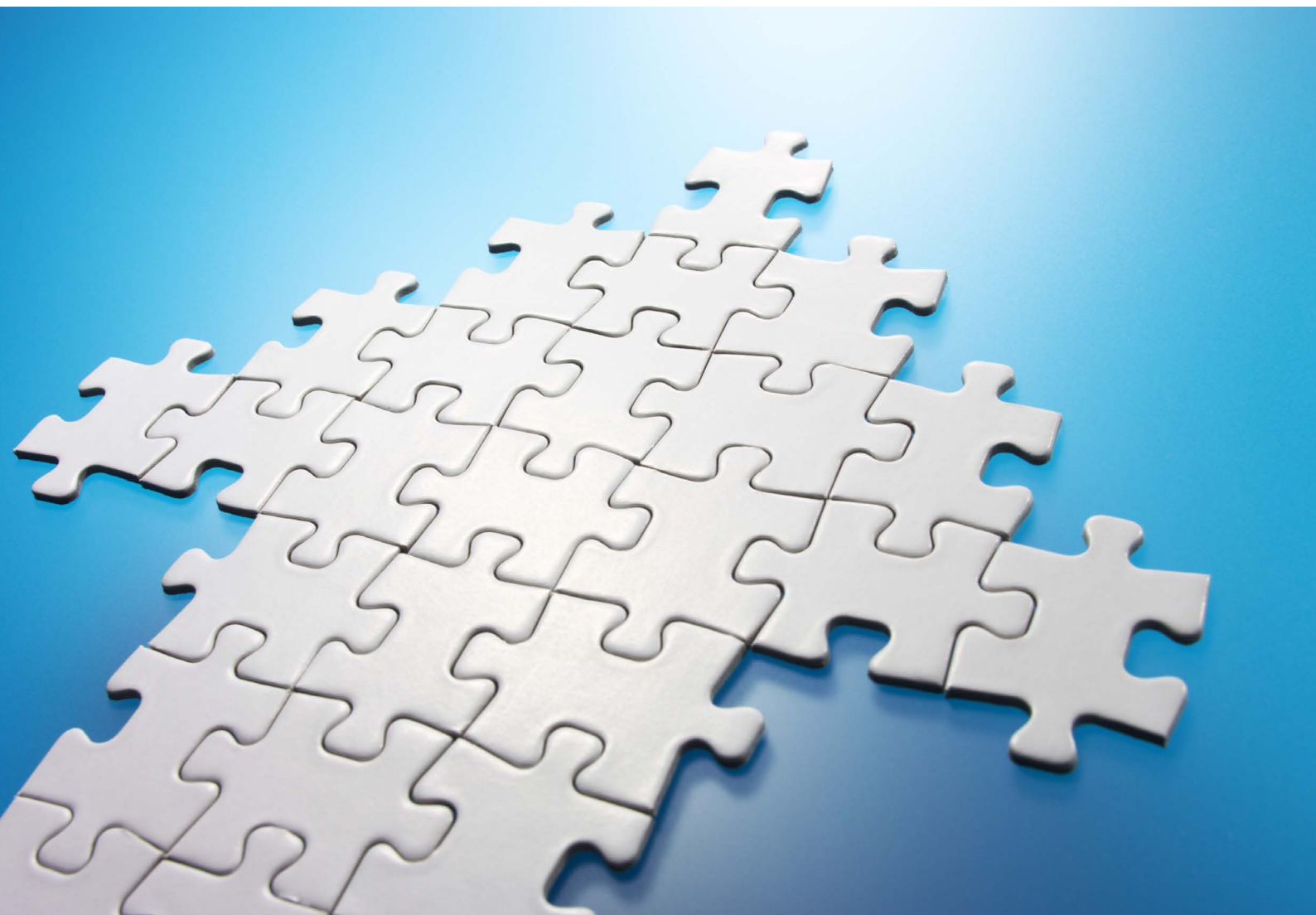




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Starting today

The future of mental health services

Final Inquiry report
September 2013

Acknowledgements

We wish to thank all those who took part in our Inquiry for their support and contributions, and especially the members of our Advisory Panel. We record their names in the Annex to this report.

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Throughout this report we quote from witnesses who attended oral evidence sessions, members of our Policy Panel (some 500 people who include mental health service users, carers and mental health professionals) and respondents to our Call for Evidence. In the latter case, responses are referenced by the number of the question asked (1-6), followed by the number of the respondent (1-1533). Hence, for example, 3.602 is the 602nd response we received to question 3.

Foreword

Mental health is an integral part of an individual's well-being. It means different things to different people, as does mental illness. There is considerable evidence to indicate that the health and economic burden related to poor mental health in the UK is significant - greater than cardiovascular diseases and cancer - and yet the emphasis on mental wellbeing is often very limited.

Reasons for this relative neglect are many, but include a perception that mental ill-health is somehow self-inflicted, with an external locus of control such as an inability to deal with pressures, and discrimination as well in poor recognition of the scientific basis of psychiatry. Fortunately in the past few years this has started to change with policymakers becoming more aware of the implications of untreated mental illness. The current economic downturn around the globe has also led to mental illness, emotional distress and resulting physical distress being better recognised and addressed than before.

There is widespread agreement, though, that more needs to be done, and that the future is very uncertain. Accordingly, in 2012 the Mental Health Foundation, as a leading charitable organisation dealing with both public mental health and mental health care, decided to set up an Inquiry to look at the future of mental health services in the UK over the next 20 to 30 years.

We were delighted to chair the Inquiry Advisory Panel. The future is always difficult to predict and we recognised the danger in trying to do so. However one thing that we can be certain of is that the future will happen, and the present will affect the future. We know that people are going to be living longer and therefore likely to experience a greater number of illnesses, whether physical or mental – or, as is likely, both. We have good predictions of the numbers of older individuals in 20-30 years' time, and we are also able to make reasonable assumptions about prevalence rates of mental disorder across all age groups and the incidence of disorders in vulnerable groups.

