying about me, what about my life in this country, what about me? What the Home Office is going to do with me, with my future?'

Asylum seeker[107]

Research indicates the mental healthcare system is not helping refugees and asylum-seekers to move on with their lives and, in particular, children and young people are being failed.

101 Mind, *A civilised society: mental health provision for refugees and asylum seekers in England and Wales*, London: Mind, 2009
102 Centre for Social Justice, *Breakthrough Britain Asylum Matters: restoring trust in the UK asylum system*, London: Centre for Social Justice, 2008
103 Mind, *A civilised society: mental health provision for refugees and asylum-seekers in England and Wales*, London: Mind, 2009
104 Centre for Social Justice, *Breakthrough Britain. Asylum Matters: Restoring Trust in the UK Asylum system*, London: Centre for Social Justice, 2008
105 Refugee Action and Refugee Council, *Inhumane and Ineffective – Section 9 in Practice*, London: Refugee Council, 2006, p3
106 Bernardes D et al, 'Asylum seekers' perspectives on their mental health and view on health and social services: Contributions for service provision using a mixed-methods approach', *International Journal of Migration*, 6, 2010
107 Ibid

- Language, cultural differences and factors bound up with their experiences as refugees can make it very hard for this group to access mental health services.[108]
- Research mapping the services that are available to refugees and asylum seekers highlights a lack of understanding of their mental health needs; which, as a result, often leads to them not getting access to crucial services and treatments.[109]

Former service users now employed in care services and broadcasting as a result of the support and therapy they obtained through a voluntary sector organisation

The Review took evidence from Sussex Partnership NHS Foundation Trust, which treats a high number of refugees and asylum seekers with mental health issues. They described how, once people have been granted leave to remain, they need a high level of *social* as well as mental health support to meet what they referred to as their human needs. Claiming benefits, accessing housing and enrolling themselves and their children in education tend to be highly stressful on top of the distress they have previously experienced both in their country of origin and as a result of the asylum-granting process in the UK (for example, the restrictive policies they have been grappling with concerning healthcare, education, accommodation and employment).[110] We were told by a community psychiatric nurse 'if this social support was there it would alleviate some of that distress.'

Research has concluded that mainstream services need to draw insights from the many groundbreaking ways specialist services in the voluntary and statutory sector have risen to the challenge to provide culturally appropriate services, which acknowledge and meet their diverse needs.[111] Other studies emphasise the need for a community approach which enable and support asylum seekers to make use of their coping strategies (which may be considerable, given all that they have endured and survived) 'to meet the challenges of pre-migration traumas and post-migration living difficulties'.[112]

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108 Ibid

109 Fernando S, *Mental Health Race and Culture,* Basingstoke: Palgrave, Second Edition, 2002

110 Mind, *A civilised society: mental health provision for refugees and asylum seekers in England and Wales,* London: Mind, 2009

111 Ibid

112 Bernardes D et al, 'Asylum seekers' perspectives on their mental health and view on health and social services: Contributions for service provision using a mixed-methods approach', *International Journal of Migration,* 6, 2010, p19

This Review visited projects, such as that run by My Time in Birmingham, which not only have professional clinicians trained in intercultural therapies but also provide vitally important 'places to go' in the community. Vulnerable people like asylum seekers need to have a 'safe haven' in a society which can feel very alien and unwelcoming, not least because of the trauma they have suffered before arrival. Services that provide communal meals, training opportunities and manageable, well-supervised challenges for people with mental health needs can make an enormous contribution to their recovery. They can also help to keep families together by tackling underlying causes of dysfunction, particularly mental illness in the parents that threaten their ability to keep children safe. Without culturally sensitive help, these problems may lead to care proceedings and, or adversely impact the mental health of children, many of whom will have already faced significant adversity.

Case study: Tackling family breakdown in asylum seeker families – My Time

My Time is a user-led third sector initiative (community interest company) established in 2002 in Small Heath, Birmingham that provides a holistic inter-cultural and multi-lingual mental health psychological and psychiatric clinical service. My Time supports people from many cultures with mental health problems, some of whom are or have been asylum seekers. It is effectively a one-stop agency working with the family that acts as a brokerage for all the agencies involved. It is able to make sure every angle is covered and that causes as well as the symptoms of mental ill-health are addressed.

The aim is to address mental health and domestic violence issues to prevent the family unit from total breakdown that would put the children into the Child Protection arena or, if this has happened, work to reverse the situation where possible so children are reunited with their family. My Time has found that many families could have improved and with the right support could have been reunified safely in the child's best interest.

Their work with women experiencing depression due to domestic violence showed that support agencies often responded by taking the mother and child(ren) out of the situation, isolating and banning the father from contact, or removing the child(ren). Domestic violence was seen in a single perspective of victim and perpetrator, and contributing factors to violent behaviour (such as unresolved trauma related to their history of seeking asylum) rarely explored. Mental health was not examined in depth and the short-term safety of child(ren) and mother would become the permanent solution. However, they found that many of the women and children involved wanted an alternative that looked at the cause rather than the symptoms, and wanted to keep their family unit together or develop a new unit that involved safe child contact with both parents. They wanted behaviour change. The Family Action for Choice Tomorrow programme engages with all family members but particularly the father, who often presents as the main 'disruptive' element.

My Time's experience of families where English is not the first language is that the process can be very slow and complex, problems can escalate unnecessarily with legal and child protection systems creating another set of problems. Yet the longer the process (court proceedings, assessments, etc) and the longer a child is in care or in care proceedings, safe family reunification becomes increasingly difficult. My Time's two year action research project found that when a community-based initiative providing a quick response multi-disciplined family therapeutic team worked closely as a bridge between legal, health and children's services, there was a stronger chance for a positive outcome.[113]

While there is no clear funding stream for this bridging work, the savings such an initiative can have on public sector costs could be significant. My Time has been working with C4EO on developing Social Impact models that provide clear evidence of intervention savings for local authorities to provide an argument that funding should be linked to social impact and cost savings.

113   Lilley M et al, *My Time CIC Evaluation Report: Family Action for Choice Tomorrow 2009-2011*, Birmingham: 2011; see C4EO, *C4EO theme: Families, Parents and Carers – further case studies* [accessed via: http://www.c4eo.org.uk/localpractice/files/403-fact-case-studies.pdf (10/10/11)]

CCGs and local authorities need to recognise the need for and invest in the development of appropriate services for refugees and asylum seekers. Mental health advocates who can provide social and emotional support, and access to education and training would also significantly benefit this group.

We recommend prioritising such community 'places to go' in local mental health service planning, especially but not exclusively where there are refugee and asylum seeking communities. One-stop agencies that can negotiate with all the agencies involved in the health and social care of vulnerable people and provide a range of person-centred services including therapy and work-related training have been shown to aid recovery and build social capital. Many of them are community interest companies with service-users in key decision-making roles who are therefore shaping services. They provide key elements of the 'locked hexagon' to the wider system by promoting education, employment, training and volunteering. They also use narrative approaches quite literally by, for example, running writing and publishing projects so that people can tell their stories and feel they have a voice. This can be highly therapeutic for a person who feels diminished and forgotten through their experiences but it also builds essential language skills.

5.8 BME older people

The proportion of people over the age of 65 years in BME groups in England and Wales is increasing. 7.1 per cent of all elderly individuals in England and Wales were from BME groups in the 2001 population census, with an estimated total of 531,909.[114] Figure 5 below shows the proportion of individuals aged over 65 in each ethnic group, the proportion of young-old (between 55 and 75 years of age) to old-old (over 75 years of age) and the sex ratio.

Dementia and depression are the most prevalent mental disorders in people of older age. According to population-based epidemiological studies, the prevalence of dementia and depression among older people from different BME groups in the UK is generally similar to or higher than that among indigenous older people.[115] BME older people who were unable to speak English were found to have a higher prevalence of dementia.[116]

Research in Islington found that African-Caribbean older people compared with White British older people were more likely neither to view depression as an illness, nor to consult their GP or psychiatric services. Rather they perceive depression as stigmatising – and consider that spiritual help could be more appropriate.[117] At the same time, African-Caribbean, south Asian and White British older people with treated and untreated depression expressed a willingness and desire to talk about psychological problems, but did not consider there GP had sufficient time to hear them.[118]

114 Royal College of Psychiatrists, *Psychiatric services for black and minority ethnic older people*, London: Royal College of Psychiatrists, 2009

115 Bhatnagar KS and Frank J, 'Psychiatric disorders in elderly from the Indian subcontinent living in Bradford', *International Journal of Geriatric Psychiatry,* 12, 1997, pp907-912; Lindesay J et al, 'The Mini-Mental State Examination (MMSE) in an elderly immigrant Gujarati population in the United Kingdom', *International Journal of Geriatric Psychiatry,* 12, 1997a, pp1155-1167; McCracken CF et al, 'Prevalence of dementia and depression among elderly people in black and ethnic minorities', *The British Journal of Psychiatry,* 171, 1997, pp269-273; Richards M et al, 'Cognitive function in UK community dwelling African Caribbean and white elders: a pilot study', *International Journal of Geriatric Psychiatry,* 15, 2000, pp621-630; Livingston G et al, 'Mental health of migrant elders – the Islington Study', *The British Journal of Psychiatry,* 179, 2001, pp361-366

116 Royal College of Psychiatrists, *Psychiatric services for black and minority ethnic older people*, London: Royal College of Psychiatrists, 2009

117 Marwaha S and Livingston G, 'Stigma, racism or choice. Why do depressed ethnic elders avoid psychiatrists', *Journal of affective Disorders,* 72, 2002, pp257-265

118 Lawrence V et al, 'Coping with depression in later life: a qualitative study of help-seeking in three ethnic groups', *Psychological Medicine*, 36, 2006b, pp1375-1383

Figure 5: Demographic characteristics – summary from the 2001 population census			
Ethnic group	Proportion of individuals aged over 65 years in ethnic group (%)	Young-old: old-old ratio	Male: female ratio
Total population	15.9	0.74	0.73
White British	17.1	0.73	0.72
All Black and minority ethnic groups combined	8.2		
Irish	24.9	0.82	0.72
Other White	10.4	0.75	1.08
White and Black Caribbean	2.36	0.76	0.92
White and Black African	2.24	0.78	0.81
White and Asian	3.5	0.82	0.84
Other mixed	3.4	0.77	0.75
Indian	6.6	0.85	0.99
Pakistani	4.1	0.88	1.24
Bangladeshi	3.23	0.93	1.96
Other Asian	5.18	0.86	1.11
Black Caribbean	10.6	0.89	1.05
Black African	2.3	0.97	1.05
Other Black	3.18	0.82	0.96
Chinese	5.13	0.87	0.87
Other Black and minority groups	2.9	0.83	0.76

Source: *Psychiatric services for Black and minority ethnic older people,* College Report CR156, 2009

The RCPsych has reported that BME older people are often unaware of available services and the procedures they need to go through to access them; they are also more likely to be turned down by service providers and, if they are accepted, be more prone to dissatisfaction.[119] Although there is some evidence that this may be changing, it also reports that progress in developing and improving services for BME older people with mental health problems has been slow, with only a few examples of good practice.[120]

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119 Lindesay J et al, 'Knowledge, uptake and availability of health and social services among Asian Gujarati and white elders', *Ethnicity and Health*, 2, 1997b, pp59-69; Bowes A and Wilkinson H, 'We didn't know it would get so bad': South Asian experiences of dementia and service response', *Health and Social Care in the Community,* 11, 2003, pp387-396

120 Redelinghuys J and Shah AK, 'Characteristics of ethnic elders of Indian sub-continent origin in a west London psychogeriatric service', Ageing and Mental Health, 1, 1997, pp243-247; Richards M et al, 'Social support and activities of daily living in older Afro-Caribbean and white UK residents', *Age and Ageing*, 27, 1998, pp252-253; Odutoye K and Shah AK, 'The clinical and demographic characteristics of ethnic elders from the Indian sub-continent newly referred to a psychogeriatric service', *International Journal of Geriatric Psychiatry*, 14, 1999, pp446-453; Livingston G et al, 'Accessibility of health and social services to immigrant elders: the Islington Study', *The British Journal of Psychiatry,* 180, 2002, pp369-373; Bhatkal S and Shah AK, 'Clinical and demographic characteristics of elderly Poles referred to a psychogeriatric service', *International Psychogeriatrics*, 16, 2004, pp351-360

Older Chinese people and mental health

While data from Count Me In census reports shows that Chinese men and women are admitted in relatively low numbers to inpatient facilities, a London borough study showed that cultural concepts of mental health, language difficulties and the stigma of mental illness (perceived by many in this community to be evidence of a lack of self-control and weakness) all have a significant bearing on whether or not Chinese older people recognise mental health problems and subsequently seek help from statutory mental health services.[121] One interviewee expressed the typical view that 'Chinese people don't think that mental illness is an illness. Chinese people can take more pressure than other ethnic group'.[122]

RCPsych recognises an urgent need to identify further examples of good practice to enable specific principles and components relating to the management, organisation and delivery of services work well for older people to be teased out so they can be widely shared and locally championed for the benefit of all old age psychiatric services (OAPS).

Evidence already suggests that OAPS aiming to be equally accessible to minorities tend to have the following characteristics:

- They employ bilingual healthcare workers and/or community psychiatric nurses;
- There is no problem obtaining professional interpreters;
- Staffing composition is representative of local demography; and
- They work collaboratively with voluntary sector organisations meeting BME older people and their carers' needs.[123]

To support the local delivery of several elements of the 'locked hexagon' approach described earlier (training, skill development, services shaped by 'expert' service users and carer/community engagement) the Policy Research Institute on Ageing and Ethnicity has identified the need to provide training to:

- Local BME voluntary sector organisations to whom GPs and other clinicians refer patients with dementia and depression;
- Develop cultural competency throughout services; and
- BME older people themselves, to raise their awareness of how care can be accessed, what resources are available and where they can find local information about depression and dementia.[124]

The aim of the latter is to encourage and enable BME older people to become informal advocates for people in their social networks so they can help them educate themselves and obtain

121 Chinese National Healthy Living Centre, *The mental health service needs of Chinese elders in Westminster, Kensington and Chelsea and Brent,* London: Chinese National Healthy Living Centre, 2008

122 Ibid, p30

123 Redelinghuys J and Shah AK, 'Characteristics of ethnic elders of Indian sub-continent origin in a west London psychogeriatric service', *Ageing and Mental Health,* 1, 1997, pp243-247; Hoxey K, Mukherjee S and Shah AK, 'Psychiatric services for ethnic elders', *CPD Bulletin: Old Age Psychiatry,* 1, 1999, pp44-46; Odutoye K and Shah AK, 'The clinical and demographic characteristics of ethnic elders from the Indian sub-continent newly referred to a psychogeriatric service', *International Journal of Geriatric Psychiatry,* 14, 1999, pp446-453; Bhatkal S and Shah AK, 'Clinical and demographic characteristics of elderly Poles referred to a psychogeriatric service', *International Psychogeriatrics,* 16, 2004, pp351-360

124 Royal College of Psychiatrists, *Psychiatric services for Black and minority ethnic older people,* London: Royal College of Psychiatrists, 2009

assistance if necessary. This is particularly important in dementia because there is often a significant length of time between the onset of symptoms and the seeking of help. This takes an average 18 to 24 months, during which time potentially irreversible changes can take place in the relationship between a person with dementia and their family, particularly to do with memory loss.[125]

Although stigma is implicated in this delay, it is still too often the case that key symptoms of dementia are put down solely to the ageing process. The Old Age faculty of the RCPsych emphasise the important role the third sector and mental health charities as well as health (particularly primary care) and social services must play in improving dementia awareness. We would add relational networks to this list. Untreated depression also leads to poor outcomes; this could be avoided in many cases by earlier diagnosis which again requires the involvement of primary care, working in partnership where necessary with OAPS.

The emphasis on the role of the BVCS in this area of need as in others, is not meant to distract or detract from the need for specialist mental health care for older people. Research indicates the superiority in outcomes from providing specialist geriatric medicine services to older people in comparison with non-specialist treatment.[126] It is the BVCS' bridging role to statutory services that is often overlooked.

5.9 BME children and young people

Government-commissioned reports such as the 2004 *National Service Framework for Children, Young People and Maternity Services* and the more recent 2008 national review of CAMHS both acknowledge that the mental health needs of BME children and young people are not being met by mainstream (statutory CAMHS) services.[127] Moreover, a more recent report states that "it is unclear how the twelve characteristics and related actions of 'Delivering Race Equality in Mental Health Care'... to improve the mental health of BME communities has been followed through into child and adolescent mental health services".[128] With the exception of a few examples of good practice, they concluded that there seems to have been a lack of significant implementation throughout CAMHS. The report also highlights the lack of voices and experiences of young people from minority groups in the shaping of these services (an essential element of the locked hexagon approach).

Relative to their proportion in the overall population, fewer children from these groups are accessing CAMHS in contrast to the greater numbers of minorities in adult services. They are, similar to adults from this group, more likely to come to the attention of services at crisis point. However, as has been said in Chapter Four, this would not always be the service of first preference for children and young people because it is stigmatising, often not easy to access and may treat the

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125 Old Age Faculty of the Royal College of Psychiatrists, *Response to (DH) National review of age discrimination in health and social care*, 2009
126 Baztan JJ et al, 'Effectiveness of acute geriatric units on functional decline, living at home and case fatality among older people admitted to hospital for acute medical disorders' *British Medical Journal*, 2009, 338, b50
127 Department of Health, Department of Education and skills, *National service framework for children, young people and maternity services*, Norwich: The Stationery Office, 2004; Department of Health, *Children and young people in mind: the final report of the National CAMHS Review*, Norwich: The Stationery Office, 2008
128 The Afiya Trust, *Enjoy, achieve and be healthy: The mental health of black and minority ethnic children and young people*, London: The Afiya Trust, 2011, p5

child in isolation, without paying sufficient attention to the wider family dynamics. Our comments in Chapter Four about the need for a family-centred service are no less relevant in this context.

The new mental health strategy, *No Health without Mental Health*, for the first time acknowledges the importance of integrating CAMHS with adult mental health services. It also states that equality in mental health care is as much about social justice as it is about health care.[129] There are many other additional factors to consider in the area of CAMHS for BME groups such as education, culture, language barriers and socio-economic factors.

> 'Few mainstream public services are mentioned as potential sources of support with greater reliance being on family, social networks and community organisations. Individuals demonstrating positive attributes and attitudes to young people and places that offer privacy and information relevant to addressing individual difficulties, emerge as the key factors being supportive to enabling young people to access help and support.'[130]

In order that these barriers are broken down and BME children and young people get access to the specialist mental health care they need, partnership working between CAMHS and community agencies working in this arena is essential; these providers tend to be able to show an empathy and understanding which makes accessing services via these agencies more feasible for these groups.[131]

We reiterate our recommendation from Chapter Four that **local commissioners should ensure child- and teenager-friendly services are available. These should be non-stigmatising, integrated with other services, designed with the involvement of the young people in the target population and easily accessible**.

5.10 Summary of recommendations

- The 'locked hexagon' approach suggested by research to be effective is consistently implemented and evaluated with its six elements of: clear, locally set targets for improvement (ideally of outcomes rather than inputs); service users shaping services; use of narrative approaches and explanatory models (patients and clinicians working together to construct a story that makes sense of mental disorder for each individual); promotion of education, employment, training and volunteering; staff and manager knowledge and skill development; carer and community engagement.

129 HM Government and Department of Health, *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*, London: HM Government, 2010
130 The Afiya Trust, *Enjoy, achieve and be healthy: The mental health of black and minority ethnic children and young people*, London: The Afiya Trust, 201, p41
131 Ibid

- Acting to ensure that no people with severe mental health problems are in prison, particularly through early and appropriate diversion, greater use of independent sector providers where necessary and freeing up NHS and other secure services by tackling risk-aversion and other causes of bed-blocking involving non-forensic patients.

- Independent investigations into preventable deaths: An independent investigation needs to be conducted whenever deaths of patients detained under the Mental Health Act occur that are not due to natural causes. A commitment also needs to be made to see a reduction in the numbers of such death nationally, with health providers publishing this data in their annual reports.

- Health- and community-based places of safety as alternatives to police-based places of safety need to be readily available for mental health patients who are sectioned by the police under the Mental Health Act. Resourcing to ensure sufficient staffing of such places must be prioritised. These facilities should adhere to the RCPyschs' standards on places of safety (2011).

- Right to advocacy before detention: Independent support and advice needs to be available before detention, when patients attend tribunal hearings and when they are being discharged in order to help patients' access aftercare services. There also needs to be advocacy support for carers who are often ill equipped to navigate the system or mental health law.

- Community Treatment Orders: Black or Black British patients are subject to these new restrictions in greater numbers than any other group, raising serious concerns because of their coercive nature and the limited international evidence for positive effects. Although they can work well in certain circumstances, this is a provision that extends compulsion and increases stigma which hinders recovery and reintegration back into the community. If the Care Quality Commission continues to find that numbers remain high, this is a priority area for parliamentary scrutiny in advance or as part of an overarching review of mental health legislation.

- The role of GPs and pathways into care: We recommend that GPs work more closely and respectfully in partnership with the BVCS (given their bridging role) and that CCGs explore how they can, jointly with local authorities, commission effective BVCS services that provide the necessary guarantees of public safety and meet agreed standards.

- Caring in the community for 'hard to reach groups': Innovative projects drawing in the BVCS and based around statutory services that have a component of outreach should also be explored, piloted and commissioned as the evidence base of their effectiveness grows to enable a shift to a more community-based and culturally appropriate pattern of care for this group.