However there are certain trends which are not very clear. For example, rates of migration and speed of globalisation and urbanisation will affect psychiatric vulnerability but we cannot predict by how much and how these needs can be met. The impact of the current economic downturn will be felt for a long time and it is highly unlikely that health and social services will ever get the same amounts of generous funding that we have had in the UK in the past two decades. Hence we need to look at fresh ways of developing and delivering services.

What is clear from our Inquiry is that we need to start taking action today to address all the factors we are aware of that challenge good mental health, and lead to mental illness. We cannot expect mental health services simply to muddle along with no clear sense of what is required, and sleepwalk into the future. If we do so, we will be failing both today's and tomorrow's generation of people who will need mental health services, and their carers and families, as well as the staff who work in mental health services. This is not just about more effective care provided by specialist mental health services. It is also about the role of primary care mental health and the crucial public mental health agenda. We hope that this Inquiry will be a major step in this direction.

To support our Inquiry, we have been extremely fortunate in getting a large number of very busy people together who have given up a considerable amount of their time and energy to this task and we are grateful for that. Staff within the Foundation have worked incredibly hard to deliver the report. We would like to thank in particular Andrew McCulloch for his support and Simon Lawton-Smith and Hannah Bullmore for their hard work and energy. While acknowledging the seriousness of the issue, Foundation staff have also made it enjoyable for us to work on this project - many thanks.

Dinesh Bhugra

Alex Carlile

Summary

We spend more across the UK on mental health services than on any other area of health, including cancer and heart disease. The economic impact of poor mental health is estimated to be over £100 billion to the economy each year in England alone. Yet despite this, we know that the care and treatment that we offer people with mental health problems is variable - many people with mental health problems have trouble accessing services; interventions are not always effective; services can be poor at providing a holistic response to people's needs, for instance neglecting people's physical health; and many simply get no help at all (some do not seek it, or give up trying due to difficulties accessing help).

At the same time, there are many challenges facing mental health services as we look to the future, including persistently high levels of psychiatric morbidity, increasing levels of comorbidity and multiple morbidity, an ageing population with high health and social care needs, barriers to providing good integrated care and severe constraints on public spending.

It is against this background that in 2012 the Mental Health Foundation established its Inquiry into the Future of Mental Health Services (FOMHS), with the following aims:

- i.* To review the provision of mental health services in the UK in the light of current and future health and socio-economic developments
- ii.* To promote debate on the proper aims and ambitions of mental health services

- iii.* To consider how to make mental health services fit for purpose to deal with challenges 20-30 years in the future.

It is estimated there will be nearly 8 million more adults in the UK by 2030. If prevalence rates for mental disorders stay the same (at around one in four), that is some 2 million more adults with mental health problems than today. It is also estimated that there will be one million more children and young people in the UK by 2030. Again, if prevalence rates for mental disorders stay the same (at around one in ten), that is some 100,000 more children and young people with mental health problems than today.

It goes without saying that future mental health services need adequate funding to ensure appropriate levels of services and skilled staff. We have not, however, specified any amount or proportion of funding that should be spent on mental health services, nor from where the funding might come. These are decisions that will need to be taken by politicians of the future, and they do not affect our key messages about what mental health services need to do today to start moving towards effective mental health care in 20-30 years' time.

Nor do we attempt to resolve all of society's ills, such as inequality, debt, unemployment and homelessness, which underpin much poor mental health and mental illness across the UK, though these issues were regularly raised in evidence put to the Inquiry. Our focus is mental health services of the future. In considering public mental health issues we do touch on the pressing need for a greater emphasis on the prevention of mental illness, to ease future pressures on services, but a fuller discussion of this falls outside the remit of this Inquiry.

We need fresh ways of working in mental health. New technology will no doubt force some changes. But much of what in our view needs to be done is simply implementing known good practice that already exists. Failure to provide good, integrated mental health care is not a failure of understanding what needs to be done, it is a failure of actually implementing good practice in organisational

strategies and the day to day business of providing people with the care and treatment that they need and want. We need to start today to rectify that.

Key messages

Personalisation

Co-production in terms of service development and service delivery should in principle be the default for all patients receiving mental health services in the future, regardless of diagnosis.

The early training of all health and social care staff, and their continuing professional development, should include as a core principle the need to provide patients with a personalised service, and to involve them, and their family and carers, as equal partners in decisions about mental health service design and service delivery. This means that we will need to recruit a workforce for the future that has a truly participative and listening approach to patient care, as well as skills helping people who may lack capacity to make decisions.

This message also applies to national and local commissioners of mental health services across the UK, who we would like to see review their commissioning processes to ensure the engagement of service users, families and carers.

Self-management

Mental health services need to build service users' capacity to safely self-manage their conditions. This will involve training service users both in their own care (whether it is, for example, adherence to prescribed medication, managing a comorbid physical health problem, self-help psychological therapy or improving diet and exercise regimes) as well as establishing ongoing monitoring and support that ensures people are self-managing their condition effectively. There may be an important role for peer support in this process.

Mental health in primary care

GPs of the future need to become leaders in mental health care. This does not mean they need to become mental health specialists, but it does mean that they need to know as much about mental health as they do about physical health.

In the future mental health services should be primary care led, with specialist interventions and expertise easily accessible in primary care settings. This will involve professionals on both sides of primary and secondary care

working together in a more collaborative way, alongside patients and family and carers. However the very language of "both sides" is unhelpful. What in effect we would like to see is a merging of primary and secondary care services so that the distinction (and many of the problems that arise from people being moved from one 'box' to the other) becomes much less evident.

This will assist a more accessible and holistic care regime for individuals, who will often have complex multiple needs, and should also help to facilitate a better coordinated care pathway for any patients who require hospital care, particularly on discharge. It will require psychiatry, and other mental health specialisms such as mental health nursing and psychotherapy, to establish themselves as primary care services within a primary care team.

Crisis care and community support

People want good, local, expert community support, both when they are in need of crisis care and in helping them to cope with the problems and challenges of daily living. There are good examples of such services in the UK, but they are patchy, and under pressure from both demand and financial constraints. If mental health services in the future are to meet people's needs in these areas, then local commissioners across the UK need to learn from these models and discuss with mental health service users and their carers how they can be implemented more widely.

Collaborative working and integrated care

What came out most strongly from the evidence was that it is people and relationships, rather than structural arrangements, which secure good integrated care. It is sobering that this message has been recognised in debates about integrated health care for, literally, decades, yet we are still talking today about how to improve staff commitment and attitude towards integrated care.

We may not be able to do much about changing human nature in terms of natural collaborative instinct. What we can do, though, is to maximise opportunities for both the current and future health and social care workforce to be better informed about the indivisibility of physical and mental health and the value of collaborative working and the skills that colleagues in other disciplines can bring to patient care. These issues need to be a core element of early basic training of all health and social care staff. There should also be an expansion of continuing cross-boundary

inter-professional training and education. All professional bodies should make such training a requirement of continuing professional development for their members.

There are a number of structural arrangements that can help to establish effective integrated care for people with mental health needs. Among the most important are having effective information-sharing systems, the ability to pool funds from different funding streams into a single integrated care budget, shared protocols and partnership agreements, co-location of services, multidisciplinary teams and liaison services. All these should be further developed so that future mental health services can be based on proven and effective service delivery mechanisms.

However while these are all necessary and helpful, it is the quality of people involved that makes or breaks integrated care – leaders with a determination to drive forward integrated care at an organisational level as a way of improving patients' experience and outcomes, and staff who understand the holistic nature of health care and have no professional defensiveness about working closely with colleagues in other disciplines, and with patients and families.

The future of effective integrated care therefore lies primarily in recruiting, training, maintaining and developing a workforce, both in health and social care, which is passionate and committed to the principles and practice of holistic care and partnership working.

Early life

Infants and young children growing up today, many in damaging environments, are the young parents of children growing up in 20–30 years' time. It is essential that mental health services both today and in the future are geared up to intervene early when problems are identified, and support parents and their children to break any generational cycle of poor mental health and mental illness.

Investment in early years support is likely to repay its costs many times over by reducing use of health and other public services, and will also significantly improve the health, educational and social outcomes for children of the future as they grow into adulthood.

Later life

The increasing numbers of people across the UK who are likely to experience dementia is a major challenge for the future. Current initiatives to address this challenge need to be actively pursued. However, there is less focus on the many other mental disorders that older people will face, such as depression. Mental

health services of the future need to recognise the prevalence of these disorders among older people and provide a comprehensive response to need.

Older people must also have a voice in future mental health services. This will require the future mental health workforce to increase its skills around mental health in later life, as well as having a better understanding of older people's ability to make informed choices about their care.

Workforce

The mental health workforce of the future needs a balance of specialist and generalist staff, with clearly defined skills and roles, but able and willing to work collaboratively in support of individual patients. While we would urge an increased knowledge and understanding of mental health issues among generalist staff, and particularly GPs, as we would physical health issues among specialist mental health staff, it will be important not to water down the specialist skills that at times mentally ill people both need and want.

The very strong backing that peer support received during our Inquiry convinces us of the need to develop both formal and informal arrangements to increase opportunities for people with lived experience of mental illness to play a role within the future mental health workforce. We are not prescriptive about the precise role that trained peer support workers could play. This would need to be decided by local services, based on local expressed needs and choices.

Again without being prescriptive about the detail, and recognising the potential overlap with formal key workers and care coordinators, we strongly support the principle of a single individual within the future mental health workforce who can help people navigate their way through complex systems across health, social care, housing, employment and education (among other services) and access integrated care packages. In our view this would go a long way to ensuring that people not only receive the best support, but also play as full a role as possible in their community. This should be a priority area for research in terms of effectiveness and patient outcomes.

Research

The mental health workforce of the future needs to know what are the best, evidence-based clinical and social interventions they can offer to people. However this knowledge will not be available to them unless there is a significant investment in mental health research over the coming years, to redress the

current imbalance between low investment and the high burden of disease caused by mental illness.

Information sharing

It is essential for good, safe and effective mental health care in the future that we develop systems across the UK to share patient data more freely, involving patients themselves in decisions to do so. This is both in terms of information about an individual patient, so that the best integrated and holistic care can be provided, and in terms of anonymised collated data to allow better research to be undertaken into cohorts of people with a mental illness.

We cannot countenance a situation in 20-30 years' time when a failure to exchange relevant data leads to the death, or even serious harm, of a patient or any other individual as a result of a mental illness. IT systems that allow comprehensive information sharing must be developed both within health and social care, and across relevant organisations such as schools, housing organisations, prisons and the police, while still ensuring that people's legally-enshrined rights to privacy remain protected.

New technology

Our message about new technology in future mental health care is twofold. First, while new technology will almost certainly bring improvements to the delivery of mental health care, and help people self-manage their condition more easily, it is not a panacea. One-to-one human contact, a smile and kind words have a timeless benefit to people with mental health problems.

Second, we should not assume that the benefits of new technology will automatically apply fully and equally to all those who use mental health services in 20-30 years' time. Many people will continue to need active support to gain equal benefit from new technology, and this support must be available from within the future mental health workforce.