- Refugees and asylum seekers: Community 'places to go' should be prioritised in local mental health service planning, especially but not exclusively where there are refugee and asylum seeking communities. One-stop agencies that can negotiate access to all the agencies involved in the health and social care of vulnerable people and provide a range of person-centred services including therapy and work-related training have been shown to aid recovery and build social capital. There is a particularly important role for community interest companies where service-users are involved in key decisions. Mental health advocates who can provide social and emotional support, and access to education and work-related training would also significantly benefit this group.

- BME children and young people: Local commissioners should ensure services authentically fit for purpose for the modern child and teenager are available, easily accessible, non-stigmatising, integrated with other services and designed with the involvement of the young people in the target population.

chapter six

Primary care – 'a stitch in time'

6.1 Introduction

This chapter describes how important primary care is in a) moving all of healthcare towards a public health approach that promotes wellbeing and prevention, and b) supporting people with mental distress and ill-health to fulfil their potential, for example by helping them become more work-ready. As Dame Carol Black's review of working age health states, 'Common mental health problems (and musculoskeletal disorders) are the major causes of sickness absence and worklessness due to ill-health'.[1] Completing the revolution to embed high quality, integrated and recovery-oriented care in the community requires primary care to be much more of an enabling gateway to the whole range of support many people need. This is vital if we are to overturn the inverse care law. Primary care also provides opportunities for early intervention, another principle guiding this Review.

We start by looking at the significant but often unacknowledged role primary care plays across the full spectrum of mental health needs. GPs and nurses help people struggling with everyday, but nonetheless profoundly demanding life events and problems as well as those living with severe disorders like schizophrenia. In this chapter we do not explore this entire continuum of need but focus a) on how primary care operates as a system within wider healthcare and b) how it could better respond to two key challenges affecting people at different points on the severity spectrum.

As always, we are predominantly concerned about how well primary care looks after the most vulnerable where the burden of mental ill-health is concentrated:

- Mental distress forms a large part of the day-to-day workload of primary care but often comes as part of a more complex set of needs. What contribution should primary care be making to address those needs?

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1   Department of Health, *Working for a Healthier Tomorrow: Dame Carol Black's review of the health of Britain's working age population*, Norwich: The Stationery Office, March 2008, p10

- The physical ill-health of those with severe mental disorders is a vital but neglected issue not least because of a lack of clarity about whose responsibility is it to provide physical care – primary care or secondary mental health care.

43 per cent of people polled said they or their relative/close friend received 'a lot' of help and support from their GP, a much greater proportion than those who said a psychiatrist (18 per cent), a therapist (26 per cent) or their friends (29 per cent), but 51 per cent said their family.[2]

We briefly describe the implications of current health reforms for primary mental health care and particularly in relation to these two challenges. Having conducted this Review it is our opinion that the reforms provide a significant opportunity to integrate mental and physical health with each other and with social care to address more effectively the complex and entrenched difficulties in vulnerable people's lives.

It is vital, however, that they are implemented in such a way as to draw in and value the unique contributions the voluntary and private sectors can, and already do, make – albeit on a playing field that is currently often tilted against them and towards statutory services. This will require the formation of strong, properly resourced partnerships with non-statutory providers. These should greatly increase access to the comprehensive packages of care and support necessary for individuals' recovery. We end by focusing on a range of measures that the CSJ believes are achievable to improve primary mental healthcare which unlock the potential of these current health reforms.

6.2 The role and character of primary mental health care

Half a decade ago, at the point when GPs in the UK were beginning to work in group practices, Shepherd and colleagues emphasised that:

'The cardinal requirement for mental health services in this country is not a large expansion and proliferation of psychiatric agencies but rather a strengthening of the family doctor in his/her therapeutic role'.[3]

This view was substantiated by the WHO when it stated in 1978 that 'The primary medical care team is the cornerstone of community psychiatry'.[4]

Our Review concluded that both these statements have incredible resonance today.

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2   CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010
3   Shepherd M, Cooper B and Brown AC, *Psychiatric illness in general practice,* Oxford: Oxford University Press, 1966 in Bennett et al, *Practical Mental Health Commissioning: A framework for local authority and NHS commissioners of mental health and wellbeing services, Volume One: Setting the Scene,* Joint Commissioning Panel for Mental Health Commissioning, March 2011 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20-%20Vol%20One%20%28web%2011_04_05%29.pdf]
4   World Health Organisation, *Alma Ata: global strategy for Health for All by the Year 2000,* Geneva: World Health Organisation, 1978 in ibid

Defining primary care

According to the WHO, primary care centres are:

'Centres that serve as first point of contact with a health professional and provides outpatient medical and nursing care. Services are provided by general practitioners, dentists, community nurses, pharmacists and midwives, among others.'[5]

Approximately nine in ten people in contact with the NHS access these services.[6]

GPs are not the only professionals dealing with mental health problems in primary care. Nurses, receptionists, social workers and pharmacists all deal with mental disorders, but the Review found that they often do so with only rudimentary training and limited confidence.

Primary care is the central provider of mental health services in the NHS, and therefore should be central to any recommendations to improve mental health care. Yet it has been largely sidelined in previous policy discussions. Most patients are treated in primary care yet the myth that mental illness is dealt with in the main by specialised mental health services and that primary care deals with the 'worried well' has so far impeded primary care mental health development.

The landmark publication by Goldberg and Huxley revealed that primary care dealt with 90 per cent of people with mental ill-health, that only ten per cent at any one time were in touch with specialist mental health services in the community, and only a small proportion of that ten per cent required inpatient hospital care.[7] Even for people with severe mental illness, 30-50 per cent receives their care solely from primary care without support from specialist services.[8,9] However, even if GPs wanted that support from mental health specialists, it can be very hard to come by as we describe later. These are mostly people who are in full, partial or temporary remission from their illness but most have continuing needs if they are to establish and maintain a good recovery.

GPs are also often responsible for making the first diagnosis of both the milder and the more serious conditions that will need referral to secondary mental health services. Only about 20 per cent of people presenting to the GP with a mental health problem are ever referred to mental health services, rising to about 50 per cent for those with severe mental health problems.[10]

Given that such a small proportion are referred to secondary care the capacity of primary care to provide a reasonable level of service is also critical to the capacity of secondary care

5   World Health Organisation, Appendix: Definition of terms, [accessed via: http://www.wpro.who.int/nr/rdonlyres/45b45060-a38e-496f-b2c1-bd2dc6c04c52/0/44definitionofterms2009.pdf, p544]

6   Department of Health, *Primary medical care*, 8 April 2011 [accessed via: http://www.dh.gov.uk/en/Healthcare/Primarycare/DH_288 (19/09/11)]

7   Goldberg DP and Huxley P, *Mental Illness in the Community: The pathways to psychiatric care*, London: Tavistock Publications, 1980

8   Kingsland JP and Williams R, 'General Practice should be central to Community Mental Health Services', *British Medical Journal*, 315, 1997, pp1377-1379

9   Kendrick T et al, 'Are specialist mental health services being targeted on the most needy patients? The effects of setting up special services in general practice', *British Journal General Practice*, 50, 2000, pp121-126

10 Goldberg DP and Huxley P, *Mental Illness in the Community: The pathways to psychiatric care*, London: Tavistock Publications, 1980

to deal with its case load. For example, if a GP were to refer, say, ten rather than five in every hundred mentally ill patients it would double the number of patients in psychiatric care. A five per cent change in a GP's threshold for referral is probably imperceptible in each individual practice but a doubling of referrals to secondary care would flood the services, making them significantly less effective.

A secure in-patient mental health unit

This sensitivity to being flooded was partly behind the policy developed in the 1990s to focus psychiatric services on the needs of severe and enduring mental illnesses (schizophrenia and some other psychoses), leaving GPs to care for the more common and supposedly less disabling conditions. That policy created a service gap at the margins – for example when patients had a severe but common condition such as depression that did not fit into the referral expectations of psychiatric services. This has led many GPs to become increasingly frustrated about the support they receive from secondary care.

6.2.1 The culture of primary care

Primary care has a distinct style of working, in a context characterised as a 'swamp where problems are messy, confusing and incapable of technical solution' and 'undifferentiated' problems are presented'.[11]

When working at its best, primary care:

- Provides most of the medical and psychosocial interventions for the majority of those using the NHS;
- Is a free, universal, voluntary, demand-led system working to whole populations and not just to small percentages requiring intensive resources;
- Sees its consumers for short times but over long periods as and when they want, presenting with, often, undifferentiated mixtures of physical, emotional, family and social problems;

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11   Schon D, *The Reflective Practitioner: how professionals think in action*, New York: Basic Books, 1984

- Feels the impact of socio-economic problems through increased consultation rates and workloads;
- Offers a health care setting which is generally preferred by consumers and carers;
- Offers a model based on continuity of care and the importance of the professional/patient relationship, which in turn lends itself to the increasingly important ideas of recovery ('getting one's life back') particularly by focusing on strengths rather than deficits; and
- Is delivered by specialists in generalism – defined by James Willis as taking an interest in whatever is of interest to its clients. It works at the important interface between clients, families, communities and professional worlds.[12, 13, 14]

6.3 The importance of primary care

There are many advantages to providing better mental health care in the primary care setting. From the perspective of people who use services, primary care offers a low stigma service close to home with care from a health practitioner who will, *ideally*,

- Know the person and family;
- Be able to provide comprehensive treatment and continuity of care for the full range of problems including physical health;
- Have good links to local community services that deal with associated social issues; and
- Be best-placed to manage problems that straddle the interface between mind and body, such as medically unexplained symptoms.

Everyone is entitled to register with a practice which means that the vast majority of the population has access to medical care free at the point of delivery. However, some people from disadvantaged groups, such as the homeless or those with severe mental illness (which are overlapping groups) are less likely to be registered with a practice, thus compounding their disadvantage.[15] Similarly many younger people, people from ethnic minorities and alcohol abusers with substantial symptoms of common mental disorder are not receiving any treatment in primary care. This is partly because they have a reluctance to disclose symptoms or report an aversion to certain treatments, particularly drug treatments.[16, 17]

12   Carr-Hill RA, Rice N and Roland M, 'Socio-economic determinants of rates of consultation in general practice', *British Medical Journal*, 312, 1996, pp1008-1012
13   Pilgrim D and Rogers, 'A mental health service users' views of medical practitioners', *Journal of Interprofessional Care*, 7, 1993, pp167–176
14   Willis J, *The Paradox of progress,* Abingdon, Oxon: Radcliffe Medical Press, 1995
15   Lester H, Tritter JQ and Sorohan H, 'Patients' and health professionals' views on primary care for people with serious mental illness: focus group study', *British Medical Journal*, 330, 2005, pp1122-1126
16   Goldberg D and Huxley P, *Common Mental Disorders, A biosocial model*, London: Routledge, 1992
17   Priest RG et al, 'Lay people's attitudes to treatment: results of opinion poll for Defeat Depression Campaign just before its launch', *British Medical Journal*, 313, 1996, pp858-859

The mental health 'triple whammy'

Mental and physical disorders often co-exist, particularly in those who are also experiencing social deprivation. For example people with schizophrenia are at least three times more likely to have diabetes than the general population,[18] and often experience extreme degrees of social isolation and financial and other hardship – while dealing with a severe mental illness. On top of this 'triple whammy' of adversity they can anticipate inferior levels of physical health care, not least because they are less likely to be registered with a GP.[19] This helps to explain why those suffering from both diabetes and schizophrenia have 50 per cent poorer survival rates than those with diabetes alone, and why the health gap for people with schizophrenia is now estimated to cause between 16-25 years reduction in life expectancy.[20, 21]

6.4 Common mental health problems in primary care

Mental health issues are the second most common reason for consultations in primary care.[22] Almost all people who develop a mental health problem see their GP first for advice and treatment. Mental health problems occupy one-third of a GP's time and mental illness and distress account for 30 per cent of GP consultations (with a mental health problem the sole reason for attending in 20-25 per cent of consultations and a feature of up to 40 per cent of consultations).[23, 24] Such problems are characterised by anxiety, depression and somatisation (bodily symptoms driven by psychological causes). They are frequently provoked by stress from family, work, social isolation, chronic physical illness and lifestyles such as substance abuse.

The so-called 'worried well' could be more accurately described as 'worried sick' and can be as disabled as most sufferers of chronic physical diseases, generate major social and financial burdens to families, friends and employers, and consume scarce health resources.[25] Many of them will also be disadvantaged in other ways, given the correlation we described earlier between mental health difficulties and other drivers of poverty. Their problems may be presented to practitioners as undifferentiated mixtures of physical, emotional, family and social symptoms, and made more complicated by shifting combinations of symptoms over time. As a result explanations in terms of discoverable causes often remain elusive. For instance only 20 per cent of patients presenting persisting symptoms in primary care had discoverable physical causes and ten per cent had clear psychological causes.[26]

18   Expert group, 'Schizophrenia and Diabetes 2003' Expert Consensus Meeting, Dublin, 3-4 October 2003: consensus summary', *The British Journal of Psychiatry*, 184, 2004, pp112-114

19   Newcomer J and Hennekens, 'Severe Mental Illness and Risk of Cardiovascular Disease', *Journal of the American Medical Association*, 298, 2007, pp1794-1796

20   Vinogradova Y, Coupland C and Hippisley-Cox J, 'Severe mental illness and survival in people with diabetes', *The British Journal of Psychiatry*, 197, 2010, pp272-277

21   National Association of State Mental Health Program Directors, *Morbidity and Mortality in People with Serious Mental Illness, 13th technical report*, Alexandria, Virginia: National Association of State Mental Health Program Directors, 2006

22   McCormick A et al, *Morbidity statistics from general practice: Fourth National Morbidity Study 1991-1992*, London: Her Majesty's Stationery Office, 1995

23   Office of the Deputy Prime Minister Social Exclusion Unit, *Mental health and Social Exclusion, social exclusion unit report*, London: Office of the Deputy Prime Minister, 2004, p40

24   Goldberg D and Huxley P, *Common mental disorders*, London: Routledge, 1992

25   Melzer H et al, *The prevalence of psychiatric morbidity among adults living in private households*, London: Her Majesty's Stationery Office, 1995

26   Kroenke K and Mangelsdorff AD, 'Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome', *American Journal of Medicine*, 86, 1989, pp262-266

Often primary care is supporting these people with a limited evidence base of what sorts of care and treatments work best because the patients do not easily fall into the diagnostic categories that were the subject of treatment research. Therefore whether the results of that research apply to the patient or not is unknown. While better diagnostic practice by GPs could change this situation many presentations would still not warrant a formal diagnosis of one of the common mental health disorders but may be just as complex and troubling. Separating the biomedical from the psychological and social is often very difficult and the reality of primary care is that only 15-25 per cent of medical decisions made by GPs are based on definable/diagnosable health disorders; the remaining decisions are based on psychosocial needs, patient preferences and the doctor-patient relationship.[27]

The limitations of health systems to cope with uncertainty can be exposed when peoples' problems defy neat diagnostic categorisation. Such uncertainty often leads to unnecessary prescribing and extensive and unproductive investigations: the highest ten per cent of health care utilisers used more consultations, as many prescriptions and more consultant referrals than the lowest 50 per cent of utilisers.[28, 29] Of these high utilisers over half were significantly psychologically distressed. In addition, the primary care practitioners found more than a third of the high utilisers frustrating to work with, as these patients tended to express their distress in somatisation and anxiety.

My Time, a service user led community mental health service in Birmingham (set up as a community interest company and running for almost a decade) made the following observation when giving evidence to the Review:

> 'There is a pattern of over reliance on bottom-line support from the GP who they will go to weekly or very regularly (a form of GP 'fix') and a dependency on the GP being a form of advocate, surrogate parent, confidante, and a passport to medication and reference for benefits or sick notes. The GP honours the patient/doctor relationship and tries to refer their client appropriately to mental health services but when these break down, the GP is left with a constant 'check up/friendly talk' that becomes perpetual'.

6.5 Primary care paradox – resisting the tendency to diagnose

It is important to be aware of a tendency in the international and national mental health fields to pathologise human distress and experience. The American Counseling Association has raised concerns about the lowering of diagnostic thresholds proposed for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, which will have a huge bearing on UK clinical practice. They argue that this:

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27 Blount A, *Integrated primary care: the future of medical and mental health collaboration*, New York, New York: WW Norton and co, 1998
28 Ring A et al, 'The somatising effect of clinical consultation: What patients and doctors say and do not say when patients present medically unexplained physical symptoms', *Social Science and Medicine*, 61, 2005, pp1505-1515
29 Katon W et al, 'Distressed high utilisers of medical care: DSM III R diagnosis and treatment needs', *General Hospital Psychiatry*, 12, 1990, pp355-362

'constitutes pathologizing or medicalizing normal behavior, which goes against the philosophical orientation underlying the counselling profession with its emphasis on individual uniqueness, wellness and development. Examples include removing the grief exclusion criterion from major depressive episode; combining substance abuse and dependence into one disorder that requires only 2 of 11 symptoms; reducing the number and duration of symptoms in generalized anxiety disorder; reducing the number of symptoms required for adults to obtain an ADHD diagnosis; and many more'. [30]

UK policy drivers such as NICE guidelines and the Quality Outcome Framework (QOF, see below) tend to promote a clinical model. Yet even where a person has reached a diagnostic threshold such as depression, this can be as much a social as a clinical condition.

The historian Lisa Appignanesi agrees with this analysis saying;

'There is a battle being waged in the area of mental health. As more and more of our unhappiness is medicalised, as diagnoses are increasingly attached to conditions or aspects of behaviour and the numbers of sufferers grows, people want more service – either more pills or more therapy, even of the kind that comes as a computer programme'. [31]

What is the QOF?

Introduced in 2004 as part of the General Medical Services Contract, the QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients.

The QOF contains groups of indicators, against which practices score points according to their level of achievement. NICE has been asked to focus on the clinical and health improvement indicators in the QOF, which includes a number of domains such as coronary heart disease and hypertension.

It gives an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas, for which they score points. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of the practice list size and prevalence with the results published annually.

The Review learnt that, as with any scheme there are drawbacks and perverse incentives, and it could be better focused on outcomes and addressing root causes of mental illness and more attached to a public health perspective. Yet whilst reform is welcome, current changes being proposed could mean the removal of three indicator measures for depression. It is vital to good quality care that mental health problems are identified early so they can be treated before they require more intensive support later on.

As the NHS Confederation's Mental Health Network director Steve Shrubb stated, 'Removing these indicators would remove any financial incentives to identify the most common form of mental illness in GP surgeries', and that as 'imperfect as the [QOF] indicators are', we agree with the Mental Health Network of the NHS Confederation that 'it would be reckless to remove the depression indicators from the GP treatment framework until suitable alternatives are in place'. [32]

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30   Frances A, 'Who Needs DSM-5? A Strong Warning Comes From Professional Counselors', Psychiatric Times, June 2011, accessed via: http://www.psychiatrictimes.com/blog/couchincrisis/content/article/10168/1874708
31   Appignanesi L, *Sad, Mad and Bad: A History of Women and the Mind Doctors*, London: Virago Press Ltd, 2008, p3
32   NHS Confederation, Press Release, Alternatives needed on depression indicated if proposed changes to QOF menu become reality, 1 August 2011 [accessed via: http://www.nhsconfed.org/PressReleases/Archive/2011/Pages/proposed-changes-to-QOF-menu.aspx (19/09/11)]

Even where a person has reached a diagnostic threshold such as depression, this is as much a social as a clinical condition. Yet treating the 'clinical condition' is what NICE guidelines/QOF promote at the risk of ignoring the social condition. Doing the minimum necessary to achieve the QOF targets is insufficient to achieve what we think is necessary to address the health inequalities affecting the poorest in our society.

Such patients tend to put off getting their health sorted out – the later they come to the GP, the less that can be done, reinforcing the negative spiral. Their presentations are typically complex and invariably have a mental health component, but usually defy straightforward diagnosis (or are 'sub-clinical'; symptoms have not yet developed enough for diagnosis to be accurate) and clinical intervention. This is natural territory for primary care, which should be the gateway to an integrated health and social care solution but at present, this is rarely the case.

Some GPs are already linking up with voluntary and community groups through models such as social prescribing of exercise or arts-based activities with the aim that people take more responsibility for their health. This remains a largely untapped direction. The rising tide of emotional distress could be tackled by such a radically different, health promoting approach to support those who are most vulnerable, rather than with ever increasing health intervention. We return to this theme later because it is a prominent issue in primary care and mental health care in general.

'Only a person-focused (rather than a disease-focused) view of morbidity, in which multiple illnesses interact in myriad ways, can accurately depict the much greater impact of illness among socially disadvantaged people and the nature of the interventions that are required to adequately manage the increased vulnerability to and interactions among diseases. It is time that primary care physicians take leadership in moving medical care where it needs to be: to the care of patients and populations and not the care of diseases. It is not only biologically correct to do so – it is also more effective, more efficient, safer, and more equitable.'[33]

Primary care can help many people in key ways precisely because a reduced reliance on diagnosis and resource-hungry specialist treatments plays to its strengths. A reduced reliance on diagnosis is helpful due to the inadequacy of:

- **Current 'disease' models:** identifying depression as the *disease* someone *has*, can have limited usefulness because of the many other social, physical and emotional factors at play. Although diagnosis and intensive treatment and chronic disease management models can help certain types of mental disorder, these approaches only partially answer the challenge of mental distress in primary care which sees, or should see, the whole person in context.
- **'Body or Mind' dichotomisation:** simplistic 'body or mind' approaches are challenged by several studies of mental disorders in primary care which consistently report the co-occurrence of physical, emotional and social problems in patients, and furthermore

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33   Starfield B, 'The hidden inequity in health care', *International Journal for Equity in Health*, 10, 2011, pp1-3

show such patients to be the highest utilisers of these services.[34, 35, 36, 37, 38] The very idea that it is useful to separate mind and body in this way is particularly problematic.