Public mental health

The case for more preventative work is undeniable. Indeed, lacking a 'cure' for mental illness, and assuming that mental health services will not have unlimited funding in the future (whether public or private), a reduction in the number of people across the UK developing mental disorders appears to us to be the only way that mental health services will adequately cope with demand in 20-30 years' time.

We touch on the need to bolster this element of future work when discussing early years, such as through parenting and school-based initiatives, although it applies to all ages. We need to be just as passionate about preventing mental illness in adult and later life as we do in early life.

Mental health professionals have an important role to play in public mental health, and must be ready to deliver advice and support as required. This means that excellent working relationships will be required between mental health services, public health services and other services that have contact with the general public, of all ages, across the UK. Mental health professionals need to be aware of how to promote good mental health, and prevent mental illness, and to consider this as part of their role and responsibilities.

Based on data from the past 20 years, we have assumed that prevalence rates of all the major mental disorders among adults and children across the UK will remain broadly stable over the next 20-30 years. We do not think this is inevitable, but it will require significant investment in public mental health, early years support and early intervention services if we are to improve the situation. Such investment has been insufficient in the past.

The training, education and continuing professional development (CPD) of all public health staff need to have mental health as a core component, and Directors responsible for public health across the UK should prioritise public mental health in their work programmes. This will bring benefits to individuals, families and the wider community, in terms of mental, physical and social health.

Stigma

The public stigma attached to mental illness will continue to blight lives in 20-30 years' time, and hinder recovery from mental illness, as it does today, unless we continue forcefully to address it through the best evidence available, and undertake more research into effective approaches.

People, carers and mental health professionals want a future without stigma and discrimination. Children and adults who are better informed about mental health issues would help to create a future environment in which the stigma of mental illness will gradually fade away, though this may be a matter of decades rather than years. Current evidence-based education and interpersonal contact initiatives need to be expanded, and more research undertaken into effective activities, so that the future mental health

and public health workforce knows what works best to tackle negative attitudes and behaviour.

The professional stigma that surrounds mental illness is a significant factor in hindering the effectiveness of mental health interventions and people's recovery, establishing psychiatry and other mental health services as the 'poor relation' within the health workforce, and deterring new trainees from specialising in mental health. Basic early education of all healthcare staff in mental health and more interprofessional education and continuing professional development would help overcome this problem in the future. Allied to this, psychiatry, and other mental health services, need to start to 'sell their successes', in particular getting across the message that many people, even with severe mental illness, can, and do, recover.

Background and Terms of Reference

The past few years have seen intense debate about the future of both the NHS and social care across the UK. This has been not just about how best to organise and deliver health and social care services to the population – with four different systems operating across the four countries – but also, how to pay for care in the future. The increasing demands made on the NHS and local authorities year on year, alongside the continuing UK recession, has made this one of the key public policy debates of our time.

Nowhere is that debate more pertinent than in the area of mental health care. We spend more across the UK on mental health services than on any other area of health, including cancer and heart disease. The economic impact of poor mental health is estimated to be over £100 billion to the economy each year in England alone (Centre for Mental Health, 2010). Yet despite this, we know that the care and treatment that we offer people with mental health problems is variable - many people with mental health problems have trouble accessing services; interventions are not always effective; services can be poor at providing a holistic response to people's needs, for instance neglecting people's physical health; and many simply get no help at all (some do not seek it).

“We live in very difficult times. As the world adjusts to emerging economies, we, the old economies, are shrinking, with all the consequences that come with this transformation: less work, more risk of poverty, then feeling of worthlessness in the unemployed, leading to a rise in mental health problems. All the while, we also have less money to invest to address the problems in question. This situation is likely to last over the next 20-30 years if not more, so there will be a rise in mental health difficulties and there will be less resources to help.” (3.602)

In order to provide good quality care, mental health services face a number of challenges – understanding better the causes and complexity of mental illness, and its relationship to physical illness; defining their role within the jigsaw of services that make up multidisciplinary health and social care; implementing the best possible evidence-based models of care; helping to develop more effective interventions, whether pharmacological or psychosocial; recruiting and training adequate numbers and types of professional staff; involving patients and carers more in care and treatment plans; coping with tight budgets and the perverse incentives that can occur through funding systems; tackling the stigma attached to mental illness; engaging with other areas of public services, such as housing, education, welfare benefits and the criminal justice system; reducing the persistent high levels of mental illness across the UK, and what appear to be increasing levels of comorbidity or multiple morbidity.

Many of the challenges facing mental health services were encapsulated in the key findings from a 2012 report from the Kings Fund looking at transforming the delivery of health and social care more generally (Kings Fund 2012), namely

- Services have struggled to keep pace with demographic pressures, the changing burden of disease, and rising patient and public expectations. Too much care is still provided in hospitals and care homes, and treatment services continue to receive higher priority than prevention.
- The traditional dividing lines between GPs and hospital-based specialists, hospital and community-based services, and mental and physical health services mean that care is often fragmented and integrated care is the exception rather than the rule.
- Current models of care appear to be out-dated at a time when society and technologies are evolving rapidly and are changing the way patients interact with service providers.
- Care still relies too heavily on individual expertise and expensive professional input although patients and users want to play a much more active role in their care and treatment.

It is against this background that the Mental Health Foundation established its Inquiry into the Future of Mental Health Services (FOMHS), with the following aims:

- i. To review the provision of mental health services in the UK in the light of current and future health and socio-economic developments
- ii. To promote debate on the proper aims and ambitions of mental health services
- iii. To consider how to make mental health services fit for purpose to deal with challenges 20-30 years in the future.

What are 'mental health services'?

The terms of reference beg the question – what are 'mental health services'? For the purpose of this report, we defined them as services commissioned by NHS and local authority commissioners, provided by NHS, independent and voluntary sector services and local authority social services, as a result of a person being assessed and diagnosed as having a mental disorder. However we

also included a discussion of public mental health services, given the importance of public mental health in terms of future mental health and mental health services across the UK.

It is possible that there will be over the next two or three decades a fundamental shift in thinking about what a 'mental health service' is. In 2040 we may well be less concerned about defining a 'service' or 'treatment' for a specific mental disorder and more concerned with the interventions which limit, reduce or remove factors (usually common to more than one illness, affecting both physical and mental health) which contribute to mental illness, such as poverty, domestic violence and child abuse. However we do assume that there will still be people in 20-30 years' time who develop mental disorders, and who need the best possible care and treatment – accessible, effective, affordable and user-friendly. That is fundamentally what this Inquiry is about.

What the Inquiry does *not* do

Although we make certain assumptions about the future, based on the best evidence available, we do not try to second-guess exactly what the world will look like in 20-30 years' time. We can be pretty sure that we would be wrong.

We consider the impact of dementia (an organic disorder), but not learning disability (a developmental disorder) – though keeping in mind that some 40% of people with a learning disability also have a mental health problem.

We do not look to reach tailored conclusions about the way forward in each of the four countries of the UK, with their separate health and social care systems, but rather choose to deliver headline messages that we believe apply equally across the UK.

We do not attempt to resolve all of society's ills, which underpin much poor mental health and mental illness across the UK. Significant numbers of respondents to our Call for Evidence argued that to establish good mental health in the future we need to address societal issues today, in particular poverty and inequality.

"We need to be promoting autonomy by providing the resources for the person to be in a position to do this. A model that responds to poverty, poor housing, emotional trauma, lack of education, and psychological and social resources, that challenges structural inequalities such as disparities in life chances and opportunity." (2.579)

We do touch on this issue when discussing public mental health, one of our key themes. We are well aware of the negative impact that social factors such as debt and unemployment can have on mental health, and the important role of housing, employment, welfare benefits and the criminal justice system can play in people's lives, and in particular their recovery from an episode of mental illness. However a fuller discussion of this falls outside the remit of this Inquiry.

Many respondents referred to resources and funding, and the current impact of Government austerity measures and cuts to mental health services. It goes without saying that future mental health services need adequate funding to ensure appropriate levels of services and skilled staff. We have not, however, specified any amount or proportion of funding that should be spent on mental health services, nor from where the funding might come. We heard views that the sort of 'free' access to NHS care that exists today will no longer exist, and we may well be in a position of insurance-based care (common elsewhere in the world) or shared or 'top-up' payments. However these are decisions that will need to be taken by politicians of the future, and they do not affect our key messages about what mental health services need to do today to start moving towards effective mental health care in 20-30 years' time.

We do not consider future mental health (or disability, or equality, or human rights) legislation. We assume that there will still be people who become very unwell, and who on grounds of risk and / or capacity will require some form of compulsion without their consent, with appropriate and effective safeguards. Other than a number of respondents telling us that there should be less compulsion in the future, a view that we shared, we heard no evidence to allow us to form a judgement on what the mental health legislation of the future should look like.

Methodology

Inquiry Panel

We invited representatives of a number of national organisations to join an Advisory Panel to the Inquiry. The Panel was co-chaired by Professor Dinesh Bhugra and Lord Carlile of Berriew. A full list of Panel members is in the Annex to this report.

Oral evidence sessions

We held 12 oral evidence sessions between January 2013 and April 2013, ten in London, to which English and Welsh witnesses were invited, one in Scotland and one in Northern Ireland. All witnesses are listed in the Annex to this report.

Formal Call for Evidence

We issued a formal Call for Evidence between December 2012 and May 2013. We received 1533 responses from a range of mental health service users, carers and family members and health professionals.

Individual interviews

We undertook three individual interviews between March and July 2013. The names of interviewees are listed in the Annex to this report.

Expert seminar / one day event

We held an all-day expert seminar on 24 June 2013 in London to discuss the initial findings from the Inquiry. 38 people attended, and are listed in the Annex to this report.

Background papers

We commissioned four short background papers to support the Advisory Panel's discussions, on Inequalities and Mental Health; a brief history of specialist mental health services; Healthcare Informatics for Mental Health: Recent Advances and the Outlook for the Future; and Mental Health Professional Education and Training in the UK. These papers are available through the Foundation's website at mentalhealth.org.uk.

Visions of the future

We did not seek to gaze into a crystal ball to second-guess what the future will look like. But we did look at a number of visions of the future for mental health, which provided us with a helpful benchmark against which to discuss what mental health services should offer in the future.

In 2005, the Centre for Mental Health looked forward ten years to 2015 – now just two years away (Centre for Mental Health, 2005). Its vision included:

- by 2015, mental wellbeing will be a concern of all public services
- the balance of power will no longer be so much with the system, but instead there will be more of an equal partnership between services and the individual who uses, or even chooses, them. Individuals will make appointments at times that suit them rather than being told when to turn up
- mental health services will be integrated into ordinary health and other services: in libraries, GP surgeries and schools. People seeing their GP with mental health problems will be able to choose from a range of treatment options based on authenticated research evidence without facing long waiting times. For those with the most serious problems, acute care will be available in crisis houses or even ‘hotels’ as well as hospitals. They will.... be advised by an ‘associate’ with expertise in employment, benefits and housing as well as treatment and care
- the physical health of people with mental health conditions will be a priority for primary care. Help to prevent weight gain and stop smoking, and advice on regular exercise will be freely available

- the Government will lead in continued efforts to combat prejudices about mental health and make discrimination difficult.