Yet, at the same time, research suggests that GPs can miss the signs of depression (for example, post-natal depression); when it is identified and treated with antidepressants, these produce superior outcomes to placebo.[39] We are not advocating abandoning diagnosis or prescribing pills, but rather further enhancing these approaches where necessary with 'whole person' solutions. It must also be pointed out that without a diagnosis people are not protected, for example by being able to claim disability discrimination by their employer. Finally, by rejecting any sense that people are suffering from mental *ill*ness this begs the question of why they should be entitled to services from the NHS at all. In summary, this Review is not arguing for a complete removal of the so-called 'illness model' and a dismissal of the importance of the biological in favour of the social, but for a more balanced approach which primary mental health care is well placed to deliver.

6.6 Valuing the GP role as a generalist and provider of comprehensive care

GPs are trained as generalists to diagnose and treat common health problems in their surgeries and in people's own homes, and to recognise when a more complex or dangerous illness requires referral to a specialist. Often GPs have entire families on their lists and are able to take decisions informed by intimate knowledge of the family environment – knowledge which can be crucial in the mental health sphere. Indeed in many countries primary care is actually called Family Practice.

The consultation lies at the heart of a positive doctor-patient relationship and its value cannot be overemphasised. A frequent misconception about the GP consultation is that it is a single ten minute event. However this should be far from the reality experienced by patients. Ideally the brief interventions it affords should be key building blocks of an evolving narrative that is built up over a life-time and enable the continuity of relationship that no other health professional can provide.

The core competencies of a GP include tolerating uncertainty, exploring patients' own health beliefs, considering probability and marginalising danger. When dealing with someone with mental health difficulties, the GP may need to work with such uncertainty and offer watchful waiting, using the passage of time to test if the psychological difficulties are transient, and so avoiding a psychiatric, and somewhat stigmatising, diagnosis.

34   Barrett JA et al, 'The prevalence of psychiatric disorders in primary care practice', *Archives of General Practice*, 45, 1988, pp1100-1106
35   Bridges KW and Goldberg DP, 'Somatic presentation of DSM III psychiatric disorders in primary care', *Journal of Psychosomatic research,* 29, 1985, pp563-569
36   Kaplan CL, Lipkin M and Gordon G, 'Somatisation in primary care: Patients with unexplained and vexing medical problems' *Journal of General Internal Medicine,* 3, 1988, pp177-190
37   Katon W et al, 'A randomised trial of psychiatric consultation with distressed high utilisers', *General Hospital Psychiatry*, 14, 1992, pp86-98
38   Katon W et al, 'Distressed high utilisers of medical care: DSM III R diagnosis and treatment needs', *General Hospital Psychiatry,* 12, 1990, pp355-362
39   Centre for Social Justice, *The Next Generation: a policy report from the Early Years Commission*, London: Centre for Social Justice, 2008

There is clearly a balance to strike here between tolerance of uncertainty and the core function of GPs in managing conditions which may present early and in an undifferentiated way. Moreover serious disorders like psychosis often start off in a similar way to more mild and common ones, and rarely present with clear cut psychotic symptoms. So alongside a tolerance of uncertainty, the GP needs a high index of suspicion.

The Royal College of General Practitioners recognises that health promotion and self-care to make people increasingly responsible for their own well-being are key and core competencies.

As many different sections of this report conclude, families are crucial to good mental health, and primary care is well-placed to recognise and work with the strengths and skills that patients, families and carers bring to the table. Primary care is also crucial in improving the experience of the early years of life (see the section on infant mental health in Chapter Four).

GPs should adopt a comprehensive approach to the patient and their family, concentrating on the advancement of their health and overall wellbeing. GPs are seen to have a responsibility for the individual patient, their family and the wider community, and so need to understand the characteristics of the community including socio-economic, ethnicity and health features.[40]

GPs and older people[41]

Risk factors for depression multiply in older age. It affects ten to 15 per cent of people over 65, though those with physical impairment or neurological disease are far more likely to suffer from depression. Anxiety in older people is less recognised than in younger people, as it is thought to be a more natural condition of older age; as such its treatment is less likely to be effective. Indeed, Dr Nori Graham, Emeritus Consultant in the Psychiatry of Old Age at the Royal Free Hospital, London (and Chair of the CSJ Older Age Review) told us that many older people themselves are more reluctant to talk about mental health issues and put any symptoms down to the ageing process.

Correspondingly, research shows that just 33 per cent of older people who have depression address it with their GP and less than half of these individuals get treatment for it. Older people are often denied the psychological services and counselling that primary care offers those under 65, notwithstanding evidence proving their equal effectiveness.

Dr Peter Connelly, Chair of the RCPsych Faculty of Old Age Psychiatry makes the point that, "In the elderly, minor depression is not 'minor'. At one year after diagnosis of minor depression patients have a seven-fold risk of developing major depression".[42]

40 Royal College of General Practitioners, *Healthy People: promoting health and preventing disease,* London: Royal College of General Practitioners, 2005 [accessed via: http://www.gmc-uk.org/5_Healthy_people_01.pdf_30450948.pdf (20/09/11)]

41 Royal College of Psychiatrists, *Consultation response to the Department of Health's National Review on Age Discrimination in Health and Social Care*, London: Royal College of Psychiatrists, 2009, pp1-15

42 Lyness JM et al, 'One-year outcomes of minor and subsyndromal depression in older primary care patients', *International Psychogeriatrics,* 21, 2009, pp60-68

6.7 Prevention of mental ill-health and promotion of wellbeing

Paradoxically over the last ten years health inequalities have increased despite the overall improvements in life expectancy that were the reward for major investment in screening, prevention and early intervention for cardiovascular and cancer care. The widening of health inequalities was highlighted in a recent report on the English north-south divide in the British Medical Journal:

> 'Inequalities in all causes of mortality in the north/south divide were severe and persistent over the four decades from 1965 to 2008...The increase in this inequality from 2000 to 2008 was notable and occurred despite the public policy emphasis in England over this period on reducing inequalities in health'.[43]

This is not, however, just a north-south issue. The principles apply just as much to smaller areas where the same influences play out to create health – and health inequalities. The better-off have been more able to take advantage of the increased health investment than the less well-off, contributing *in extremis* to the creation of a disadvantaged 'underclass' at the margins of society, whose members have a sense of fatalism, and a loss of autonomy and resilience. Primary care provides valuable opportunities to build in a preventive approach that will promote mental health and not leave any group of people behind. We believe many aspects of current health and social care reform are creating the necessary flexibility for these to be grasped.

In summary, primary care is steeped in a culture of generalism. Ideally, it should be well-placed to provide continuity and holistic practice where the primary care professional ideally sees the connections between family and socio-environmental influences and seeks to improve these dynamics. Seeing the whole picture and understanding the story behind someone's mental distress can help to explain it in a way that might have been inexplicable by adopting a specialist approach or using a biomedical model. It should also be the starting point for joined-up and integrated solutions to the underlying problems.

6.8 GPs and other statutory mental health services

General practices are usually owned by the general practitioner partners in the practice, who are therefore independent contractors to the NHS. They are paid by the NHS on the basis of how many patients are registered with them, and receive additional payments for some services such as vaccinations and minor operations. The size of practices varies from the single-handed doctor to large 'polyclinics', which are like small hospitals. Some GPs are specialists in various aspects of medicine while still working as a GP. These are called GPSIs (GPs with a Special Interest) and they can increase the scope of the practice to treat illnesses that otherwise might have needed referral to secondary care such as a district hospital. The

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43   Hacking J, Muller S and Buchan I, 'Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study', *British Medical Journal*, 342, 2011, p1

exact numbers of GPSIs that specialise in mental health are unavailable[44] but evidence given to the Review suggested that they are few and far between.

Most group practices employ a range of non-medical professionals paid for out of their practice income, such as practice nurses. They also, ideally, work collaboratively with other front line practitioners such as health visitors, district nurses, pharmacists, chiropodists and counselors. The last 30 to 40 years has seen the emergence of the extended primary healthcare team, the expansion of the scope of primary care provision and a reduced need for referral to more expensive secondary care services.

Problems that cannot be dealt with in primary care are referred to secondary care: up to now this has been exclusively a Mental Health Trust. As stated earlier, in 90 per cent of cases the referred patients are not admitted to hospital but are treated in the community while the other ten per cent may be admitted for a period of time during their care. Mental Health Trusts have many professionals working in community settings within a range of specialist services like Community Mental Health Teams, Assertive Outreach Teams, Early Intervention Teams and CAMHS teams. They operate almost entirely independently of primary care.

Despite the fact that both primary care and mental health trusts operate mainly in the community, very few mental health staff work in a way that is closely aligned with primary care practices or employed by them. Although there is a long history of attempts to bridge the divide between primary and secondary care by placing mental health specialists such as psychiatrists or community psychiatric nurses in practices alongside GPs, it is not commonplace across the country. Without being prescriptive, consultees to the Review identified many advantages to such co-location in terms of a) the insights mental health professionals would provide to clinical commissioning processes and b) the potential to provide a less stigmatised service, enabling better access for vulnerable groups:

> *'My only concern [with GPs being far more responsible for commissioning services] is that they may not always know the best course of action for particular diagnoses. I would like to see mental health professionals embedded within GP practices much more than they are now. This would address this issue and others such as reluctance of certain groups to attend mental health services (e.g. increasing self-harm in Asian girls)'.*[45]

GPs often want to be able to call a mental health professional for advice about a patient rather than making a cumbersome referral by letter and waiting a long time for the answer. They want assessments carried out by a mental health professional who knows more about mental health than they do themselves, and who has access to the resource that will keep the patient safe and provide them with expert treatments. As Professor Barbara Starfield pointed out:

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44   The Review submitted a Parliamentary Question through an interested Member of the Houses of Parliament, who was told that this information is not routinely collected and it would be uneconomic to obtain

45   Consultant Psychologist speaking at the CAMHS roundtable hosted for the Review by the Mental Health Network of the NHS Confederation, 3 September 2011

'In the case of common conditions (perhaps more than 2 per thousand in a practice population), there is strong imperative, when the disease is likely to be serious and persist or recur over time, for a shared mode of relationship between primary care physicians and specialists. In these instances, more thought might be devoted to considering the role of the specialist as a consultant to the primary care physician rather than referring the patient to the specialist when there is no need for a definitive intervention'.[46]

At the moment, because of a DH initiative called 'New Ways of Working' the first professional the GP speaks to is often more junior and less experienced than they are themselves. GPs who gave evidence to the review described the systemic boundaries that exist within the healthcare system: 'I used to be able to pick up the phone and discuss a case with a psychiatrist. Silo working makes that much more difficult now'. In summary, the alignment of secondary mental health services needs to provide greater support than at present to practices with reduced barriers to informal consultation between practice staff and mental health staff.

In our polling of those who had close experience of mental health problems, two-thirds agreed that gaining access to the correct mental health services means coping with a lot of red tape.[47]

We recommend that generic community mental health services should be closely aligned to primary care practices to reduce barriers to referral and facilitate advisory conversations between specialists and generalists. Whether this means that the professionals are employed by CCGs or by a contracted organisation, whether they work in the practice themselves or in nearby offices, are questions CCGs must answer for themselves when designing their mental health services. The current plurality of organisational structures providing 'community care', each with their own management systems, also makes it hard for patients and their families to navigate healthcare.

Addressing this should offer savings that could be ploughed back into raising the quality of care.

The commissioning reforms offer an opportunity for creative and flexible service design that breaks out of current professional silos. **We recommend that CCGs, especially those serving the more deprived areas, should make this a priority and vigorously use the new paradigm of competition, choice and payment by results/outcomes to increase access (for example to psychological therapies)** and drive up quality. They should seek advice on the best care models for helping those with severe illnesses and chaotic patients with whom they may have less experience so that their commissioning does not succumb to the inverse care law.

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46   Starfield B, 'Research in general practice: co-morbidity, referrals, and the roles of general practitioners and specialists', *Semergen*, 29, 2003, pp7-16
47   CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010

6.9 Constraints on the effectiveness of primary mental health care

We have gone to some lengths to lay out the importance of primary care and its potential to drive key improvements in outcomes for mentally ill patients, and to consider what is constraining those efforts. We are particularly interested here in identifying shortcomings in primary mental health care that affect the most vulnerable in society but first we look at general features of primary care and how they relate to mental health provision. We then go on to look at the need for better integration to meet interrelated physical, social and mental health needs – how primary care can work more effectively with secondary care and with other local health-related providers to address current health inequalities.

6.9.1 Lack of appropriate and continuous care

As well as the lack of alignment described above, the Review was informed of other shortcomings in primary mental health care from patients and from GPs themselves that affect people across the socio-economic spectrum. Despite what is said above about the potential for GP consultations to build up into an evolving narrative providing valuable insights into patients' lives, in many cases their short duration and 'one problem per consultation' approach prohibit a proper conversation between GP and patient that goes beyond simple diagnosis and prescribing. General practitioners who are interested in mental health find this frustrating and feel that the current disease and target driven culture leads to a commoditisation of care. Their objective is to provide a holistic approach, incorporating human and community values alongside psychiatric treatment. This requires greater flexibility and is an example of how much has been lost in the target culture of the NHS.

The right to access GP appointments within 24 hours disrupted continuity of care within practices because patients had to be fitted in with the next available GP to hit the target, rather than waiting for their own GP to have a slot available. Each time this happens the patient has to tell their story all over again, which is an example of how a well intentioned target can disrupt quality of care. In some surgeries where there is mental health expertise, receptionists direct patients to the most appropriate doctor (in much the same way as asthma sufferers might be routed to the asthma specialist). Others offer much longer appointments for mental health issues (40 minutes was not atypical, indicating the gains to be made if there is more of an ambition than maintenance). While each surgery will obviously have its own strategies for best patient care, greater awareness of the particular needs of mental health patients and more expertise within practices, such as we recommend below, would guide these in a beneficial direction.

Some GPs profess to have no interest in mental health and argue that it is not a core part of medicine. Similarly, research carried out by the National Audit Office in 2009 found that 80 per cent of GPs felt that they needed more training to help people with autism.[48] We would argue that it is unacceptable for GPs to continue avoiding their responsibilities for mental health problems and for the physical care of the mentally ill. In any other area of medicine

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48   National Audit Office, *Supporting People with Autism Through Adulthood,* London: National Audit Office, 2009, p9

such an approach would not be tolerated; it would be akin to a GP denying any interest in diabetes. It is particularly unacceptable in mental health since mental health problems have such a profound impact on the overall health of the individual, those around them and society in general. The Review concluded that the appraisal process needs to be tightened up to ensure that all GPs remain up to date on mental health through continuing professional development.

Too few GPs have experience of post graduate training in mental health and there is no postgraduate qualification in mental health specifically for GPs as a marker of superior specialty competence. In contrast, diplomas can be studied for in other areas such as child health and obstetrics (leading to the DCH and the DRCOG respectively). **We recommend that the number of GPSIs in mental health is increased and the qualification required to be a GPSI is made clearer.**

When we consulted on this recommendation to develop GPs with special interest in mental health we were warned that an unintended consequence might be the deskilling of the average GP and the tacit diminution of the contribution of generalism. Part of the GPSI role should therefore be geared towards championing mental health in primary care and ensuring it is a priority area for CCGs in terms of:

- Suitable mental health training;
- Audit (to encourage local improvement of practice); and
- Commissioning.

In addition **we recommend that mental health should form a greater part of postgraduate training for GPs and the Royal College of GPs should review their curriculum accordingly. All GPs should be able to demonstrate continuing professional development activity in mental health topics at the time of their appraisal**. This subject is too central to good practice to be left to the whim of individual GPs.

In summary, the sheer volume means that no GP (or practice nurse, given that most manage the care of those with long term conditions) can be considered to not require expertise and an understanding of mental health. All GPs should be able to demonstrate appropriate competence as part of their professional development.

6.9.2 A lack of integration to meet interrelated physical, social and mental health needs

In the mental health sphere GPs are expected to screen the chronically ill for depression and conversely to screen patients with severe mental illnesses for physical illnesses. Thus, the framework under which this screening work is incentivised (the QOF system described above) already recognises the importance of primary care in integrating the physical and mental aspects of illness. There is substantial debate in public health, primary care and psychiatric circles about whether screening for mental health problems, analogous to screening for cancers or infectious disease, is effective. Although it is a start, much more could be done in primary care to improve the health of the mentally ill and integrate physical and mental care.

For example, the mentally ill are much more likely to smoke and the life expectancy gap between them and the rest of the population is widening as a result. Half of all smoking related deaths now occur in people with a mental disorder and yet smoking cessation campaigns have tended to bypass those with mental illness.[49, 50] This is despite evidence that this group is just as motivated to stop as the general population; that smoking cessation results in improved mental health, reduced depressive symptoms, reduced doses of some psychiatric medications and improved physical health.[51, 52, 53]

Tobacco use is, in many cases, strongly driven by the need to self-medicate (as is substance misuse) but nicotine substitutes and other aids are not being offered despite the implications for poor physical health. This should be a mainstream issue for primary care and yet smoking cessation services are not designed for mental health populations and are hardly ever provided for them in primary care.[54]

Smoking and mental health[55]

The NHS Stop Smoking services are based in primary care and have been very effective in helping smokers to quit, by providing access to medication and support to change behaviour by trained advisers in GP practices, pharmacies and a wide range of other settings.[56] They are also cost-effective, leading to objectively verified success rates in quitting that are three times as high as those trying to quit unaided. Smoking cessation interventions represent excellent value for money compared with all other health care interventions, costing under £1,000 per quality life year gained compared to the NICE upper threshold cost of £30,000 per quality life year gained for medical interventions.

From their inception the NHS Stop Smoking Services were set up to target poorer smokers and they have been successful in achieving this; in fact they are recognised to be one of the very few health care interventions shown to reduce health inequalities.[57] However, they have been aimed at routine and manual workers, not the most disadvantaged subgroups of smokers, such as those with psychiatric disorders.

Standard quit targets, used to measure the performance of smoking cessation services, refer to 'four week quitters', i.e. to the proportion of clients treated by the services who have successfully given up smoking after four weeks. These act to discourage services to target people with psychiatric disorders, as they will often require more time or multiple attempts to achieve abstinence.[58]

49   Lasser K et al, 'Smoking and mental illness: A population-based prevalence study', *Journal of the American Medical Association*, 284, 2000, pp 2606-2610
50   Campion J, Checinski K and Nurse J, 'Review of smoking cessation treatments for people with mental illness', *Advances in Psychiatric Treatment*, 14, 2008, pp208-216
51   Ibid
52   Siru R, Hulse GK and Tait RJ, 'Assessing motivation to quit smoking in people with mental illness: a review', *Addiction*, 104, 2009, pp719-733
53   Taylor D, Paton C and Kapur SR, *The Maudsley Prescribing Guidelines*, London: Informa, 2009
54   Faculty of Public Health, *Mental Health and Smoking: A position statement*, London: Faculty of Public Health, 2008, pp1-2
55   Evidence submitted to the Review by Deborah Arnott, Chief Executive Action on Smoking and Health; Professor Ann McNeill, PhD, UK Centre for Tobacco Control Studies, University of Nottingham; Elena Ratschen, MPH, UK Centre for Tobacco Control Studies, University of Nottingham
56   Chesterman J et al, 'How effective are the English smoking treatment services in reaching disadvantaged smokers?', *Addiction*, 100, 2005, pp36-45
57   Ibid
58   Faculty of Public Health, *Mental Health and Smoking: A position statement,* London: Faculty of Public Health, July 2008

> We endorse the Faculty of Public Health position statement recommendations for government and health services, expanded upon by the organisation Action on Smoking and Health (ASH).[59] These include:
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> - Tailored education campaigns aimed at service users, carers and health professionals (both specialist mental health and primary care) about the effects of smoking on mental health, as well as on physical health.
> - Training for staff in primary care settings, particularly GPs and primary care nurses, in how to support smokers with mental health (and substance use disorders) to quit. Such training should advise on:
>   - Best practice for assisting those with mental health problems to give up smoking;
>   - Withdrawal symptoms of nicotine dependence which can resemble symptoms of certain mental disorders; and
>   - The need to monitor weight gain induced by quitting, and encourage patients to increase their levels of physical activity (given that weight gain is already a problem for many patients due to medication).

In terms of social needs, GPs can at present refer patients to those non-health services they are aware of, such as community support groups (some of whom offer evidence-based therapies and work-related assistance) which are funded by local authorities or from non-health sources. However, if the funding for a community service is cut and its capacity curtailed or it ceases to function, it is no longer available to the GP as a health-related solution. The GP may then have no choice but to prescribe anti-depressants or some other pharmaceutical intervention when they are aware of the more pressing and underlying social need but are unable to meet it.

Similarly, busy practices might simply be unaware of the wealth of the voluntary and private sector offering that is locally available or be generally uneasy to refer a patient without a high degree of familiarity with the service. Not only can primary and secondary health services be somewhat disconnected, primary care can be hampered by a lack of join-up with the local voluntary and private sectors.