In 2009, the Future Vision Coalition, a consortium of leading voluntary sector and professional organisations, produced its own future vision, to assist the Government of the day to develop its new mental health strategy for England (Future Vision Coalition, 2009). The coalition suggested that

- all government departments work collectively to create the conditions where good mental health can flourish. And all public services ensure that their actions promote mental well-being among their clients, their staff and in their wider communities
- people of all ages, backgrounds and social groups receive support to attain good mental health and to build their resilience in tough times. Those who are most vulnerable, because of their life circumstances, should receive additional help to prevent mental ill health, while children and families get early support when problems emerge
- people experiencing mental health difficulties are supported to make their lives better on their own terms. Those seeking work are supported into appropriate employment or other meaningful occupation and, once there, are offered ongoing support for as long as needed
- people with mental health problems are enabled to take control of their own healthcare. A range of care and support services are offered, from which individuals can choose to enhance their quality of life and achieve their goals. A different relationship – a partnership – is established between health and social care professionals and service users and their families.

By their nature, the mental health strategies of Governments across the UK tend to focus on shorter periods of time (generally linked to electoral cycles) rather than 20-30 years ahead. However they still point the way towards the future for mental health services.

The Northern Ireland Executive's Action Plan for 2012-15, its response to the Bamford Review of Mental Health and Learning Disability, refers to the original 10-15 year 'Bamford vision'. This aimed to

- promote the mental health and wellbeing of the whole community and in parallel decrease the prevalence of mental ill-health through preventative action
- value those with mental health needs or a learning disability by asserting their rights to full citizenship, equality of opportunity and self-determination
- reform and modernise services in a way that will make a real and meaningful difference to the lives of people with mental health needs or a learning disability and their carers and families.

The Action Plan points out that "The Bamford Vision for these services though will only be fully realised through the commitment not just of health and social care staff, and an intergovernmental and agency approach, but also through the drive of service users, carers and the voluntary and community sectors".

The Welsh Government's new 5 year mental health strategy (Welsh Government, 2012) sets out "our vision for 21st century mental health services". It points out that economic constraints mean services need to be redesigned to maintain standards and meet future demands. A key theme is the need to bring services together to form "a single, seamless, comprehensive system for addressing mental health needs across all ages". The strategy's 'High Level Outcomes' are

- a. the mental health and wellbeing of the whole population is improved
- b. the impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely, is better recognised and reduced
- c. inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced

- d. individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions
- e. access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result
- f. the values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

The Scottish Government's mental health strategy (Scottish Government, 2012) addresses a shorter time period (2012-2015) and focuses less on a future vision than on practical short-term objectives. Nevertheless, the commitments it does set out "to ensure delivery of effective, quality care and treatment for people with a mental illness, their carers and families" echo many of the ambitions set out elsewhere:

- reducing variation in the availability of good quality mental health services such as intensive home treatment and first episode psychosis services
- partnerships between national and local government, other national organisations, the voluntary sector and most importantly with service users and carers - increasing the involvement of families and carers in policy development and service delivery
- developing a Scotland-wide approach to improving mental health through new technology
- making basic infant mental health training more widely available to professionals in the children's services workforce; faster access to specialist mental health services for young people
- improving access to psychological therapies, including for children and older people
- increasing the number of people with long term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness
- enabling early intervention services to respond to first episode psychosis
- building on the prevention agenda, with a greater focus on the first years of life

- targeting key connections between mental health and other policy areas such as employment, justice and early years services.

The strategy adds that

“While these commitments are valuable and necessary, our ambition is greater. We must take a step into the future and think beyond how services are currently structured and delivered.... Self-help, self-referral, self-directed, self-management and peer to peer are all concepts that will only grow in importance and which demand a different mindset and approach to service design. The system of the future must develop to embrace and adopt these approaches alongside the more traditional approaches to service delivery, which will also continue to be necessary.”

The aspirations set out in all these visions, whether short-term or longer-term, are validated by what some 1,500 people – a mix of people with experience of mental health problems, family members and carers, and mental health professionals – told us in responding to our Call for Evidence. When asked what they thought mental health services should look like in 20-30 years’ time, there was an overwhelming call for mental health services of the future to be holistic / integrated and multidisciplinary / local / community-based / person-centred / easy to access / early to intervene / recovery-based / and co-produced with service users and carers.

Over and above that, the responses, collectively, also indicated strong support for more specific features, as below.

Primary care – to provide expert support for people with mental health problems

- GP surgeries with specialist mental health staff / training for GPs on mental health awareness and identification of mental health problems
- support predominantly available through primary care; secondary care services required only for the very few
- physical health needs met as well as mental health needs
- choice of treatment, a range of support offered

Secondary care – to be accessible when required, but not just the ‘medical model’

- hospitals to offer “asylum in the true sense of the word” – calm, restorative, with a range of therapeutic activities for patients

- more crisis provision in the community, as an alternative to hospital
- no coercion; more positive risk-taking by professionals
- less (and better) medication, more talking therapies
- consistency of staff; not seeing a new person every time
- support for staff themselves, reduced caseloads, less paperwork
- self-management and self-help
- more involvement of carers and families
- peer support, and peer support workers in the mental health workforce

Community support and public mental health – non-stigmatising and easily accessible, helping people get on with their lives

- small local hubs or wellbeing centres providing a range of support / drop-ins
- someone to help people navigate through the system
- employment and housing support - help with just getting on with life and recovery
- prevention not cure; mental health education and promotion, especially in schools and workplaces
- no stigma or discrimination, whether from the public or from professionals

New technology – to improve service delivery and patient choice / control

- better technology leading to better information / delivery of support.

It is of course easy to pass off all these future visions as Utopian. But we think it is important to take them seriously as a benchmark, even if the pragmatist (and historian) in us retains some doubts as to their achievability. They reflect the majority view of what Governments, mental health professionals and people who use mental health services and their carers want. And if we do not know what we are aiming for, then shifting mental health services, and the staff who provide them, in the right direction becomes a considerably harder task.

The world in 1983

In trying to assess what the future may look like, we also found it useful to cast a eye back 30 years to 1983.

This was the year in which Margaret Thatcher gained a majority of 144 seats in the general election; unemployment stood at a record high of 3.2 million; inflation fell to 4.5%, the lowest level since 1966; the pound coin was introduced in England and Wales; the first breakfast TV programme went on air; seatbelts became compulsory; the compact disc revolutionised the recorded music industry; the average price of a house in Britain was around £26,000; the average salary was around £10,000; a loaf of bread was 38p and a pint of milk 21p. The NHS began to privatise cleaning, catering and laundering services; the first heart and lung transplant was carried out in Britain.

The Government passed a new Mental Health Act for England and Wales, with improved safeguards for detained patients and the establishment of a Mental Health Act Commission to oversee use of the Act. In England, there were around 13,000 compulsory admissions under the Act to some 80,000 psychiatric beds (compared to about 48,000 compulsory admissions in 2011/12 to some 23,000 psychiatric beds).

Assumptions about the future, and past and present trends

We made certain assumptions about the future to provide a framework to our thinking about what mental health services in the future might look like. It is impossible to know if we are right in making these assumptions, not least because the backward glance to 1983 shows how dramatically the world can develop. But they are based on solid past evidence, current trends and the views of those we spoke to during the Inquiry.

Mental illness

Although there is a debate about the whole concept of ‘mental illness’ that occasionally comes to the fore, and there are widespread concerns about what some see as the ‘medicalising’ of normal behaviour, we assume that there will still be people who are diagnosed as having a mental illness in 20-30 years’ time, who will require care and treatment.

There will be no ‘miracle cure’ for mental illness.

UK population

We have assumed that the population of the four countries that constitute the UK today will rise over the next 20-30 years. It is currently growing at over 1,000 people a day.

According to the Office for National Statistics (2012) the population of the UK is projected to increase by 4.9 million over the next 10 years from 62.3 million at mid-2010 to 67.2 million at mid-2020, an annual average rate of growth of 0.8%. It is projected that the UK population will be 73.2 million at mid-2035, a total increase of 10.9 million over the next 25 years.

Given the increasing ease with which people can travel across countries and continents, we also noted that the world population, some 4.5 billion in 1980 and 6.8 billion in 2010, is estimated to reach 8.8 billion by 2040 (US Census Bureau, 2013).

Demographic changes

We have assumed that there will be significantly more older people in the UK in the future – but a smaller increase in younger people. It is of course older people who have the greatest health and social care needs across the population, with depression and dementia particular risks.

The House of Lords Select Committee on Public Service and Demographic Change (2013) has reported that in England in 2030, compared to 2010, there will be 51% more people aged 65 and over (an increase from some 10 to some 16 million older people) and a doubling of the numbers of people aged 85 and over. Its report argues that

“These demographic shifts are occurring for two different reasons. First, people are living longer; secondly, we are now reaping the consequences of significant changes in the UK’s birth rates in the period following the Second World War—the ‘baby boom’. The first is a long-run phenomenon. The second is beginning to hit now, and will last for around the next 30 years”.

The population under 16 will increase less – although still by one million, from some 12 million to 13 million. Although there is some debate over the reliability of estimates, the report also notes that babies that were born in 2011 can expect a median lifespan of 93.75 years for males and 96.7 years for females.

Ethnic diversity

We also assumed that the proportion of people living in the UK who come from a minority ethnic background will increase. At present some minority ethnic groups have higher rates of diagnosed mental disorder than the national average.

The Office for National Statistics (2012) estimate that some 47% of the projected 10.9 million increase in the UK population between 2010 and 2035 is directly attributable to the assumed level of net inward migration. The remaining 53% is attributable to projected natural change (an excess of births over deaths) of which 32% would occur with zero net migration. The remaining 21% arises from the effect of net migration on natural change. It is estimated therefore, that some 68% of projected population growth in the period to 2035 is attributable, directly or indirectly, to net migration.

Research undertaken by the Economic and Social Research Council (2103) suggests that in 40 years' time the UK will be a more diverse but more integrated society. Ethnic minorities will make up 20% of the population (from 8% in 2001) but they will be less concentrated in the big cities. At a regional level, the ethnic minorities will shift out of deprived inner city areas to the suburbs and surrounding towns. In particular the Black and Asian populations of affluent local authorities will increase significantly. In addition, a large part of the future growth of ethnic minority populations is built into their youthful age structure, irrespective of the future level of immigration from abroad.

Trends: mental health policy across the UK

In 1999 the Westminster Parliament devolved powers over health and social care to Scotland, Wales and Northern Ireland through the Scotland Act 1998, the Government of Wales Act 1998 and the Northern Ireland Act 1998. This allowed each country to develop its own health care services (including mental health services) as they wished, and has led to different health service structures across the UK, and differing priorities in terms of mental health investment and priorities.

Despite these variations, there has been a good deal of consistency in terms of general policy trends across all four countries. All four countries have at various times introduced mental health strategies outlining the services they seek to offer, and they all continue to pursue a move away from hospital care towards community care; an expansion of psychological therapies alongside more traditional pharmaceutical interventions; a push towards more integrated health and social care for mentally ill patients; a focus on prevention (including mental health promotion) and early intervention; efforts to tackle stigma and to reduce the number of suicides; and a greater involvement of the patient themselves in terms of the care and support they are offered.