Funding mechanisms should reflect the contribution that non-statutory health-related providers make to health and particularly to prevention-oriented public health. Social enterprises and community interest companies are springing up all over the country (some of which are service-user led) and could, for example, organise themselves into local partnerships and work with lead providers that can broker their services to GPs making relationships easier to manage (see Figure 6 below).[60] Sustainable funding and better integration of statutory primary care with other providers could be revolutionised by maximising the opportunities present by the planned health reforms described below.

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59 Evidence submitted to the Review by Deborah Arnott, Chief Executive Action on Smoking and Health; Professor Ann McNeill, PhD, UK Centre for Tobacco Control Studies, University of Nottingham; Elena Ratschen, MPH, UK Centre for Tobacco Control Studies, University of Nottingham

60 For further information please see Year of Care, *Thanks for the Petunias – A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions 2011*, NHS Diabetes, May 2011 [accessed via: http://www.diabetes. nhs.uk/year_of_care/commissioning/thanks_for_the_petunias_a_guide_to_developing_and_commissioning_nontraditional_providers/ (11/10/11)]

Figure 6: Locally accessible provision

Key activities
Physical activity
Healthy eating/cooking
Arts/health
Befriending
Welfare rights/benefits
Volunteering opportunities

GP

£££

Lead provider

££

Neighbourhood

Local provider

Other funding sources

Source: Diagram reproduced with kind permission from Professor Chris Drinkwater
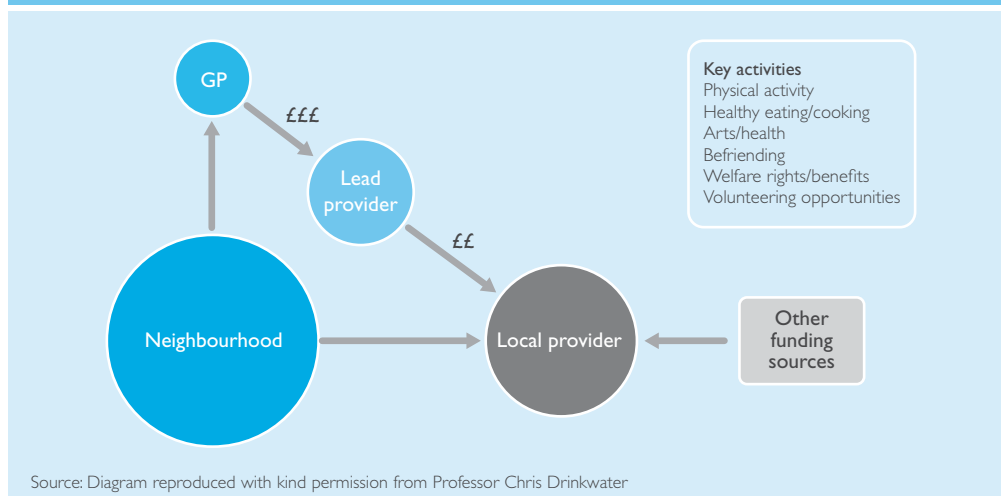
6.10 Commissioning reforms – tackling fragmented care

A particularly contemporary reason for the critical importance of primary care is that general practitioners will be at the heart of the CCGs that are set to become responsible for commissioning all secondary health care including mental health. GPs will therefore have a greater influence on the design and delivery of those services. As the Joint Commissioning Panel for Mental Health explained:

> 'The concept of GP commissioning [the former designation for the work of CCGs] is built on the pivotal role that GP practices already play in co-ordinating care and advocating for their patients. Given this long-standing proximity to their patients, it is seen to be a natural extension for GP practices to play the lead role in deciding what wider health care services to commission on their patients' behalf'.[61]

Over the last 20 years the funding flows in the health service have been changed many times. A brief history of commissioning shows that the new arrangements are not entirely revolutionary.

6.10.1 A short history of commissioning

Until the separation of purchasing and providing in the late 1980s and early 1990s, NHS finance went straight from the DH directly through various layers of bureaucracy such as Health Districts, to GP practices and hospitals. Then Health Districts became Health Authorities and family health services authorities (FHSAs), which became the purchasers of care from GP practices and hospitals. In addition some of the larger and more robust practices were allowed

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61 Joint Commissioning Panel for Mental Health, *Practical Mental Health Commissioning: A framework for local authority and NHS commissioners of mental health and wellbeing services, Volume One: Setting the Scene,* March 2011, p15 [accessed via: http://www.rcpsych. ac.uk/pdf/JCP-MH%20-%20Vol%20One%20(web%20copy%2011_04_05).pdf (11/10/11)]

to buy some services for their patients directly – this was the GP fund-holding scheme which lasted until its abolition in 1997 by the incoming Labour Government. The most common extra service purchased by fund-holders was in-house counselling for their distressed, but not necessarily mentally ill patients, and many also chose to buy care from whichever provider they believed could best serve their patients needs. Many used the funds to bring in private sector providers to reduce waiting lists, as is now being proposed across the health service.

Unfortunately GP fund-holders, being the larger practices, tended to be in suburban areas with low deprivation rates. It is harder to get GPs to work in deprived areas and so more single handed practices which were ineligible to become fund holders exist. Thus any improvements the fund-holders made in the provision of mental health services tended to increase the effect of the inverse care law, with greater resource going to those in less need.

GP involvement in commissioning has persisted in various ways: in 1999 Health Authorities established Primary Care Groups (PCGs) which were sub-committees of Health Authorities, mostly composed of local clinicians, and responsible for managing devolved budgets to commission health for their local populations and supervised by Health Authorities. PCGs were seen to benefit from obtaining better local and clinical involvement in local health care decisions than the more remote Health Authority structures were capable of.

The devolution of power to local levels was a central feature of the then Government's policy on health between 2000/01; exemplified by the declaration in 2001 that within the following year, PCGs would become independent statutory bodies known as Primary Care Trusts (PCTs).[62, 63] It was planned that these 302 PCTs would replace approximately 100 Health Authorities and become responsible for the whole NHS purchasing budget (including almost the entire mental health budget) – and so enabling local decision making.[64]

Clinical involvement was a central principle of PCTs, which were each required to have a Professional Executive Committee made up of local clinicians. These developments in purchasing were accompanied by a consolidation of mental health service providers from various ancestors into large organisations, most of which are now NHS Foundation Mental Health Trusts, sometimes covering several PCT areas. The most recent direction of travel is for these Mental Health Trusts to take over the community care provision of the PCTs before they are abolished. Thus many of them are becoming generic community care trusts incorporating mental health.

6.10.2 CCGs – primary care at the centre

Under present plans, CCGs will be required to commission (i.e. design and procure or 'buy in') almost all specialist health services including mental health. In many CCGs it is likely that these new commissioners will seek to redesign the interface between primary and secondary care, bringing in more competition through the 'any qualified provider' policy. This policy levels

62   House of Commons Health Committee, *Changes to Primary Care Trusts: Second report of sessions 2005-2006*, Norwich: The Stationery Office, 2006 [accessed via: http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/646/646.pdf (20/09/11)]

63   Department of Health, *Shifting the Balance of Power*, London: Department of Health, April 2001 in ibid, p11

64   Ibid

the playing field between the three sectors of health care – NHS Trusts, the private sector and the voluntary sector – such that each will compete on quality for the business of the CCGs.

When GPs do make a referral to secondary care under the new system they will have to provide patients with a choice of provider, as they do now for operative procedures. Some are concerned that although increased choice is likely to drive up quality through competition, it may reduce the continuity of care. Others are concerned that the current system of 'choose and book' in which patients choose their hospital care is already 'a bureaucratic nightmare' that itself needs to be improved before adding to it the burden of another service.

Nevertheless, this Review has concluded that these reforms provide key opportunities to promote mental health and tackle the inverse care law. This is not least because a central aim of the NHS reforms is to give GPs the freedom and budgets to commission more broadly. Potentially, in addition to traditional clinical services, GPs will be able to commission a range of public health services jointly with local health and wellbeing boards and so make a greater impact in reducing health inequalities.

As the Joint Commissioning Panel for Mental Health states:

'The strong role GPs are set to play in commissioning across the country has the potential to make primary care the hub of all mental health services and support, and thus ensure services are better able to meet the spectrum of need of the wider population, as well as those with severe mental illnesses.

This model also...can, where appropriate, shift resources (investment and skills) towards the community end of people's care pathways. It may also enable better and more active management of people's journeys into and out of specialist mental health services, in part through increased availability of these services in surgeries and health centres...It gives increased potential for health, social care and other key stakeholders to collaborate at locality level to meet the totality of individual or family needs... It gives GP commissioners and local authorities greater flexibility to design and deliver specific services that meet specific local needs. It extends opportunities for shared care and expands access to specialist professional skills where they are most needed and most useful, closest to people's homes and within their communities'.[65]

The role of health and wellbeing boards

The Government is proposing to create statutory health and wellbeing boards in every upper tier local authority to improve health and care services, and the health and wellbeing of local people. Health and wellbeing boards will bring together locally elected councillors with the key commissioners in an area, including representatives of CCGs, directors of public health, children's services, adult social services, and a representative of local HealthWatch. Their purpose willl be to assess local needs and develop a shared strategy to address them, providing a strategic framework for commissioners' plans.

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65   Joint Commissioning Panel for Mental Health, *Practical Mental Health Commissioning: A framework for local authority and NHS commissioners of mental health and wellbeing service, Volume One: Setting the Scene,* March 2011, p18 [accessed via: http://www.rcpsych.ac.uk/pdf/JCP-MH%20-%20Vol%20One%20%28web%2011_04_05%29.pdf]

The boards will provide the vehicle for local government to work in partnership with commissioning groups to develop robust joint health and wellbeing strategies and maximise opportunities for integrating health and social care. Health and wellbeing boards will have a stronger role in promoting joint commissioning and integrated provision between health, public health and social care. They can be the vehicle for 'lead commissioning' for particular services, for example social care for people with long-term conditions – with pooled budgets and joint commissioning arrangements where the relevant functions are delegated to them. There could, for example, be a joint commissioning plan for specific services between the clinical commissioning groups and the local authority. They can also promote more integrated provision for patients.

Given this remit health and wellbeing boards could be key drivers of the reforms we propose below.

6.11 Making mental health a priority for CCGs

We have argued throughout this report that mental health, in regards to its impact on the health of the nation and to the availability of effective but unfunded treatments, remains a poor relation in the NHS. CCGs have the opportunity and the responsibility to correct that. However, this new approach will be a challenge for general practitioners, most of whom have plentiful experience of common mental health problems but less of rare and severe conditions. Without expertise specifically for mental health commissioning within the CCGs, services may be designed that favour articulate middle class patients and ignore the more difficult patients with severe and enduring mental illness, especially those with chaotic lives who do not visit GPs, and thus perpetuate the inverse care law. One person at the NHS Confederation Roundtable expressed a typical concern: 'The risk is that areas that are not straightforward might *not* be commissioned'.

Members of the Working Group travelled to Northern Ireland to gather evidence of their approach to mental health services

It is therefore vital that CCGs (and health and wellbeing boards) have mental health representation; this is one of the critical roles a GPSI would fill with their generalist 'bias' balanced with specialist expertise, and with service-user and carer input to challenge the professional view. Voluntary sector expertise in mental health would also help to build in balance.

These reforms potentially offer GPs the much greater flexibility that could facilitate the necessary integration to meet people's interrelated physical, social and mental health needs far more successfully than at present. There are unprecedented opportunities to connect health and social care, through joint commissioning with local authorities and engagement with health and wellbeing boards in ways we suggest below. GPs will also be in a better position to prioritise treatment for physical conditions that co-exist particularly with severe mental health conditions, not least by addressing the lack of clarity about whether it is the responsibility of primary or secondary mental health care to provide care. Addressing both of these challenges should be highly beneficial to many of our most vulnerable users of mental health services.

6.11.1 Social prescribing: an underused approach

Good primary care should be doing all it can to help people with mental illness get back to work, work for the first time, look after their families, complete their education and, generally, get their lives back. However, given that mental distress is usually as much a social as it is a clinical condition, the overarching goal of recovery requires the provision of a much more comprehensive package of support than is typically provided by a GP alone.

Social prescribing for patients in primary care with mental health problems provides alternative and/or complementary responses to mental distress and recognises that mental health outcomes are influenced by a broad range of social, economic and cultural factors.[66] Research carried out in 2005 found that 78 per cent of GPs prescribed an antidepressant in the previous three years, regardless of the existence of possibly more suitable alternative treatments, such as psychological therapies.[67] Two-thirds of these GPs did so due to the lack of appropriate alternatives, 62 per cent because of a waiting list for the alternative, and one-third because the patient asked for antidepressants. The research also showed that three-fifths of the GPs said that if other options were accessible to them, they would prescribe antidepressants less regularly. Three years later, in 2008, some progress had been made in the area of exercise on prescription.

One service user told us:

> 'I am totally convinced that as a 'stand alone' intervention medication is useless. Many comment that medication helps to 'take the edge off' their condition. It is not the edge that needs addressing but the underlying condition including identifying and where possible tackling causation particularly where the illness (maybe depression) is situational. Don't tackle the symptoms tackle the situation'.

While both medication and psychological therapies have a role, social prescribing provides an opportunity to strengthen the capacity of primary care to respond effectively and at an early stage to symptoms of mental distress, as well as initiating a more proactive approach to mental health improvement.

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66   Friedli L et al, Care Services Improvement Partnership, *Social prescribing for mental health: a guide to commissioning and delivery*, London: NHS Institute for Innovation and Improvement, 2009, p3

67   Mental Health Foundation, *Up and running? Exercise therapy and the treatment of mild or moderate depression in primary care*, London: Mental Health Foundation, 2005 p18

Social prescribing

Social prescribing is a way of connecting at-risk or vulnerable patients with non-medical sources of community support such as art workshops and physical activity, in parallel with support for welfare issues such as employment and housing.[68]

Social prescribing is usually delivered via primary care for example, through 'exercise on prescription', 'prescription for learning' or by simply helping patients to connect with existing sources of help and information within the community or third sector. For many people, the social contact provided by referral to (for example) a walking group will be sufficient.[69]

Social prescribing can provide the relationships and support structures which research has shown can be vitally important to achieving better mental health.

Key DH current and historical policy papers emphasise the need to shift resources towards public health and refer to social prescribing's role in preventing ill-health, increasing the range of interventions available to people, and forging partnerships between statutory health, social care and third/private sector services.[70]

Social prescribing can increase access to opportunities, resources and social relationships for disadvantaged, isolated and vulnerable people, many of whom have enduring mental health problems by providing psychosocial and/or practical support.[71] It can be particularly appropriate for isolated or marginalised groups, and for groups whose needs may be best met from within the voluntary and community sector. Indeed, some BME communities have 'expressed a strong preference for support provided from within the BME voluntary sector'.[72]

Friedli et al cite the following potential outcomes:

- Participants in social prescribing have an improved understanding of the social attributes and skills that best promote mental health;
- Greater social interaction and support among those who were previously marginalised in society or isolated;
- A reduction in unnecessary prescription of antidepressants for mild to moderate depression, in line with NICE guidelines 2004;

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68   Friedli L et al, *Social prescribing for mental health- a guide to commissioning and delivery,* Care Services and Improvement Services [accessed via: http://www.mhne.co.uk/files/MHNE126.pdf (11/10/11)]
69   Ibid
70   *Choosing Health,* the public health White Paper, which prioritises the improvement of mental wellbeing; Department of Health, *Choosing Health: Making healthy choices easier,* London: Department of Health, 2004; *Our health, our care, our say* identifies social prescribing as a mechanism for promoting good health and independence and ensuring that people have easy access to a wide range of services, facilities and activities; Department of Health, *Our health, our care, our say,* London: Department of Health, 2006; Lord Darzi's final report reviewing the NHS (Department of Health 2008) further prioritises local provision of preventative services to improve mental wellbeing and to tackle the wider determinants of health; Department of Health, *High Quality Care for All,* London: The Stationery Office, 2008
71   Bates P (ed.), *Working for inclusion: Making social inclusion a reality for people with severe mental health problems,* London: Sainsbury Centre for Mental Health, 2002; Gask L et al, *Improving quality in primary care: A practical guide to the national service framework for mental health.* Manchester: National Primary Care Research and Development Centre, University of Manchester, 2000; Frasure-Smith N, 'Social support, depression, and mortality during the first year after myocardial infarction', *Circulation,* 101, 2000, pp1919-1924; Greene J, 'Prescribing a healthy social life', *Hippocrates,* 14, 2000, pp1-8; Harris T, Brown GW and Robinson R, 'Befriending as an intervention for chronic depression among women in an inner city 1: Randomised controlled trial', *The British Journal of Psychiatry,* 174, 1999, pp219-224
72   Friedli L et al, *Social prescribing for mental health- a guide to commissioning and delivery,* Care Services and Improvement Services [accessed via: http://www.mhne.co.uk/files/MHNE126.pdf (11/10/11)], p5

- Waiting lists for such as counselling and psychological services are shortened; and
- Frequent attendance of GP services (defined as more than 12 visits in a year) is also reduced.[73]

Moreover at a community development level, social prescribing can reduce the incidence of mental disorder and improve community wellbeing by recognising the importance that communities attach to social contact, social activity, opportunities to learn and develop skills, being involved and having a role, as positive influences on mental health.

Effective social prescribing will depend on the quality of partnership, joint working and co-operation between primary care staff and a wide range of voluntary and community groups, as well as statutory providers like local authorities and schools. The development of health and wellbeing boards provides a real opportunity to forge the necessary links. Cultural differences between medical and community development models are, however, a key challenge to overcome.

Funding streams for social prescribing

In many cases there should be a financial component to the prescription which reflects the cost of providing the service by the third (or private sector) organisation, thus helping to put their work on a sustainable footing when other sources of funding are becoming unobtainable.

The funds could either come wholly from the CCG's budget or the service could be jointly commissioned with local authorities (with a role for health and wellbeing boards in developing partnerships). Finally, there is potential for the prescribed services to be part of care plans in personal health budgets.[74] Drawing on all such sources of funds would obviously require evidence of effectiveness and relevant guarantees of safety.

Our recent policy report on older age includes a case study on social prescriptions for respite care sessions for carers who are overburdened by their responsibilities.[75] The success of a pilot study led them to recommend that GPs write social prescriptions to attach a tangible resource to their responsibilities towards patients on their caseload. Payment from central government money earmarked for carers is used to fund a third sector provider of respite care.

Many providers already evaluate their work but a heightened emphasis on outcomes (possibly through some form of payment according to effectiveness/results) has the potential to drive up quality and accountability – and influence practices in statutory healthcare. Over the course of the Review it became clear that mental health care within the NHS was not always delivered with fidelity to the treatment model and that there was little or no pressure on healthcare workers to measure the effectiveness of what they were doing.

Social prescribing is already happening in some places with certain GPs linking up with voluntary and community groups; we are not recommending something completely new. However, this is a largely untapped direction and there is potentially significant benefit to be gained by

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73   Ibid
74   Department of Health, 'About personal health budgets', August 2011 [accessed via: http://www.personalhealthbudgets.dh.gov.uk/About/faqs/ (20/09/11)]
75   Centre for Social Justice, *Age of Opportunity: transforming the lives of older people in poverty*, London: Centre for Social Justice, 2011, p112

developing this model, where it does exist, to a much greater extent. Friedli et al argue that a 'whole-system approach to social prescribing' which builds on existing arrangements to improve coordination, simplifies how people are referred and measures impact, has the potential to transform the way mental health is treated, particularly in primary care.[76]

During the course of the Review we heard a lot of enthusiasm for the creativity and the potential to put the patients' needs at the centre which the reforms could unlock. In a discussion on CAMHS it was suggested that if spending on non-health interventions was permitted, resources could be focused in a truly enabling way to address issues such as supporting young people with psychosis into university. The solution may lie in GPs commissioning more things from schools and less from mental health trusts.

We recommend that social prescribing should become a common feature of local health economies and increasingly pervasive where appropriate to meet local need. To this end there is a clear role for health and wellbeing boards to facilitate local partnerships that can deliver more comprehensive solutions to mental ill-health.

Case study: Social prescribing – Learning for Life

The Mental Health Foundation conducted an evaluation of adult learning courses prescribed for people with mild to moderate depression and anxiety. This programme 'Learn 2b' was a three-year collaboration between Northampton PCT and Northamptonshire County Council Adult Learning Service. The courses were structured around three themes: creative expression (creative writing, painting, drawing and card making), wellbeing (stress management and confidence building) and healthy living (healthy eating, yoga and other complementary therapies), and lasted between four and nine weeks each.

A total of 256 people participated in the evaluation.[77] The results showed that people with mild to moderate depression and anxiety experience significant and lasting improvements in their symptoms as a result of the courses. Using the standardised Hospital Anxiety and Depression Scale to assess the progress of the participants, *Learning for Life* found that between the start and completion of the adult learning course, symptoms of depression and anxiety reduced by an average of 26 per cent and 22 per cent, respectively. Follow up after six and 12 months saw even greater improvements, with average reductions in depressive and anxiety symptoms reaching 35 per cent and 31 per cent, respectively, compared to pre-course levels.

'The Learning for Life study has shown that adult learning courses can be very effective in improving mild to moderate depression. Such programmes help people build social relationships, teach self-management strategies, raise self-esteem and help people to take control of their recovery, without the stigma and fear often attached to traditional mental health services. This study has demonstrated the value of adult learning services, and we hope that such approaches will be considered more extensively by mental health commissioners, as part of a more cost-effective alternative or supplement to existing high-cost specialist mental health support.' [78]

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76   Friedli L et al, Care Services Improvement Partnership, *Social prescribing for mental health – a guide to commissioning and delivery*, London: NHS Institute for Innovation and Improvement, 2009
77   Mental Health Foundation, *Learning for Life: Adult Learning, Mental Health and Well-being*, London: Mental Health Foundation, [accessed via: http://www.mentalhealth.org.uk/content/assets/PDF/publications/learning-for-life.pdf (21/09/11)]
78   Quote from Dr Eva Cyhlarova, Head of Research at the Mental Health Foundation, given in evidence to the Centre for Social Justice.

While social prescribing has much untapped potential to improve outcomes, medication is also important for many people's wellbeing and another primary care responsibility lies in prescribing drugs

6.11.2 Better treatment of physical health problems for people with severe mental disorders

We have already described the severely reduced life expectancy of these patients and the shocking truth that this gap is widening.[79] Although suicide is responsible for about a third of the premature deaths, most likely in the first five years of the condition, this is not causing the widening gap.[80] If anything, suicide rates have actually fallen for this group, the explanation being that the majority of premature deaths are due to the 'usual suspects' such as heart attacks and stroke.[81] It is an increase in the rates of these physical conditions that is causing the health gap to widen.

Why this is the case:

1. This group suffers particularly restricted opportunities, for instance roughly 90 per cent are without employment (greater than any other group with disabilities), many have impoverished social networks, take little exercise, experience poor nutrition and have very high smoking rates.[82] These risks are interrelated, not all actively chosen, and arise from a mixture of poor mental health and discrimination.

2. Treatments with anti-psychotic medicines can adversely affect metabolic risk factors for cardiovascular disease, particularly glucose metabolism (there is also a three-fold risk of diabetes), high cholesterol and obesity. Collectively referred to as the metabolic syndrome, these potentially modifiable metabolic risks appear within months of commencing anti-psychotic medicines making the early phase of illness a key opportunity for cardiovascular disease prevention that has yet to be exploited.[83]

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79 Saha S, Chant D and McGrath J, 'A Systematic Review of Mortality in Schizophrenia: Is the Differential Mortality Gap Worsening Over Time?', *Archives of General Psychiatry*, 64, 2007, pp1123-1131

80 Brown S, 'Excess mortality of schizophrenia' , *The British Journal of Psychiatry*,171, 1997, pp502-508

81 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report*, Manchester: University of Manchester Centre for Suicide Prevention, 2010

82 McCreadie R, 'The Scottish Schizophrenia lifestyle group: Diet, smoking and cardiovascular risk in people with schizophrenia', *The British Journal of Psychiatry*, 183, 2003, pp534-539

83 The Lancet, 'No mental health without physical health', *The Lancet* 377, Issue 9766, 2011, p611

3. This group generally experiences poor access to physical health care. For instance, screening rates for diabetes in routine clinical practice in psychiatry and primary care appear sub-optimal, and people with comorbid psychosis and diabetes may receive fewer routine eye checks and have poorer glycaemic and lipid control.[84, 85] Notwithstanding higher general practice consultation rates (13-14 per year for people with psychosis compared with approximately three per year for the general population), cardiovascular risk factors, in particular, were less likely to be recorded or acted upon.[86]

Anti-psychotic medicines and obesity

It is particularly important to emphasise that poor physical health is not just experienced through illness or premature death. Anti-psychotic medicines are seriously implicated in the development of obesity: a recent reappraisal of evidence concludes that drug-induced weight gain has been underestimated for young people treated for a first episode of illness by a factor of three to four.[87] It is worth considering the effect of weight gain on the self-esteem of young people; how stigmatising and limiting in terms of fitness and wellbeing it may be in addition to having a psychiatric illness.

Our evidence suggests this contributes to young people ceasing to take their medication and defaulting from clinic attendance, with the result that they suffer a relapse of their psychiatric illness. This contributes to a vicious cycle of disillusionment with the life ahead of them. So ignoring these side-effects of medicine when they could be mitigated, fosters ill-health and disease, and also adversely impacts wellbeing.

6.11.3 The current primary care response

At any one time about 15-20 people with severe mental health disorders and physical health problems are on an average GP's practice list. Despite the considerable use this group make of primary care services, many GPs feel that, in contrast with patients with complex diabetes or heart failure, care of such patients is beyond their remit. A study of focus groups with patients who had a severe mental disorder, GPs and practice nurses provided some insights:

'I know that I cannot look after people with severe and enduring mental health problems. I do not have the skills or the knowledge. I couldn't do it well'.[88]

This contrasted with the views of the majority of the patients interviewed who described primary care as the 'cornerstone' of their physical and mental health care, for example:

'I mean, the GP has to have some understanding of mental health but I don't expect my GP to know all of the issues to do with my illness. I would though expect him or her to

84   Tarrant CJ, 'Blood glucose testing for adults prescribed atypical antipsychotics in primary and secondary care', *Psychiatric Bulletin*, 30, 2006, pp286-288

85   Frayne SM et al, 'Disparities in diabetes care: impact of mental illness', *Archives Internal Medicine*, 165, 2005, pp2631-2638

86   Kendrick T, 'Cardiovascular and respiratory risk factors and symptoms among general practice patients with long-term mental illness', *The British Journal of Psychiatry*, 169, 1996, pp733-739

87   Alvarez M, Blanch C and Crespo-Facorro B, 'Antipsychotic-Induced Weight Gain in Chronic and First-Episode Psychotic Disorders A Systematic Critical Reappraisal', *CNS drugs*, 22, 2008, pp547-562

88   Lester H, Tritter JQ and Sorohan H, 'Patients' and health professionals' views on primary care for people with serious mental illness: focus group study', *British Medical Journal*, 330, 2005, p1122

refer me to a specialist person. The important thing is that somebody is looking after you so it's not just you on your own'.[89]

Most patients, GPs and practice nurses agreed that primary care had a responsibility to continue prescribing drugs started in secondary care, monitor side effects and tackle physical health issues. All participants felt that interpersonal and longitudinal continuity (where the patient is seen by the same practitioner for the entire course of treatment) was vital for good-quality care. Most patients favoured seeing the same GP for their physical and mental health needs, preferring a continuous doctor-patient relationship, and a positive attitude and willingness to learn, over the opportunity to consult a different GP with special expertise in mental health. This does not negate the need for more mental health GPSIs as these could be a vital resource to the wider practice in primary care, but it indicates where patients' expectations lie.

6.11.4 The interface with secondary care

A UK national study of community based assertive outreach services for people with severe mental illness concluded that all patients prescribed antipsychotic drugs should undergo medical checks on an annual basis, at the very least. These should comprise, as a minimum, of measuring their blood pressure, BMI or waist circumference, blood glucose and plasma lipids.[90] The researchers did so on the basis firstly, of the association between psychotic disorders, the metabolic syndrome, diabetes and antipsychotic drugs described earlier and secondly, of their findings that:

■ Physical health checks were patchy despite the well known risk factors for patients described earlier. Recorded measurement had taken place within the previous year for blood pressure in 26 per cent of the patients, obesity in 17 per cent, blood glucose in 28 per cent, plasma lipids in 22 per cent, and all four measures documented in 11 per cent.

■ Six per cent were diagnosed with diabetes, six per cent with hypertension and six per cent with dyslipidemia (high cholesterol). Given what is known about the prevalence of these disorders in comparable populations, it is possible to extrapolate from these findings that for every known case of diabetes, there is one other which has not been recognised. Similarly, it may be extrapolated that for every case of hypertension diagnosed, four are missed and for every known case of dyslipidemia, seven go undiagnosed.

The responses of the clinical teams to a questionnaire explored some of the obstacles to screening in routine practice.[91] This revealed:

■ A lack of clarity as to who was responsible for this;
■ Insufficient confidence in interpreting abnormal screening results; and
■ Unsatisfactory access to fundamental equipment.

89   Ibid
90   Barnes T et al, 'A UK Audit of Screening for the Metabolic Side Effects of Antipsychotics in Community Patients', *Schizophrenia Bulletin*, 33, 2007, pp1397-1403
91   Ibid

The reason these results are worrying is that these patients are being followed up by an assertive outreach service precisely because they have struggled to engage other services and are highly unlikely to engage with primary care for their physical healthcare. Despite their acknowledged risks of having poor physical health (much of this due to their psychiatric medication) these patients are routinely missing out on the most basic level of care. These findings are by no means unique to assertive outreach teams. A proliferation of articles and editorials on the poor physical health of these patients emphasises the need for secondary care to improve this aspect of practice, indicating a degree of system failure rather than isolated poor practice.[92]

6.11.5 Implications for CCGs

Addressing this particular health inequality will be a key test of the new commissioning arrangements and their ability to broker more collaborative systems of working between primary and secondary care. This is a subject that will be returned to in the following chapter on secondary care. Promisingly, the new mental health strategy prioritises the physical health issue and this is further reinforced by NICE guidance on schizophrenia (CG82)[93] which lays out where responsibilities lie for both primary and secondary care.[94] The guidance makes it clear that primary care carries the key responsibility for providing these patients with appropriate physical healthcare and indeed some of the potential solutions are already in place.

For example:

- Primary care has great strengths in health promotion and disease management programmes for conditions like heart disease and diabetes, so the skills and knowledge are already there;
- The population at risk are 'known' to the system;
- We know when to target prevention (risks begin to come into play within a few months of commencing antipsychotic medicines);
- We know the nature of the lifestyle issues that are factors (e.g. tobacco smoking, obesity, lack of exercise);
- We have good evidence to show that conditions like diabetes and cardiovascular disease can be prevented or delayed by a combination of increased activity, improved diet and weight loss; and
- We can identify and track data on specific modifiable risks (like BMI, lipids, glucose and smoking). The revisions to the QOF (April 2011) for this group of patients make it easier to measure delivery of effective care.

Thus these facets mean there is a real opportunity, and indeed a challenge, for CCGs to overturn a major health inequality. This requires commissioning programmes which offer

92   De Hert M et al, 'Cardiovascular disease and diabetes in people with severe mental illness. Position statement from the European Psychiatric Association', *European Psychiatry*, 24, 2009, pp412-424 [accessed via: http://www.easd.org/easdwebfiles/statements/EPA.pdf (20/09/11)]
93   NICE, *Schizophrenia (CG82): Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care*, NICE, 2009
94   Department of Health, *No health without mental health: a cross-government mental health strategy for people of all ages*, London: HM Government, 2011

collaborative models of care to break down unhelpful service divisions like primary/secondary and health/social. Priorities that should be considered include the need to:

- Get the basics right:
    - Ensure the basic needs of housing, poverty and social isolation are met, and
    - Value and support families and other key care-givers as partners in care;
- Provide patients, right from the start of treatment, informed choice and skilled medicines management which acknowledges potential weight gain and metabolic disturbance;
- Guarantee that these patients will receive regular physical health screening and early identification and intervention for established risk;
- Address lifestyle issues through health promotion on issues like diet, smoking and physical activity, perhaps along the lines of smoking cessation programmes, so that they can change their lifestyles; and
- Demonstrate improvement of healthcare (for example through audit, practitioner development and service improvement programmes).

Our overarching recommendation is that, even though GPs are already incentivised to carry out physical health checks in the mentally ill and screen for depression in the chronically physically ill, they need to go much further in integrating physical and mental health care. To revisit an earlier example, **targeting smoking cessation services on the mentally ill has been shown to be successful when properly designed and would make a huge difference to the life expectancy of this group, and have a discernible effect on overall health inequalities**.

6.12 Summary of recommendations

- Generic community mental health services should be closely aligned to primary care practices to reduce barriers to referral and facilitate advisory conversations between specialists and generalists.

- The commissioning reforms offer an opportunity for creative and flexible service design that breaks out of current professional silos. CCGs should make this a priority and vigorously use the new rules on competition and choice to increase access (for example to psychological therapies) and drive up quality. They should seek advice on the best care models for dealing with those severe illnesses and chaotic patients with whom they may have less experience so that their commissioning does not succumb to the inverse care law.

- Mental health should form a greater part of postgraduate training for GPs and the Royal College of GPs should review their curriculum accordingly.

- All GPs and nurses should be able to demonstrate continuing professional development activity in mental health topics at the time of their appraisal. This subject is too central to good practice to be left to the whim of individual GPs.

- There should be more specialist GPs in mental health (GPSIs) and the qualification required to be a GPSI should be clearer.

- Social prescribing should become a common feature of local health economies and increasingly pervasive where appropriate to meet local need. To this end there is a clear role for health and wellbeing boards to facilitate local partnerships that can deliver more comprehensive solutions to mental ill-health.

- GPs are already incentivised to carry out physical health checks in the mentally ill and screen for depression in the chronic physically ill but they need to go much further in integrating physical and mental health care.

- Smoking cessation services should be properly designed for and focused on the mentally ill given evidence of effectiveness and the huge negative impact smoking has on the life expectancy of this group and their overall experience of health inequalities.

chapter seven

Secondary care – completing the revolution

7.1 Introduction

This chapter describes the importance of secondary mental health care and treatment for those who are mentally ill. It is of particular relevance to those with severe conditions or forms of disorder, and who require more specialist or intensive help than is available through primary care. Severe mental illness, such as schizophrenia, can have a dramatic and profound effect on patients and their families, given that the psychotic symptoms patients with schizophrenia frequently experience are often highly disturbing. Patients may be convinced that government or other agencies are 'out to get them', or hear voices continually telling them that they are disgusting and useless. Understanding and being able to engage and empathise with a patient who is experiencing distressing symptoms is at the heart of effective mental health care. A productive therapeutic relationship can be transformative, enabling a patient to be a full and active member of society – and the CSJ believes this outcome should be the default ambition. Working with patients with mental illness is demanding work requiring great interpersonal skills and professional commitment. The way in which we organise mental health services must always seek to support and facilitate these relationships.

Even though those accessing secondary care are towards the higher end of need, it is our view that these services should be focused to a much greater extent than is currently the case on helping people to break out of vicious cycles: not just of mental illness but also of poverty and disadvantage where this has further entangled them. It is also vital that they take a public health approach which emphasises wellbeing and prevention, and supports people with mental distress and ill-health to fulfil their potential. To reiterate what was stated earlier about primary care, 'completing the revolution' to embed high quality, integrated and recovery-oriented care in the community requires secondary care to be a) much more of

an enabling gateway to the whole range of support many people need, and b) guided by an early intervention approach. These are essential if the most vulnerable are to be cared for in the least restrictive setting and in such a way that their human potential is unleashed.

As we have stated from the outset, all those working with the mentally ill should see themselves as an integral part of the much wider social movement to tackle welfare dependency and the other main drivers and effects of poverty: family breakdown, addictions, serious personal debt and educational failure. One of the ten key messages from the National Social Inclusion Programme on social inclusion and mental health is that 'The public sector duty is an active duty, not a passive one'.[1]

An unapologetic emphasis on doing all that is necessary to help as many people as possible become or stay work-ready has to be at the heart of such an approach, even if it is clear that their journey may be a long one. The strong message coming out of this and the last Government is that illness is not incompatible with being in work. The Black Review urged the medical profession to issue 'fit notes' rather than 'sick notes', and emphasised their and employers' responsibility to focus on what people can do rather than on what they cannot.[2] Dame Carol Black also pointed out that the DWP's Pathways to Work programme has had a limited effect for those whose main health condition is a mental illness. The report recommends that 'Government fully integrate the option of specialist mental health provision into its employment support programmes – not just for those on incapacity benefits – but for all those who are workless, whether lone parent, jobseeker or Income Support recipient'.[3, 4]

Our focus in this chapter is on how secondary mental health services can and should be part of the much wider project referred to above. Essentially, we have been concerned to identify ways in which dependency on services and particularly on intensive (and therefore costly but also usually more restrictive) services is inappropriately maintained. This may be the result of risk aversion or defensive practice, lack of therapeutic intervention, for example in hospital settings, or because of perverse incentives in funding structures.

The term 'secondary mental health care' covers an enormous range of services, both in hospitals and in the community and, as in the previous chapter on primary mental health care, we do not explore the entire continuum of need or provision but have selected a limited number of areas that emerged from the Review as being priority areas for reform. Our overarching concern is with the extent to which secondary care looks after the most vulnerable (where the burden of mental ill-health is concentrated) and how it could better ensure individuals' full range of needs are addressed. Again, as the National Social Inclusion Programme states:

1   National Social Inclusion Programme, *Vision and Progress: Social Inclusion and Mental Health*, National Institute for Mental Health in England, 2009, pi [accessed via: http://www.socialinclusion.org.uk/publications/NSIP_Vision_and_Progress.pdf 15/10/11]

2   Department of Health, *Working for a Healthier Tomorrow: Dame Carol Black's review of the health of Britain's working age population*, 2008 [accessed via: http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf]

3   See Department for Work and Pensions, Pathways to Work [accessed via: http://www.dwp.gov.uk/policy/welfare-reform/pathways -to-work]

4   Department of Health, *Working for a Healthier Tomorrow: Dame Carol Black's review of the health of Britain's working age population*, 2008 [accessed via: http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf]

'For people with mental health problems to recover and rebuild their lives they need access to those social, economic, educational, recreational and cultural opportunities, and physical health services, that most citizens take for granted'.[5]

Finally, although this chapter is mainly concerned with improving mental health services in the community, we reiterate our earlier emphasis from Chapter Two on the need for wider community development and an improved social fabric that is conducive to better mental wellbeing for the whole population.

7.2 Secondary care services and how patients access them

Across England there are currently 60 mental health trusts that provide specialist treatment and health and social care to patients experiencing a range of severe long term mental health problems, such as schizophrenia and bipolar disorder. Figure 7 below illustrates the current allocation of resources in the mental health system and Figure 8 provides more accurate costings.[6] Both show that despite the shift to care in the community, the vast majority of funding is still spent on inpatient and secure wards, while very little is invested in preventing mental health problems or on the promotion of mental health.

Figure 7: Cost of mental health services in 2009/10

■ Reported investment (£ millions)

* Crisis resolution, assertive outreach and early intervention in psychosis teams
Source: Mental Health Strategies (2010) and Children's Service Mapping (2010) in The King's Fund (2010)
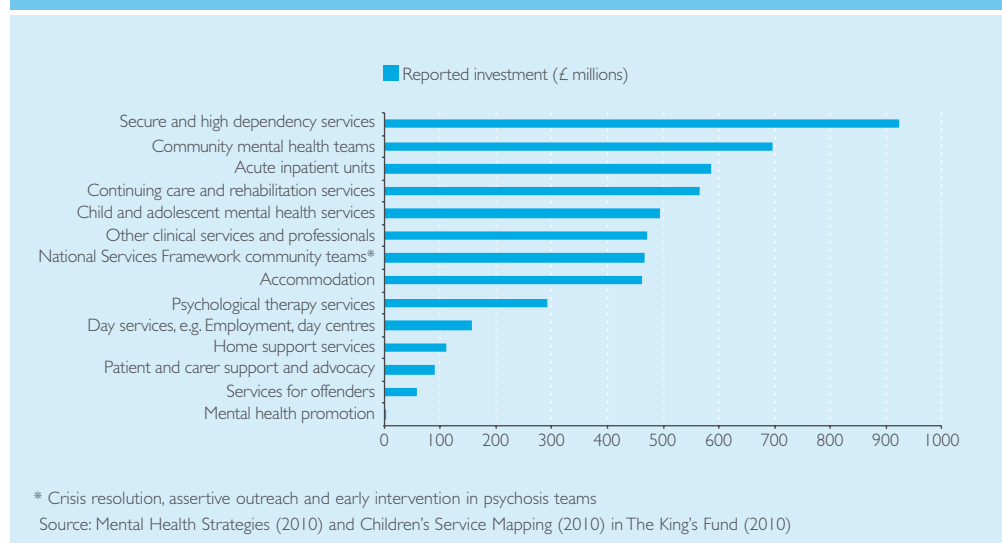
Figure 8 below shows NHS and local authority spending on mental health services for working-age adults in 2009/10.[7]

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5   National Social Inclusion Programme, *Vision and Progress: Social Inclusion and Mental Health,* National Institute for Mental Health in England, 2009, pi [accessed via: http://www.socialinclusion.org.uk/publications/NSIP_Vision_and_Progress.pdf 15/10/11]

6   Naylor C and Bell A, *Mental Health and the Productivity Challenge: Improving Quality and value for money,* London: The King's Fund, 2010

7   Mental Health Strategies, *2009/10 National Survey of Investment in Adult Mental Health Services,* report prepared for the Department of Health, Manchester: Mental Health Strategies, 2010 [accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_117695.pdf (24/10/10)]

Figure 8: Mental health services for working-age adults reported investment (£ million)	
Mental health services for working-age adults	Reported investment (£ million)
Secure and high-dependency	924
Community mental health teams	696
Acute inpatient units	585
Continuing care and rehabilitation services	566
Accommodation, e.g., care homes and supported housing	462
Psychological therapy services:	293
Improving Access to Psychological Therapies services	*(120)*
Non-Improving Access to Psychological Therapies services	*(173)*
Crisis resolution and home treatment teams	239
Day services, including day centres and employment services	156
Assertive outreach teams	129
Home support services	110
Early intervention in psychosis teams	98
Specialist mental health services	94
Patient/carer support services, e.g., peer support and advocacy	90
Psychiatric outpatient clinics	83
Services for people in the criminal justice system	59
Primary care mental health workers	45
Personality disorder services	30
Direct payments	18
Mental health promotion	3
Other clinical services and professionals	201
Total direct costs	**4,881**
Total including indirect costs, capital charges and overheads	**6,001**

Source: Mental Health Strategies (2010)[8]

The provision of specialist mental health services is not restricted to large mental health trusts. Mental health services are already a model for the rest of the healthcare sector in terms of the plurality of the market. For example, about 35 per cent of all inpatient medium secure places were provided by the independent (largely for-profit) sector in 2009.[9] Community services are widely provided by voluntary sector organisations. However, there remain opportunities for wider scale pluralisation, with clear benefits for cost efficiencies through competition that we hope will be realised through current reforms. At present

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8   Ibid
9   Laing and Buisson, *Mental Health and Specialist Care Services, UK Market Report 2008/2009*, London, 2009

not enough services are tendered to the full range of organisations when they are being re-structured, and it is almost impossible for a non-statutory provider to be given the lead role for a geographical area; these responsibilities at present falling exclusively to NHS trusts and foundation trusts.

Secondary care services

Mental health trusts typically provide a range of inpatient and community services that will include:

- **Early intervention teams (community) responsible for providing:**
    - Intensive community treatment for up to three years when patients start to develop psychotic symptoms for the first time;
- **Crisis or home treatment teams (community) responsible for:**
    - Management of acute episodes of mental illness in the community. Patients receive an increased level of intervention for a few weeks;
- **Crisis houses (community) these are:**
    - An alternative to a hospital inpatient ward. Typically patients are admitted for a few weeks;
- **Acute inpatient care (inpatient) where:**
    - Patients are admitted to acute ward for a few weeks to be treated for an acute episode of mental illness;
- **Psychiatric intensive care units (PICU) (inpatient):**
    - Disturbed or violent behaviour is managed in PICUs. Patients are admitted for a few days and;
- **Assertive outreach or recovery services (community) these:**
    - Coordinate and provide care and treatment for patients with severe mental illness – many of those referred to Assertive Outreach are people who have previously had high use of inpatient beds. Mainstream mental health services have found it hard to engage with them and multiple complex needs.

7.2.1 Access to services

Typically secondary care services are accessed by patients through referral from GPs to Community Mental Health Teams, when they consider that a more specialist psychiatric assessment than they can provide is necessary. As we said in the previous chapter, primary care deals with 90 per cent of people with mental ill-health; only ten per cent at any one time are in touch with specialist mental health services in the community, only a small proportion of which require inpatient hospital care.[10] After an assessment with a community psychiatric nurse, social worker or community consultant (depending on the problems experienced; those requiring medication for their symptoms will usually need to see the community consultant), the patient and the person who has undertaken the assessment will work out a care plan that aims to provide the best form of support. This care plan is designed to be reviewed jointly by both parties to ensure that the help received is actually meeting the individual's needs. We look at the Care Programme Approach (CPA) behind the care plan later in this chapter.

As we described in Chapter Five on BME groups, there are other more coercive routes of entry into secondary services, including hospitals, such as through the criminal justice system – and it

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10   Goldberg DP and Huxley P, *Mental Illness in the Community: The pathways to psychiatric care*, London: Tavistock Publications, 1980

has to be acknowledged that coercion is sometimes necessary. There are rare occasions when people with mental illness are dangerous to the population, and especially to their relatives.

7.2.2 The relationship between hospitals and community services

Occasionally a patient will require hospitalisation, although healthcare policy over the last half decade has, as we have stated throughout this report, been focused on helping people in the least restrictive environment, and providing whatever care and support is necessary to meet that criterion, most often in the community. Just as primary care's ability to look after most people with mental illness prevents secondary care from being swamped, as we described in the previous chapter, a similar relationship exists between community care and hospitals. The more successful community services are at helping people to get better and stay well, the greater the likelihood that people will not need to spend periods of time in hospital. Similarly, when patients no longer need to be in hospital, good community services have to be in place to prevent 'bed blocking'. This Review and other studies found that people are often being 'held' in more restrictive and expensive care because less secure and community-based settings are not available.[11]

Funding patterns are strongly implicated in this; National Audit Office figures for 2007-2010 reveal that primary care trusts spent an increasing proportion of their allocation on general and acute secondary care (and a decreasing proportion on primary care) with the proportion spent on community health services for those with mental illness and learning difficulties decreasing.[12]

It would be helpful at this point to consider why people tend to be admitted into hospitals, the purpose for which is set out below.

Ideally, the purpose of acute inpatient care is to:

- Provide rapid intensive treatment for those with disturbed behaviour driven by mental illness that cannot be effectively managed by a crisis team or in a crisis house;
- Provide a safe and secure environment;
- Allow close observation of patients;
- Manage, in a proportionate and considered manner, aggressive and violent behaviour;
- Manage medication and;
- Provide a space free of illicit drugs (although this does not always happen);

We believe the following would be hugely beneficial to patients in hospital, if provided as standard (although this is by no means the case at present):

- Psychological support for patients;
- Meaningful occupation/activity whilst inpatient (rare);
- Effective working with patients family and friends; and
- Effectively work with the patient's care coordinator.

Acute inpatient care is not a long stay option when community housing and other essential services cannot be identified.

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11   Centre for Mental Health, *Pathways to unlocking secure mental health care,* London: Centre for Mental Health, 2011
12   National Audit Office, 2010, cited in Humphries R, *Social care funding and the NHS: An impending crisis?,* The King's Fund, 2011, p15

7.3 Improving hospital care

Through the course of the Review, for example when we visited Norway, it became clear that in many ways mental health services in the UK are considered to be among the most advanced in the world, particularly regarding the extent to which services have been 'deinstitutionalised' (provided in the community wherever possible). For example, few countries can boast national coverage with crisis or early intervention teams, one of the great gains achieved by the National Service Framework.

Yet one of the drivers behind the push to establish a crisis team in every mental health trust was dissatisfaction with acute (typically psychotic) inpatient care; patients and their families are extremely dissatisfied with acute wards. They consider them untherapeutic, dangerous environments that do little more than provide a 'place of safety' (which may not be particularly safe) where medication can be given. In our polling, of those with experience of hospitalisation, more than half did not feel that the settings and facilities aided recovery and 44 per cent felt the treatment they received was fairly or very ineffective.[13] Arguably such facilities are really being used to control the risk the person poses outside hospital.

Given these criticisms, the Review thought it important to consider if acute relapse of psychotic symptoms could be effectively managed in patients' own homes. To some extent the answer is yes; there is evidence from one randomised controlled trial and a number of uncontrolled service evaluations that crisis teams are effective at treating acute episodes in the community rather than in hospital.[14] However a key component of the crisis team model is 24/7 on call access, and many trusts that implemented crisis teams chose to drop this element presumably for cost saving reasons. Observational data clearly shows that teams which do not have 24/7 cover are dramatically less effective at preventing admission to hospital than those who do.[15]

Other 'alternatives' to inpatient admission exist; such as crisis houses, which offer intensive short-term support so that people can manage and resolve their crisis outside hospital, precisely because the latter is considered so undesirable.[16] Evaluations of crisis houses have generally found them an effective model for treating acute illness.[17] Given the concern of this Review to 'complete the revolution' and ensure as many people as possible receive the care they need to make progress in the community, **we recommend that acute inpatient psychiatric wards are eliminated altogether and replaced by PICUs** – which many already are, *de facto,* yet without the status, seniority and expertise of the staff that would be warranted by such a classification in physical health care. We argue here that this is a logical extension of the community care policy of the last 50 years and, if properly implemented, could pave the way for a range of other, much-needed improvements.

13   CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010
14   Johnson S et al, 'Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study', *British Medical Journal*, 331, 2005, pp599-602
15   Glover G, 'Crisis resolution/home treatment teams and psychiatric admission rates in England', *The British Journal of Psychiatry,* 189, 2006, pp44-445
16   Faulkner A et al, *Being there in a crisis*, London: Mental Health Foundation and Sainsbury Centre for Mental Health, 2002
17   Howard LM et al, 'Admission to Women's Crisis Houses or Psychiatric Wards: Women's Pathways to Admission', *Psychiatric Services,* 59, 2008, pp1443-1449 [accessed via: http://psychservices.psychiatryonline.org/cgi/content/abstract/59/12/1443]

When patients are acutely unwell, distressed, vulnerable, aggressive or violent, inpatient care is necessary. As already stated, inpatient care consumes a significant proportion of mental health trust funding. However, in comparison to a just a decade ago, in order to get admitted onto an acute inpatient unit now it is likely that a patient will need to be extremely psychotic, require detention in hospital under mental health law and be compelled to receive treatment. In our judgement, acute wards have effectively become Psychiatric Intensive Care Units. Yet the former are not perceived as a specialist area of practice where clinical staff find work desirable. If intensive care was being delivered in a physical health context it would demand and attract highly qualified clinicians.

Indeed we found that the opposite seems to be true. Newly qualified nurses are expected to 'cut their teeth' on an acute ward before they advance to a community position. It is hard to imagine any other area of medicine where the most unwell are treated by the most inexperienced. This is bound to affect outcomes for people under their care. In one study of hospital care, albeit in secure settings, some participants, including clinicians, expressed concern that so many patients spent a large proportion of their time without meaningful occupation and that clinical interventions should be more intense. Indeed, the lack of intensive engagement with patients was considered a possible reason why some patients were staying such a long time in hospital and 'bed blocking' as a result.[18]

Over the course of the Review the Working Group heard similar comments about lack of meaningful occupation and poor access to therapeutic interventions. As a result, our concern is that people are simply not improving as much as they could as a result of being in hospital. Indeed, as we said in our interim report, they are often perceived by their families to be standing still or 'going backwards' rather than making progress.

'I made one of the biggest mistakes of my life when I rushed my son to the hospital... finding that he had been trapped in the wilderness. He went in expecting to come out. When they catch a bird in the wilderness they mend its wing so it can fly. They didn't do that for my son.'

'When he went into hospital they didn't ask him nothing, they just gave him drugs, they turn him fool... he just wanted some back up.'

Mothers of Black Caribbean men with mental health problems[19]

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18   Centre for Mental Health, *Pathways to unlocking secure mental health care,* London: Centre for Mental Health, 2011
19   Testimony taken from 'Carers' Journeys' DVD (produced by Care Services Improvement Partnership), 2008

Patients' fears and wider problems with inpatient care

The largest survey of acute inpatient care shows that people are routinely being let down in important aspects of their care, including perceived safety. Data by the Care Quality Commission shows that less than half of those surveyed, (45 per cent) feel safe in a hospital ward at all times. 39 per cent said that they felt safe some of the time and 16 per cent saying that they did not feel safe at all.[20] The CSJ's own polling revealed similar trends with 14 per cent of those with hospital experience saying they felt very unsafe and only 15 per cent feeling very safe. 39 per cent said they felt fairly safe.[21]

Patients' fears for their safety were also brought out in our hearings by a psychiatrist who described how one female soldier who had spent two months in a hospital in Lambeth felt less safe there than she had as a front line combatant in Afghanistan where she had just completed a tour of duty.

One community-based service provider giving evidence to the Review talked about the need to:

'send out a clear message to service providers that if people are unwell and need hospitalisation that they need to be kept safe. How can the healing take place? There will be anxiety about staying safe rather than recovery'.

Additionally, close to a third (27 per cent) of patients sectioned are not being given any explanation about their rights in any way.[22] This failure has also spilled over into aspects of patient care with almost half (48 per cent) saying that the potential side effects of medicines that were prescribed to them while in hospital were not explained in a way that they could understand.[23]

The amount of time patients were given to discuss their health conditions with psychiatrists is also an area which needs to be addressed; with 50 per cent saying that more health professionals needed to spend more time explaining details of their care to patients.[24]

Finally, there was a lack of activities available for inpatients; 35 per cent of those surveyed reported that there was very little to do, with this figure going up to 54 per cent during evenings and weekends.[25]

Completing the revolution in inpatient care requires a) effective treatment for acute episodes in the community rather than in hospital whenever possible, and b) a shift away from acute wards where the model of care is poorly defined and their transformation (of most but not all of existing infrastructure, as fewer should be needed) into PICUs: specialist services that mental health professionals, especially nurses, aspire to work in. In such settings there is more of a focus on working intensively with the patient so that their care can be 'stepped down' to a community setting at the earliest, most therapeutically appropriate point.

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20 Care Quality Commission, *National NHS patient survey programme: Mental health acute inpatient service users survey,* 2009, p3 [accessed via: http://www.cqc.org.uk/_db/_documents/2009_survey_of_mental_health_acute_inpatient_services_Full_national_results_tables.pdf (12/10/11)]
21 CSJ/YouGov polling of 1,005 people with personal or close family/friends experience of mental health, July 2010
22 Care Quality Commission, *National NHS patient survey programme: Mental health acute inpatient service users survey,* 2009, p9 [accessed via: http://www.cqc.org.uk/_db/_documents/2009_survey_of_mental_health_acute_inpatient_services_Full_national_results_tables.pdf (12/10/11)]
23 Ibid, p7
24 Ibid, p5
25 Ibid, p8

We argue that all the elements are already in place to enable such a transformation of acute inpatient services but what is required to spark this particular revolution is clinical leadership. Clinical leadership is of paramount importance in acute care and we were particularly struck by the importance of senior members of the nursing profession in this regard. Our attention was drawn to examples of good practice where nurse consultants in particular have innovated, as in the development of zoning or the championing of Protected Engagement Time described below.[26]

We were told by respondents that nurses have a strong part to play in leadership alongside other professionals in multidisciplinary teams. Without downplaying the importance of psychiatrists, clinical psychologists, occupational therapists and others working closely together, we wanted to emphasise the importance of nurses' contribution in this report. **Clinical leadership is vital to drive up the effectiveness of nurses – if nurses are going to leave the nurses' station and engage meaningfully with patients, the role of the ward manager will be very important.** Confirming the importance of leadership, one of our senior nursing consultees told us 'it takes tall poppies' to drive through this kind of change in the prevailing culture.

7.4 Nursing

Mental health nursing is a sizeable workforce, whose role is central to helping individuals with mental health problems make progress. Our consultation process led us to conclude that the mechanisms considered below would facilitate change.

7.4.1 Getting the training right

Whatever is in nurses' training curriculum needs to be justifiable in terms of preparing trainees to meet the needs of future patients. We learned that, at present, there are schools of nursing where what is taught reflects the preferences of the teaching staff rather than evidence-based mental health practice.

Currently there are four branches of nurse training: children, adult, mental health and learning disability. Yet the comments made in Chapter Six on primary mental health care about the need for all GPs to have the necessary background to help the many patients who come to them with mental health issues equally apply to the nursing profession. In order to achieve this outcome **we recommend that nurse training, like medical training, should start by laying a sound general foundation, with a generic period of study, whereas now it specialises too early.** Additionally **we recommend that a significant proportion of any nursing curriculum should relate to mental health (its prevention, recognition and treatment) and to co-occurring physical and mental health problems.** Once trained, for example, cardiovascular nurses need to be as attentive to depression as to smoking and mental health nurses need to understand the risk of a patient suffering from a heart attack. This Review has concluded that **the importance of the nursing role in joining up mental, physical and public health should not be underestimated.** By virtue of their

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26   Gamble C et al, 'Zoning: focused support: a trust wide implementation project', *Journal of Psychiatric and Mental Health Nursing,* 17(1), 2010, pp79-86 [accessed via: http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2850.2009.01515.x/full]

training, **all nurses need to be competent to promote good mental health behaviours if a public mental health approach is to be embedded throughout services (and deliver interventions such as smoking cessation programmes)**.

7.4.2 Greater skills levels in nursing staff on PICUs

If in-patient care was, as we recommend, treated as a specialism then we would not have fairly newly qualified mental health nurses starting out in these environments. Currently, patients with the most profound needs are being looked after by the least experienced professionals. Moreover, the nurses who have received the most training are often tied up in the office with administrative tasks while agency nurses and health care assistants do the observations. There needs to be an attitude that 'every interaction is a chance to do a health intervention'. The move towards health promotion and prevention should also affect what happens in hospital. People in hospital need to be kept occupied, have plenty of fresh air and exercise and also, vitally, need preparation for their departure from hospital.

7.4.3 Protected engagement time

Much criticism and concern has been expressed on the subject of how mental health patients spend their time on hospital wards.[27] The DH has called for improvements to 'ensure adequate clinical and support inputs to inpatient wards and to maximise the time spent by staff therapeutically engaged with service users'.[28] Insufficient one-to-one time is being spent by nurses with patients to help meet their mental health problems and other needs.[29,30] One study found that only 16 per cent of patients' time was passed in what is loosely termed therapeutic interaction. A distinct lack of purpose characterised the remaining 84 per cent; patients had nothing else to do but sit around or walk around the ward.[31] According to the Mental Health Act Commission, nurses were unhappy about being too busy to develop therapeutic rapport with patients. The Commission concluded that **all hospital wards caring for detained patients should ensure that patients have guaranteed time with nursing staff away from all other distractions, by instituting 'patient protected time' schemes and we echo that recommendation.**[32]

The RCN's (2007) survey of mental health nurses showed that two thirds deemed staffing numbers to be too low and 42 per cent considered that inadequate staffing levels compromised patient care at least once per week.[33] It also found that three-fifths of nurses considered that administrative tasks took up too much of their time and the RCN concluded that this correlated with the perceived inadequate number of staff in nursing.[34]

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27   Edwards K et al, *Evaluating protected time in mental health acute care*, 2008 [accessed via http://www.nursingtimes.net/evaluating-protected-time-in-mental-health-acute-care/1833922.article]

28   Department of Health, *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*, London: Department of Health, 2002

29   Edwards K, 'Service users and mental health nursing', *Journal of Psychiatric and Mental Health Nursing*, 7(6), 2000, pp555-565

30   Edwards K, *Partnership Working in Mental Health Care*, Edinburgh: Elsevier Churchill Livingstone, 2005

31   Yawar A, 'Time and humanity on psychiatric wards', *The Lancet*, 371(9609), 2008, pp285-286

32   Mental Health Act Commission, *Risk, Rights and Recovery, The Mental Health Act Commission Twelfth Biennial Report 2005-2007*, Norwich: The Stationery Office, 2008

33   Royal College of Nursing, *RCN policy Unit Policy Briefing 10/2007 – Untapped Potential: A survey of RCN members working in mental health*, London: Royal College of Nursing, July 2007, p2 [accessed via: http://www.rcn.org.uk/__data/assets/pdf_file/0007/287719/10-2007_Untapped_Potential_-_a_survey_of_RCN_members_working_in_mental_health.pdf (12/10/11)]

34   Ibid

While the administrative burden may be high, ways must be found to release clinical staff to provide the care they were trained for. In Chapter Two we recommended that the cultural change in risk management called for by the Munro Review has to take place in mental health. Munro implicated over-bureaucratisation in the current failing child protection system and nurses' administrative load should be scrutinised through that lens.[35] Moreover, it has to be acknowledged that nursing staff could be prioritising that aspect of their work over direct patient care. Although many nurses find working directly with patients particularly satisfying, research also suggests that, in some cases, nurses are anxious about getting involved with patients' distress, not least when it raises issues of personal concern, and time-consuming systems can actually be created by nurses as a defence against this.[36, 37] In other aspects of our Review we learnt how professionals can protect themselves against people's needs, due to the understandable concern that they will be emotionally overwhelmed. Protected time can be a way of helping to ensure that nurses play a therapeutic role but, without adequate supervision, they may well 'withdraw into a custodial role as a defence against their own vulnerability and lack of expertise... mental health nursing is not a straightforward or easy task. However, nurses have to try to make sense of the difficulties and complexities in patients' lives'.[38] Supervision is therefore essential and at least one study of protected engagement time suggests its availability is inconsistent.[39]

As well as supervision, private and comfortable places where there will not be constant interruptions need to be made available. Crucially however, the prevailing culture needs to treat one-to-one sessions as indispensible to the working day, with everyone involved being clear about the purpose of protected time. Again, for these changes to be properly implemented there has to be leadership at the ward manager and more senior levels.

7.4.4 Evidence-based psychosocial interventions

However, we would go further than simply saying nurses should spend uninterrupted time with patients. They are also well-placed to deliver actual therapies and many have received training to do so. Before examining the role they can play, we look briefly at the more general subject of what interventions can be delivered in secondary care.

There is good evidence from randomised studies that a range of psychosocial interventions (PSI) are effective in the treatment of mental illnesses, predominantly schizophrenia and bipolar disorder, that is managed in secondary care. Family work, CBT, some medication adherence interventions (such as treatment adherence therapy[40]) and emerging treatments, such as cognitive remediation which aims to enhance patients' cognitive function through repetition of mental exercises, may also be helpful.[41] When PSIs

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35   Department for Education, *The Munro review of child protection: Final report- a child-centred system*, Norwich: The Stationery Office, 2011

36   Clarke V, 'Working with survivors of trauma', *Mental Health Practice*, 11, 2008, 7, pp14-17

37   Menzies I, 'The functioning of social systems as a defence against anxiety', *Human Relations*, 13, 1960, pp95-121

38   Edwards K et al, *Evaluating protected time in mental health acute care*, 2008 [accessed via http://www.nursingtimes.net/evaluating-protected-time-in-mental-health-acute-care/1833922.article]

39   Ibid

40   Staring et al, 'Treatment adherence therapy in people with psychotic disorders: randomized controlled trial', *The British Journal of Psychiatry*, 197, 2010, pp448-455

41   Wykes T and Reeder C, 'Cognitive remediation therapy in schizophrenia', *The British Journal of Psychiatry*, 190, 2007, pp421-427

are delivered within the context of a clinical trial, intervention is frequently provided by highly trained and motivated clinical psychologists (because they are researchers invested in showing the therapy works). Arguably there will never be sufficient numbers of clinical psychologists in the UK (there are currently under 10,000 on the Health Professions Council register) to meet the need and demand for psychosocial intervention in the secondary care population.[42]

7.4.5 Nurses delivering evidence-based interventions

Mental health nurses make up the largest proportion of the secondary care work force in both inpatient and community settings (latest figures for 2006/07 showed that there were 100,050 registered with the Nursing and Midwifery Council). **Nurses are a group who are, in many ways, ideally placed to deliver evidence-based PSI and we recommend that the numbers who are trained to do so could be markedly increased.** Making nurses a major delivery army of PSI is not a revolutionary idea; in the early 1990s the Thorn Programme, a joint initiative between King's College London and the University of Manchester, provided mental health nurses (and other mental health and social care professionals) with a rigorous and intensive one year skill based training programme. It was taught by expert practitioners with the aim of making family work and other PSIs available to every patient and family with severe mental illness in the UK.

The rather limited evaluations that were undertaken seemed to show that Thorn training was effective at producing competent practitioners that were able to deliver PSI to a faithfully high standard resulting in improved clinical outcomes for their patients. There are a number of other examples in the literature where brief PSI training packages have been shown to be effective at equipping mental health nurses with new competencies that improve patient outcomes. For example Gray et al showed that a brief ten day medication management (adherence) training package was effective at improving nurses' consultation skills[43] and patients' mental symptoms.[44]

Many universities offered accredited Thorn training but, since the late 1990s, Thorn training seemingly went 'out of fashion' and has now disappeared almost completely from university prospectuses. Indeed family work as a discreet intervention has seemingly 'slipped of the radar' and does not now seem to be routinely provided in the majority of mental health services. There is a responsibility to ensure that patients and their families are offered treatments that are known to work, delivered by workers that are competent in faithfully delivering the intervention.

Family work, for example is based on the observation that patients with psychosis living in a high expressed emotion (EE) environment (determined by the amount of emotion; hostility, over-involvement, critical comments, displayed in the family) are more likely to relapse than

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42   Health Professions Council, *Number of clinical psychologists*, September 2010

43   Gray R et al, 'Effect of medication management training on community mental health nurse's clinical skills', *International Journal of Nursing Studies*, 40, 2003, pp163-169

44   Gray R et al, 'Effect of a medication management training package for nurses on clinical outcomes for patients with schizophrenia: Cluster randomised controlled trial', *The British Journal of Psychiatry,* 85, 2004, pp157-162

those where these features are minimised. Intervention, laid out in a treatment manual, that focuses on helping families decrease levels of EE can reduce the risk of relapse.[45]

7.4.6 Evidence-based training

Effective training can lever evidence-based interventions into routine practice, making new ways of working with patients available to the majority rather than a select, privileged few. In terms of the provision of post-registration training and education for mental health nurses and allied health professionals, it is a challenging but necessary question to ask education providers whether they produce evidence that the training they offer will equip practitioners with the competencies they need to work more effectively with patients and families to produce better outcomes. Often the answer is no. Accordingly, we question why those who commission it (often Directors of Nursing) continue to purchase training that has no established benefit. Where the commissioning of training is based simply on the rolling over of what was commissioned previously, regardless of evidence base, this is an unsatisfactory way of spending very large amounts of public money.

We recommend that awareness of the evidence for emergent new treatments should inform the development and testing of new training packages that will equip the mental health workforce to deliver the intervention competently and faithfully.

7.4.7 Why training may not change practice

Over the course of the Review we have made a number of observations about how mental health workers incorporate new interventions into their practice. During training, clinical competence gets stretched, and at the end of a training programme it may be possible to demonstrate that the worker is able to deliver any given intervention to a satisfactory standard. It may even be possible to show that they have implemented what they have learned with patients and/or families in practice and improved clinical outcomes. However, almost inevitably, once training stops, practice returns to a default standard of care. Sometimes this happens almost immediately, sometimes more gradually. Helping workers to keep on faithfully delivering evidence-based interventions months, even years, after training has finished, represents a serious challenge.

Focus group-based research asking a range of mental health professionals, not just nurses, about how they incorporate new PSI skills acquired in training into their clinical work suggests that a lack of time is often perceived as a major barrier.[46] The RCN survey cited earlier found that of the 43 per cent of nurses who report they have skills lying dormant; two-thirds had

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45   Brown G et al, 'Influence of family life on the course of schizophrenic illness', *British Journal Preventative and Social Medicine*, 16, 1962, pp55-68; Vaughn CE and Leff JP, 'The influence of family and social factors on the course of psychiatric illness: a comparison of schizophrenic and depressed neurotic patients', *The British Journal of Psychiatry*, 129,1976, pp125-137; MacMillan J et al, 'The Northwick Park Study of First Episodes of Schizophrenia (IV) Expressed emotion and relapse', *British Journal Psychiatry*, 148, 1986, pp133-143; Leff J and Vaughn C, 'The role of maintenance therapy and relatives: expressed emotion in relapse of schizophrenia: a two year follow up study', *The British Journal of Psychiatry*, 139, 1981, pp102-104

46   Jagessar J, Staff perceptions of their abilities to implement psychosocial interventions within a mental health rehabilitation service following an investment in training, The Continuing Treatment and Recovery Service and The Complex Psychological Problems and Psychosis Service Leeds, 2008, p18 [accessed via: http://www.leeds.ac.uk/lihs/psychiatry/dclin/SEP09/Jillian%20Jagessar%20SEP.pdf (12/10/11)]

unused psychological therapy skills and a quarter were not implementing family-centred approaches they had received training to provide. Again, insufficient time was given as the main reason.[47] Practitioners sometimes describe themselves metaphorically as if they were a bath full almost to overflowing. Opening the tap to new ways of working would cause the bath to overflow; it is perhaps then unsurprising that while clinicians may attend training and learn new skills they resist putting them into practice, at least in part because they perceive that they 'can't do everything'.

However, the Review found that in many cases ineffective interventions are consuming an enormous amount of clinicians' time. Much mental health care is custom and practice, simply handed down over generations and never questioned. Helping clinicians to have the confidence to 'pull out the plug' (extending the bath metaphor) and let go of old ineffective practices requires support, good supervision and therefore, again, good leadership. Helping nurses and other health professionals *not* do things is as important as supporting them to take on new ways of working.

7.5 Reducing dependency on hospitals by improving community services

If the focus of in-patient settings shifts towards more intensive interventions with the aim of discharging people back into the community, it is essential that community teams and other services are able to take on the care of relatively vulnerable people and prevent unnecessary rehospitalisation (the 'revolving door' patient syndrome) or other first-time admissions. The focus of this chapter now moves on from hospitals, towards care in the community.

7.5.1 'Family-sized' care

Importantly, as we said above, acute inpatient care is not (or should not be) a long stay option when community housing and other essential services are not available. Where another form of residential care is necessary, **we recommend that local authorities bolster or initiate the provision of 'family-sized' care through initiatives such as Shared Lives (SL)**.[48] Involvement in a family can have very high therapeutic value, providing people with a sense of belonging that they may rarely, if ever, have experienced before.

A business case has been produced for SL showing the cost-benefit of decreasing reliance on residential care, which would have much transferability to other local settings.[49] There are also likely to be significant social returns on investment; anecdotal evidence suggests SL schemes can achieve higher rates of employment and better health outcomes (research and evaluations are currently underway).[50]

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47   Royal College of Nursing, *RCN policy Unit Policy Briefing 10/2007 – Untapped Potential: A survey of RCN members working in mental health*, London: Royal College of Nursing, July 2007, p2 [accessed via: http://www.rcn.org.uk/__data/assets/pdf_file/0007/287719/10-2007_Untapped_Potential_-_a_survey_of_RCN_members_working_in_mental_health.pdf (12/10/11)]
48   Naaps, *The Shared Life of My Choice*, 2010 [accessed via http://www.naaps.org.uk/downloads/The_shared_life_of_my_choice_final.pdf]
49   Ibid, p9
50   Ibid

In SL (previously known as Adult Placement) schemes, an individual or family receives a modest payment for including an older or disabled person in their family and community life in a wide range of ways. Personal budgets can be used to purchase SL care. The person often lives with a SL carer and their family, but support is also available for people living in their own homes in the form of day support, respite care to give unpaid family carers a break and home-from-hospital care. SL care is also used as an intermediate stage for someone working towards having their own home.

Around 10,000 SL carers in the UK have been recruited, trained and approved by SL schemes, and these are all regulated by the Care Quality Commission, the Government's social care inspectors for England. There are other regulated adult support schemes but SL schemes are unique in ensuring that carers and those they care for are matched for compatibility. The aim is to develop genuine relationships where all the parties act as an 'extended family' to each other, enabling supported adults to stay rooted in their community.

Inspection indicates the success of such schemes: NAAPS report that:

> *"The Care Quality Commission's last ever annual report giving quality ('star') ratings to providers of adult social care in England (November 2010) showed that, in 2010, 38% of Shared Lives schemes received the top rating of excellent (three star). This is nearly double the percentages for other forms of care. 83% of all forms of support were rated good or excellent, whereas 95% of Shared Lives schemes were good or excellent. No Shared Lives scheme has been rated as 'poor' for the last two years, whereas all other forms of care have a small percentage of poor services".*[51]

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51   Ibid, p1

Case study: Alternatives to residential care – family-sized solutions[52]

Dave

'Dave is a man in his fifties. He sustained head injuries inflicted by his father as a child and has experienced a lifetime of mental health difficulties, often in the form of symptoms of bipolar disorder, which Dave is not able to recognise and manage himself. Dave has never been able to live fully independently and has spent many years living in various hostels and shelters, where he was seen as 'looking like a tramp' and was very vulnerable, running errands or being coerced into sexual acts, in exchange for money or cigarettes.

He has been living within Shared Lives for the nine years in two very successful arrangements. Although it is possible he may never live completely independently, Dave now has a network of positive friendships and relationships, attending the local football club with the son of his previous Shared Lives carer. He dresses smartly and manages his personal care with support, receiving regular medical and dental treatment. When his mental health deteriorates this is noticed and appropriate treatment is sought. He saves money and has had several holidays. Dave no longer has to exchange errands or favours to keep friends, but likes to help neighbours up and down the street to put out their wheelie bins and always receives many Christmas cards in return.'

Barbara

'Barbara is in her forties. She has been known to mental health services for many years. She has lived in different settings with varying support and had intermittent periods as an inpatient. For the past two years she was staying with her elderly mother who is now in a care home. Barbara has a diagnosis of schizophrenia. She suffers from extreme anxiety and cannot manage to stay on her own overnight. Barbara moved into a long term Shared Lives arrangement three months ago. She has started participating in community groups, travelling on her own by bus to the town centre. She has been away for a weekend with her Shared Lives carers and is planning a short holiday: this will be the first holiday she has ever had.

Mainstream mental health services have long struggled to meet Barbara's needs in a community setting. Barbara's social worker who has known her for several years states that she has never seen her so relaxed. She is extremely happy with the progress in confidence and skills that Barbara has made. Barbara is much less anxious and is hearing voices less.'

It is essential that these and other family- and community-oriented schemes are available because in our evidence gathering, we learnt that it was not uncommon for particularly vulnerable people (often those with very little or no social and other support) to be retained in hospital beyond the point where this was essential (for the purposes of inpatient care itemised above) due to lack of appropriate care in the community. This is typically a result of a lack of funding – yet retaining people in hospital is the most expensive option.

This point was most forcibly put to us not by a provider of community services, who would have most to gain by arguing for hospital funding to be diverted into the community, but by the chief executive of a voluntary sector hospital, who recommended that money follow the patient rather than being tied up in their staying in hospital. This applies both to the stretched

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52   Verbatim case studies from Naaps, SharedLivesPlus, *Shared Lives innovations in mental health support* [accessed via: http://www.naaps.org. uk/en/115/news/news-article/?ContentID=11 (19/10/11)]

acute psychiatric wards of the NHS[53] and to longer stay secure services.[54] In complete contrast to payment by results/outcomes (PbR) models in operation in other publicly funded services, mental health funding streams tied up in hospitals are not incentivising clinicians to do all they can to ensure that patients make progress. It is essential that this is prioritised as mental health services increasingly move towards delivery through PbR.

7.5.2 Money following the patient

Such 'forward funding' models have been investigated by, amongst others, the King's Fund and PricewaterhouseCoopers LLP (PWC), who focus particularly on aligning social and mental health care funding to achieve the best outcomes for each individual. Humphries (2011) describes how adult social care could improve the effectiveness of the NHS in the following ways:

> *'Investment in services that reduce the need for NHS care, especially in hospital, and its duration. Examples of this might be intermediate care that enables people to be discharged from hospital in a safe and timely fashion, thus reducing the likelihood of re-admission, and prevention and early intervention services that reduce the need for health care by enabling people to stay well and live independently in their own homes.*
>
> *Collaborative processes that enable professionals from different disciplines and agencies to achieve better outcomes for patients, for example, through single or shared assessment frameworks, integrated locality teams and integrated care pathways...*
>
> *Organisational arrangements that commit councils and their local NHS partners to work together, for example, through pooled budgets, integrated commissioning, joint appointments and shared back-office functions. The ultimate expression of this would be complete organisational integration through the establishment of a care trust'.[55]*

Humphries emphasises that culture, leadership and the quality of relationships between people and organisations all play an important local role; time is required to build mutual trust.[56] These factors also emerged during our consultation process. The case for aligning health and social care resources locally to meet needs is very strong. However, less than a twentieth of combined NHS and public social care budgets is spent through joint arrangements.[57]

In the previous chapter we point towards the role of new NHS and local authority structures such as health and wellbeing boards and clinical commissioning groups and their need to work together and pool funds but emphasise, with others, that being clear about the desired outcomes is more important than specifying exactly how to fund services through

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53   The Daily Telegraph, *Mental Health Services 'understaffed and overcrowded'*, 21 June 2011[accessed via: http://www.telegraph.co.uk/health/8588242/Mental-health-services-understaffed-and-overcrowded.html]

54   Sugarman P, *Payment by results: unleashing the potential of mental health services,* Government Gazette, September, 2011

55   Humphries R, *Social care funding and the NHS: An impending crisis?*, The King's Fund, 2011

56   NHS Confederation 2010

57   Humphries R, *Social care funding and the NHS: An impending crisis?*, London: The King's Fund, 2011

joint arrangements.[58] However, models have been designed which can be learned from which show significant potential savings. For example, PWC's Optimal Outcomes Project in Birmingham and Coventry has demonstrated the financial benefits that might be realised by aligning resources with care pathways across a whole system (see Figure 9 below).[59] They have also formulated a 'roadmap' which builds in a design stage where they, local clinicians and people using mental health services worked in partnership to "design a citizen-led 'optimal' care and health pathway focused on delivering better outcomes."[60]

Figure 9: PWC's estimated potential savings			
Topic	Areas for savings		Potential saving (£m)
	Health	*Social Care*	
Dementia	High	High	£33.9
Stroke	High	High	£12.6
Mental health disorders	High	Low	£20.7
Coronary	High	Low (except for over 65s)	£4.5

Source: PWC, published in Humphries R, *Social care funding and the NHS: An impending crisis?,* The King's Fund, 2011

We found substantial support for the kind of alignment described above. Respondents to the Review told us that in many other ways "in-patient care needs to have a 'seamless connection with the community'". Yet one senior hospital-based psychiatrist expressed concern that silos seem to be increasing, that clinicians working under her were being compelled to work in only one part of the mental health system and, effectively, not leave the hospital. This contradicts key principles for practice as stated by the National Audit Office, who emphasise the need for community and in-patient services to work together closely.[61]

Their recent report on the effectiveness of Crisis Resolution Home Treatment (CRHT) teams found that, to realise their full benefits, 'teams need to be a fully functional and integral part of acute mental health services, gatekeeping all potential admissions and communicating effectively with inpatient services to facilitate early discharge.' In order to do this they recommended that 'clinical directors and service managers should seek to maximise effective collaboration and communication between all elements of the acute mental health pathway.'[62] They gave some examples of how this might be achieved, such as by basing CRHT and inpatient teams on the same site, ensuring CRHT and inpatient teams discuss referrals, admissions and discharges and reconfiguring roles within teams so that managerial and clinical staff either move between inpatient teams and CRHT or work in both at the same time.

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58   Audit Commission, *Means to an End: Joint financing across health and social care*, Health National Report, London: Audit Commission; Centre for Social Justice, *Outcome Based Government*, London: Centre for Social Justice, 2011
59   Humphries R, *Social care funding and the NHS: An impending crisis?* The King's Fund, 2011, p18
60   Ibid
61   National Audit Office, *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment Services,* Norwich: The Stationery Office, 2007 [accessed via: http://www.nao.org.uk/publications/0708/helping_people_through_mental.aspx]
62   National Audit Office, *Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services*, Norwich: The Stationery Office, 2007, p8

Throughout this report we have described the need for integrated services that work well together and so fully endorse the NAO's specific recommendations in regard to CRHTs and in-patient services. We argue, however, that this logic needs to be extended throughout the secondary mental care system (and to the relationship between primary and secondary care in the ways described in Chapter Six). Evidence from our hearings indicated that this will require more effective data-sharing but that this should be undertaken in ways that impose a minimal bureaucratic burden so that it is not achieved at the cost of patient care.

The need for a continuum model is particularly clear in the accessing of secondary mental health care. Crucially, the personalisation/personal budgets agenda could and should be instrumental in unlocking funding and achieving truly individualised responses to need.

To improve community provision therefore **we recommend that money and services seamlessly follow the patient, and that the patients' needs are not at the mercy of inflexible and disconnected funding and organisational structures**. 'Completing the revolution' to embed high quality, integrated and recovery-oriented care in the community requires a quantum shift in the personalisation agenda.

7.5.3 Care coordination

Such a seamless and personalised approach does of course require coordination of care and support focused wholly on the bespoke needs of the individual. In Chapter Two we emphasised that a care pathway should not be fixed or rigid and that people with long-term conditions or multiple needs will require a series of care pathways to reflect changes in their needs and circumstances. We pointed out that the coordination of care is essential and suggested this is most effectively achieved through a named care coordinator. We look in more detail at policy history in this specific area before making further recommendations for improvement.

7.5.3.1 The Care Programme Approach (CPA)

For 20 years legislation has been in place to facilitate coordination, with the introduction of the CPA in 1991 intended to provide a framework for effective mental health care.[63] Its four main elements are:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a key worker (now referred to as a care-coordinator) to keep in close touch with the service user and to monitor and coordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.

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63 Joint Health and Social Services Circular, 11 HC (90) 23/LASSL (90) 11, The Care Programme Approach for People with a Mental Illness Referred to Specialist Psychiatric Services, Department of Health, 1990

In 1999 the report, *Effective Care Coordination in Mental Health Services*, was published on the CPA process. It was based on research, reviews, inspections and feedback from professionals and provided new guidance which aimed to achieve:

- Integration of the CPA and Care Management;
- Consistency in implementation of the CPA nationally;
- More streamlined process to reduce the burden of bureaucracy; and
- A proper focus on the needs of service users.[64]

Nearly ten years later, in 2008, another key document, *Refocusing the Care Programme Approach,* further updated guidance and outlined the competencies of the care coordinator: 'To ensure that services are person-centred and values and evidence-based an appropriately trained and committed workforce is needed'.[65] It emphasised, as has this Review, the importance of whole systems approaches to support CPA, integrated care pathway approaches to service delivery, improved information sharing and joint working.

In his foreword Professor Louis Appleby (who gave evidence to this Review in his capacity as National Clinical Director for Health and Criminal Justice) stated that:

> '…mental health policies have increasingly focused on personalisation through an emphasis on meeting the wider needs of those with mental illness, addressing equalities, tackling the problems of social inclusion, and promoting positive risk management…The Care Programme Approach (CPA) is at the centre of this personalisation focus, supporting individuals with severe mental illness to ensure that their needs and choices remain central in what are often complex systems of care. It provides an excellent framework, the principles of which are supported by all'.[66]

However, he went on to sound a note of caution which our Review found still needs to be heeded today:

> '…there needs to be more consistency in applying these sound values and principles across the country. There is much good practice, but more needs to be done so that individuals directly feel the impact of policy advances in their daily interactions with services, and can recognise and realise the tangible benefits and outcomes from receiving them'.[67]

Our Review heard that since its inception in 1991 the CPA has been subject to robust and forceful criticism. Not only is the evidence about the fundamental effectiveness of case management equivocal at best, but the CPA is viewed as being excessively bureaucratic and as effectively turning skilled clinicians into administrators. Perhaps the most damming critique is that most patients and their families are not even aware what the CPA is.

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64   Department of Health, *Effective Care Coordination in Mental Health Services: Modernising the care programme approach*, 2009, p3
65   Department of Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance,* London: Department of Health, 2008, p2 [accessed via http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf]
66   Ibid, p1
67   Ibid, p1

7.5.3.2 Involving effective voluntary sector organisations

Ensuring the complex health and social care needs of patients with severe mental illness are met requires effective brokerage, a central feature of all case management models. **We recommend that care brokerage should be taken outside of the national health and social services and done by independent third sector organisations.** This confers a number of important potential advantages over the current CPA framework:

- The administrative burden of the CPA would be removed from clinicians enabling them to refocus their efforts on direct clinical work with patients and their families;
- Third sector organisations often have a better understanding of patients' full range of health, care and social needs; unless these are all addressed people can find it very hard to break out of vicious cycles of dependency and poverty;
- Their greater independence will make it easier for them to put the person, not the limitations of the various systems, at the centre: this is, after all, the central aim of the CPA and
- It removes the conflicts of interest that apply when a 'broker' works for a provider agency such as an NHS Trust. However, it is vital that new conflicts of interest do not emerge within the voluntary sector – we need new organisations to emerge which do not themselves provide services but are community-based and close the people they are commissioned to assist.

The voluntary sector 'army' that would be required would be composed of many people who are already embedded in service provider organisations (across the private, voluntary and statutory sectors) but who would have to be willing to leave those bodies to establish or join truly independent entities (most likely community interest companies) which could also provide the advocacy services described in Chapter Five. With appropriate training and properly commissioned posts, the creativity which we saw during field trips for the Review in the work of agencies like My Time in Birmingham and The Bridge in Loughborough can be unlocked far more effectively.

> In our polling 58 per cent of people supported or strongly supported using health budgets to pay community organisations or charities to support patients.[68]

Many organisations like these have people within them who are already acting as unofficial brokers of care and a vast range of other services because the 'can do' attitude which they bring to problem solving is essential to help those with mental illness find hope – instead of being mired in bureaucracy and unimaginative services. One trainee undergraduate psychology student who had just finished a one year placement in a community mental health team told the Review about his new ambivalence about entering the profession:

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68   CSJ/YouGov polling of 2,084 British adults, September 2011

Care UK speaking to Dr
Samantha Callan
in evidence to the Review

'I really want to work with people with mental illness. I think I am good at it and want to make a difference, but there seems to be so little flexibility about what statutory services can actually do to help them. There's a lot of rhetoric about having a holistic approach but services feel almost, well, naïve. So much is lacking, services are not varied, they all seem to touch on the same things. There are so many areas in people's lives where change is needed but this variation seems to be left to the mental health charities to provide: the social enterprises and community interest companies that have often been set up by service users frustrated at the lack of really useful support. Yet almost all the money is tied up in the NHS.'

Voluntary sector organisations who gave evidence to the Review also expressed concern at how statutory services cornered the funding when they were also making a significant difference in the lives of patients. A key example concerns family breakdown, one of the overarching concerns of this Review. When a parent with mental health problems becomes involved with social services, CAFCASS[69] and the courts due to child protection concerns, there are often over a dozen full-time statutory sector employees (local authority barristers, social workers, guardians and others) involved in a case. As part of their support across people's full range of needs, some voluntary sector organisations will represent the mentally ill person and their family in court and at case conferences, but will be the only ones sitting at the table who are not paid for their time.

Involving independent voluntary sector services in care brokerage, with the appropriate safeguards, training and accountability currently required for employing statutory sector care coordinators should level the playing field significantly as they will be driven by achieving the best outcomes for their clients. This could be vital to unlocking the potential of full-orbed care in the community as imagined half a decade ago.

We emphasise here the need for training because of doubts raised by some NHS healthcare workers that the voluntary sector would be capable of fulfilling the care

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69   The Children and Family Court Advisory and Support Service

coordinator role. They correctly drew attention to the high levels of skill, sensitivity, experience and awareness of services available locally (across all sectors) it requires. For it to be done to the high standard necessary, it requires individuals with sophisticated people skills as well as familiarity with complex healthcare systems. However, these skills can also be found outside the NHS – indeed many people have left the NHS because they want to work in the more flexible way more typically found in the voluntary (and private) sector.

An extended period of transition might be required before brokerage has completely shifted away from clinicians and other NHS workers and over to the voluntary sector because of a) existing relationships with patients and their families and carers and b) the time it will take to build capacity within a new type of organisation. However, we concluded that such a move is essential if people are to receive not only specialist treatment, but also all the other support and care they need to reduce their dependency and help them fulfil their potential.

7.5.3.3 Use of the internet to coordinate a locality's full range of opportunities

The Review came across many examples of good practice where statutory services were leveraging their partnerships with other sectors for patients' benefit. It is essential that patients in the community, across a wide range of need, are given information about interconnected services and the tools to navigate all that is available within their area as independently as possible. When combined with whatever support they need as individuals, this maximises their sense of personal responsibility for their recovery.

Case study: Brighton ROCK

Sussex Partnership Trust has an online tool called the ROCK (Recovery Oriented Community Kit) which is geared towards gradually 'pushing' people back into the community (the concept of 'leveraging' people through services is well-established in the literature, although it is often associated with coercion).[70] Its aim as a service is to take people *beyond* accessing services and facilitate their increasing participation in the community.

The ROCK is a way of coordinating and mapping local information so that people with mental health difficulties receive the help they need across the full range of what are termed 'life domains' to achieve personal recovery or a sense of wellness. Work related activity, finance, education, health and wellbeing, and community involvement are just some examples of life domains. Given the greater emphasis on helping people with mental health problems move towards work, it is likely that the first of these will become increasingly important.

It also helps people with personal budgets (some people can only use these with support, particularly in the early stages); we were told that personalised services are one of the defining values of recovery used in the ROCK model.

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70   Sheehan K and Burns T, 'Extent and pattern of leverage use in community mental healthcare: an exploratory study from the UK', *Boston Medical Centre Psychiatry*, 7, 2007, (Suppl 1):S69; Monahan J et al, 'Use of leverage to improve adherence to psychiatric treatment in the community', *Psychiatric Service*, 56, 2005 pp37-44

It facilitates partnerships with local gyms and other mainstream leisure facilities to help people recovering from mental illness access life experiences that could help them but feel remote and inaccessible without someone helping to bridge that gap. Importantly, the kit is backed up with the help of occupational therapists and other professionals so that people are not simply being referred to an online tool.

It also uses peer support and joins up with other parts of the local mental health system with the aim of aiding the process of people's discharge from secondary care services into primary care and subsequently, when and if they are ready, more or less solely into accessing support through ROCK itself.

One example of the highly bespoke assistance occupational therapists can make available to people when they are facilitating access to a full range of community-based and other support, is expertise in setting up social enterprises and community interest companies. They described a patient who had been in and out of hospital, and who is now becoming increasingly less dependent on the benefit system as a result of setting up his own community interest company, with the help of expertise from officials in City Hall. Through a whole range of these and other means, the virtual infrastructure the ROCK provides offers staff and service users a bridge to community engagement and to a much greater degree of choice and control.

We recommend that the full potential of the internet for joining up health, mainstream and other services is developed in every mental health trust or comparable structure, in a way that is wholly accessible for the users of mental health services. It is essential that people are not simply referred to an online directory of services but receive bespoke support to maximise the benefit of such virtual tools, for example by helping them forge links with key individuals in the locality who can help them make progress.

7.5.3.4 Community Treatment Orders

The Mental Health Act 2007 introduced Supervised Community Treatment (SCT). In essence this means that patients, who were previously detained in hospital under the Mental Health Act, could on discharge be placed on a CTO, which would require them to comply with certain conditions including taking their medication. Anyone on a CTO who does not comply with these conditions could find themselves being taken to hospital for compulsory treatment without having to be formally readmitted. While it was intended to help avoid the scenario of patients leaving hospital and not continuing with their treatment (with the result that their health deteriorates and they require detention again), we and others have been concerned about the much higher use of CTOs than was originally envisaged. BME patients are subject to CTOs in disproportionately large numbers; we were told by respondents that it is not uncommon for African Caribbean patients to refer to them as a 'mental shackle' they are forced to wear for an indefinite period when out of hospital.

CTOs were introduced in November 2008, so 2009/10 was the first full year in which SCT had been implemented in England. While it is too early to draw decisive conclusions about their effectiveness, particularly in ensuring that the most vulnerable get the support and treatment they need, we feel that the available data raises significant concerns about broader features of the mental health system. Lack of positive risk taking and defensive

practice are inimical to completing the revolution in mental health care we are calling for, and we shall turn to these issues after considering CTOs as they are currently implemented.

7.5.3.5 Pros and cons of CTOs

- In their favour, CTOs are perceived to:
- Be a less restrictive alternative to hospital admission;
- Enable the severely mentally unwell to live safely in the community;
- Increase social inclusion;
- Prevent the 'revolving door' syndrome;

Alternatively we heard the following concerns:

- They impose restrictions and replace one form of coercion with another, rather than building on positive risk taking.
- They may be replacing working with other agencies to support the individual and helping them to access services, by imposing control through the CTO; in other words, they could be providing a short cut, rather than looking at other ways to support 'difficult to engage' individuals (these other ways, however, might require disproportionately focusing community resources on this client group rather than sharing resource out amongst all community service users).
- They represent increased compulsion: the Department of Health estimate that individuals will stay on CTOs for an average of nine months which is far longer than hospital detention (currently 3.5 months on average).[71]
- Although intended for the 'revolving door' patient, it is possible to place someone on a CTO after their first compulsory admission for treatment.
- CTOs are imposed on people who have capacity to make treatment decisions; the Care Quality Commission recently found that fewer than half of CTO patients, 45 per cent, were perceived to lack insight into their illness. This overrides patient choice and autonomy to make decisions and arguably reinforces the stigma and discrimination that people with mental disorder face.
- They can entail forcing patients to take medication that has side effects.[72]

A range of CTO arrangements operate in different countries with identifiable *least restrictive* versus *preventive* features of design. Least restrictive CTOs' primary purpose is to provide community treatment as a least restrictive alternative to admission to hospital. Preventive CTOs on the other hand aim to put in place measures that will prevent a patient from becoming dangerous due to the deterioration of their mental state, where this is deemed to be likely.[73]

The 2004 draft Mental Health Bill proposed 'non-resident' orders with features best described as *least restrictive* by the above criteria.[74] CTOs as set out in the 2007 Mental Health Act were

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71   Department of Health, *Mental Health Bill: Regulatory Impact Assessment,* London: Department of Health, 2006
72   Care Quality Commission, *Mental health acute inpatient services survey 2009,* 2009 [accessed via: http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/mentalhealthservices.cfm 17/10/11]
73   Department of Health, *International experiences of using community treatment orders,* London: Department of Health, 2007
74   Ibid

similar to these 'non-resident' orders in design, but the Act also stated that SCT might be used for the express purpose of preventing deterioration or relapse.[75] Current SCT arrangements therefore have both least restrictive *and* preventive features.

7.5.3.6 Evidence Base

An International review of CTO's came to the following conclusions:

> *'Proponents of CTOs argue that they will lead to a decrease in hospital admissions and that they are less coercive than the hospitalization or imprisonment alternative. There is, so far, no evidence to support this. Despite obtaining data on approximately 20 different outcomes between them, with the exception of one secondary outcome, neither of the two available trials reported any statistically significant differences between the CTO and the Control groups. There were no significant differences between groups on any measures of health service utilization, social functioning or satisfaction at one year. CTO recipients were no less likely to be readmitted to hospital, and they were just as likely to comply with medication as those receiving standard care. The numbers of acts of violence and arrests, and the numbers of people who were homeless by one year were also similar in both groups. In fact, none of the nine experimental studies found evidence suggesting that CTOs reduce either hospital readmission or length of stay, or that they improve compliance.*

> *...Only patchy evidence exists on the direct effects of CTOs on patients. None of the nine studies found any effect of CTOs on social functioning, offences resulting in arrest, homelessness, general mental state, psychopathology, quality of life, carer satisfaction, or perceived coercion...In summary, this review has found very little evidence of positive effects of CTOs in the areas where they might have been anticipated'.*[76]

Much of the research came from the US where CTO's are court appointed, unlike the UK where a clinician makes the decision. The review found evidence of a measure of support for CTOs from service users and their families, where these enabled them to avoid being admitted to hospital and to access services that were previously unavailable.

Our own Review encountered mixed views about CTOs. We were told that for CTOs to work well, the engagement of patients is essential. They need to have a good rapport with the Community Mental Health Team that works with them and CTOs tend to work best for those who have a psychotic illness that responds well to medication. The Review heard from psychiatrists who had formerly only seen particular patients in a hospital setting but were now, under the conditions of the CTO, having contact with these patients in their homes. This continuity of care gave them greater insight into the lives of their patients and potentially enhanced their therapeutic relationship with them.

However concerns were expressed among people administering the Mental Health Act that clinicians and patients appear to have a lack of knowledge about what CTOs entail. GPs were not having sufficient contact with such patients, despite their vulnerability. Some patients did

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75   Mental Health Act 2007 (c.12) Pt I Ch 4 Section 32 [accessed via: http://www.legislation.gov.uk/ukpga/2007/12/section/32 17/10/11

76   Department of Health, *International experiences of using community treatment orders*, London: Department of Health, 2007

not appear to be aware that they were subject to a CTO. Some felt CTOs involved a lot of form-filling which restricted therapeutic time while others argued that the bureaucratic burden was fairly light.

Given how important we consider a seamless connection between hospitals and community settings to be, we were concerned to hear from a number of different professionals how little communication there can be between the team responsible for the care of the patient in hospital and the community mental health team responsible for aftercare (in contrast to the continuity of care described above). We were informed of patients being discharged from hospital on CTO without the community team being aware that the patient had been discharged or that a CTO had been made. In addition, we were informed that the clinician making the CTO does not always consult the community team before making the conditions attached to the CTO and that the conditions made might not be achievable if the clinician responsible for making them was not fully aware of what was available in the community. This can set patients and community teams 'up to fail' if the goal is to make progress and avoid unnecessary distress and repeat hospitalisation.

Finally, both the frequency with which CTOs are imposed and the length of time many patients are under them (and therefore subject to the threat of recall to hospital) were considered problematic by some of our consultees and also by the Care Quality Commission.

7.5.3.7 Early findings on the implementation of CTOs

The Care Quality Commission (CQC) have, since April 2009, had a duty under the Mental Health Act 1983 to monitor the way services use the powers and responsibilities invested in them by that Act concerning patients who are detained in hospital, subject to CTOs or guardianship. Its report on the first full year of CTO rollout highlighted the following concerns with CTOs based on statistical analysis of their usage and qualitative research on patients' experiences.

- Since supervised community treatment powers were introduced in November 2008, more than 6,000 Orders have been made; this is far in excess of the number of CTOs expected when the new legislation was introduced. A higher proportion of BME patients (than might be expected from either the general or the detained population census) had been placed on a CTO.
- Sampling showed that 30 per cent of people on these orders did not have a history of non-compliance with their medication or broader treatment. The CQC speculated that this might indicate CTOs are being applied preventively and unduly coercively for a significant minority of CTO patients, rather than as a response to previous unwillingness to cooperate or engage with services.
- The number of applications to the Mental Health Tribunal increased markedly in 2009, with 12,122 hearings in the year; the annual average since 2000 was slightly below 10,000. Much of this increase was due to applications from CTO patients – but these appeals are more likely to fail than appeals against detention.
- An important principle of mental health practice is that patients, including those on CTOs, should be fully involved in planning their care and treatment; patients' attitudes towards being on a CTO depended largely on whether or not the details of their order had been decided through discussion with them. Positive views towards CTOs tended to

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be correlated with a high degree of patient participation. Where patients had been less involved (and some patients did not know or understand the conditions with which they were expected to comply) they commonly treated CTOs as a mechanism for coercing them to comply with a medication regime.[77]

To address these concerns, *inter alia*, the Care Quality Commission urged service providers to avoid unnecessary restrictions and blanket security measures:

'that compromise patients' privacy or dignity, or unnecessarily restrict their autonomy. Not only may these be countertherapeutic, but they could also breach human rights principles and are wrong. To help reduce the chance of incidents that might lead to the use of more restrictive interventions, and to promote dignity and safety, we also emphasise the importance of a positive therapeutic environment, supported by an appropriate staffing level and skill mix.'[78]

While emphasising the need for more research they concluded that 'It would be an extremely unfortunate distortion of Parliament's intention if CTOs were to become the 'normal' route for the discharge of civil detainees from hospital'.[79]

Writing in The Guardian shortly after the Care Quality Commission report came out, Dame Jo Williams, Chair of the Care Quality Commission referred to the fears it raises that '''defensive' practice, increasingly apparent in mental health services driven by concepts of risk rather than just treatment, could lead to CTOs being the default discharge power for detained patients, rather than a measure applied only to those for whom it is really needed.''[80] She points particularly to the finding noted above that almost a third of patients had no history of non-compliance. In other words, control was being imposed without due cause.

Defensive practice is not limited to the imposition of CTOs (and unlikely therefore to be simply a possible artefact of the relative newness of this legal instrument in the UK). The University of Liverpool's recently published investigation into institutional and individual responses to the Mental Health Act 2007, was particularly concerned with its impact on perceived patient risk profiles and decision making responses.[81] Given the evidence we received on CTOs and the Care Quality Commission's concerns we concur with the researchers that:

"Defensive practice is a controversial problem, especially where a clinician's 'erring on the side of caution' can have profound consequences for his/her patient's civil liberties. The researchers believe that defensive practice in mental health services warrants proper investigation".[82]

77   Care Quality Commission, *Monitoring the use of the Mental Health Act in 2009/10: The Care Quality Commission's first report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983*, London: Care Quality Commission, October 2010
78   Ibid, p5
79   Ibid, p99
80   The Guardian, *Are community treatment orders being over-used?*, 27 October 2010 [accessed via http://www.guardian.co.uk/society/joepublic/2010/oct/27/community-treatment-orders-mental-health]
81   Glover N, *An Investigation into Initial Institutional and Individual Responses to the Health Act 2007: Its Impact on Perceived Patient Risk Profiles and Responding Decision-Making – Final Report, Thomas School of Law and Social Justice University of Liverpool* [accessed via: http://www.liv.ac.uk/law-and-social-justice/research/health/publications/An_Investigation_into_Initial_Institutional_and_Individual_R.pdf] (12/10/11])
82   Ibid, p127

We also accept that it is possible some 'settling down' in the use of CTOs will take place; for example we know of at least one trust where people administering the act are asking for an internal review that will ask, for example, how often non-compliance with medication is an issue, the level and types of risks involved and how many recalls to hospital were made. However, where defensive practice and a lack of positive risk-taking prevails we will not see the transformation in outcomes for the most vulnerable in society that is of foremost concern to this Review.

In summary, while they can work well in some circumstances, CTOs can extend compulsion and increase stigma, which hinders recovery and reintegration back into the community. **We recommend that, if the Care Quality Commission continues to find that numbers of CTOs remain high, this should be a priority area for parliamentary scrutiny in advance or as part of an overarching review of mental health legislation.**

Similarly, over the course of the Review we have been concerned that, overall, mental health legislation may still not be fit for the purpose of facilitating the completion of the revolution in the care of the mentally-ill that we are calling for. **We therefore support the Future Vision Coalition's call to carry out a major review of the use and impact of the 2007 Mental Health Act after a sensible waiting period:**

> *'We believe that the legislation will need to be reviewed within the next decade to ensure we have the right legislation to underpin modern services, and at the very least to introduce a coherent approach... if the legislation does not meet the needs of a 21st-century service, it should be amended so that it does'.*[83]

7.6 Summary of recommendations

7.6.1 To improve the care patients receive in hospital:

- Acute inpatient psychiatric wards should be replaced by PICUs (as many are already *de facto* performing this function) which have higher status, better defined models of care and more of a focus on working intensively with the patient so that their care can be 'stepped down' to a community setting at the earliest, most therapeutically appropriate point.

- Clinical leadership will be indispensable to realise the potential of such a shift; nurses have a strong part to play in leadership alongside other professionals in multidisciplinary teams. Ward managers should ensure that far more proactive approaches such as protected engagement time, evidence-based psychosocial interventions and other practices are faithfully implemented and delivered by more nurses. They are an essential part of the in-patient workforce who are potentially under-utilised.

- All nurse training should start with generic skills and knowledge, including about mental illness. It should reflect the prevalence of mental health problems, the co-existence of mental and physical ill-health and the need to avoid stigma and promote good mental health behaviours in whichever specialism they practice.

83 The Future Vision Coalition, *A future vision for mental health* 2009 [accessed via http://www.newvisionformentalhealth.org.uk/A_future_vision_for_mental_health.pdf]

- Nurses should be seen as playing an indispensable role in joining up mental, physical and public health, by ensuring that patients receive care to treat or prevent the emergence of comorbid conditions.

- Training for all mental health professionals should lever evidence-based interventions into routine practice and aim to terminate ineffective traditional practices.

7.6.2 To improve the care people receive in the community:

- Local authorities should bolster the provision of 'family-sized' care through initiatives such as Shared Lives that provide viable and more compassionate alternatives to residential care.

- Forward funding models which ensure money follows the patient into the community and is not tied up in hospitals (hampering the 'stepping down' of care), should be adopted by local commissioners as part of the broader project of aligning social and mental health care funding and delivering services through Payment by Results/Outcomes. Patients' needs should not be at the mercy of inflexible and disconnected funding and organisational structures.

- Shift responsibility for care brokerage over to independent voluntary sector services, with the aim of ensuring better access not only to specialist treatment but also to all the other support and care patients need to break out of vicious cycles of dependency and poverty wherever possible.

- The full potential of the web for joining up health, mainstream and other services should be developed in every mental health trust or comparable structure in a way that is wholly accessible for the users of mental health. It is essential that people are not simply referred to an online directory of services but receive bespoke support to maximise the benefit of such virtual tools, for example by helping them forge links with key individuals in the locality who can help them make individual progress.

- CTOs can extend compulsion and increase stigma which hinders recovery and reintegration back into the community. If the Care Quality Commission continues to find that numbers remain high, the CSJ calls for parliamentary scrutiny in advance or as part of an overarching review of mental health legislation.

- More broadly we support the Future Vision Coalition's call to carry out a major review of the use and impact of the 2007 Mental Health Act after a sensible waiting period,[84] that will consider, *inter alia* the extent to which positive risk taking is encouraged, defensive practice discouraged and the law is fit for purpose for twenty-first century expectations surrounding mental healthcare.

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84   Ibid

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