Trends: prevalence rates

Based on data from the past 20 years, we have assumed that prevalence rates of all the major mental disorders among adults and children across the UK will remain broadly stable over the next 20-30 years. We do not think this is inevitable, but it will require significant investment in public mental health, early years support and early intervention services if we are to improve the situation. Such investment has been insufficient in the past to lower prevalence rates.

Adults

The past three Adult Psychiatric Morbidity Surveys of those living in private households, going back 20 years (for Great Britain in 1993 and 2000, and just for England in 2007), have all found that around one in four adults meet the criteria for a diagnosis of a mental disorder (Office for National Statistics, 2007):

“Just under a quarter of adults (23.0%) met the criteria (or screened positive) for at least one of the conditions under study. Of those with at least one condition: 68.7% met the criteria for only one condition, 19.1% met the criteria for two conditions and 12.2% met the criteria for three or more conditions. Numbers of identified conditions were not significantly different for men and women.”

Comparing just the English data across the three surveys, the 2007 survey reported that overall, the proportion of people aged 16-64 meeting the criteria for at least one common mental disorder (CMD) increased between 1993 and 2000, but did not change between 2000 and 2007 (15.5% in 1993, 17.5% in 2000, 17.6% in 2007). It also reported that “there was no change in the overall prevalence of probable psychosis between the 2000 and 2007 surveys: the rate was 0.5% of 16-74 year olds in both years. In both surveys the highest prevalence was observed among those aged 35 to 44 years (1.0% in 2000, 0.8% in 2007)”.

If we take it that there will be nearly 8 million more adults in the UK by 2030, if prevalence rates for mental disorders stay the same (at around one in four), that is some 2 million more adults with mental health problems than today.

Children

Two surveys of the mental health of children and young people in Great Britain have been published by the Office for National Statistics, in 1999 and 2004 (Office for National Statistics, 2004). The latter report showed that

- in 2004, one in ten children and young people (10%) aged 5-16 had a clinically

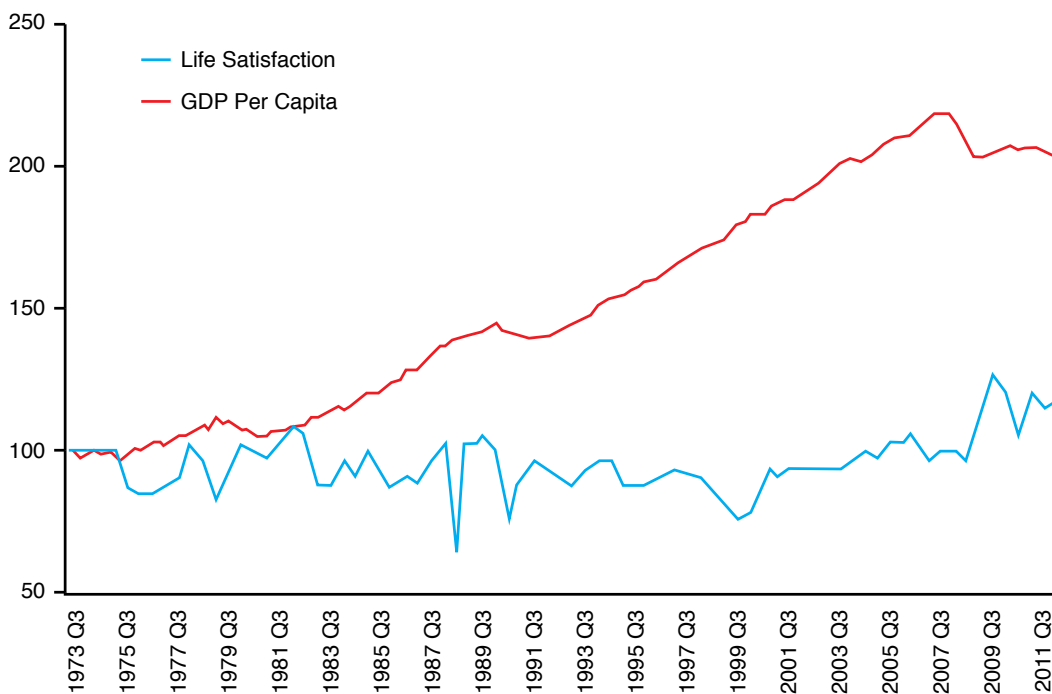
diagnosed mental disorder. Some children (2%) had more than one type of disorder

- there were no differences in prevalence between 1999 and 2004 in the overall proportions of children with a mental disorder. The only change that was statistically significant was a decrease in the proportion of boys aged 5–10 who had an emotional disorder, which declined from 3% in 1999 to 2% in 2004.

If we take it that there will be one million more children and young people in the UK by 2030, if prevalence rates for mental disorders stay the same, that is some 100,000 more children and young people with mental health problems than today.

Trends: Satisfaction with life

We have assumed that levels of overall life satisfaction across the UK will remain broadly stable, whatever the future ups and downs of the UK economy. We realise this might change if there is a total economic collapse at some point in the next 20-30 years, which would lead to major social tensions – it was pointed out to us in our oral evidence sessions that the UK was likely to slip down the world table of economic performance over the coming decades, relative to countries in the developing world.



Cabinet Office (2013)

Trends: Medication

Despite prevalence rates of mental disorders being broadly stable for the past 20 years, the use of prescription medication has significantly risen. It is difficult to judge the volume of prescribed psychiatric medication that will be consumed in the future. The long-term trend of year on year increases may be countered by the development of new non-pharmaceutical interventions (including developments in genetics) and the continuing expansion of talking therapies as an effective response to mental illness. Responses to our Call for Evidence showed enormous support for a future with less (though better) medication, but we made no assumption that this would happen, and thought on balance that medication would still be playing a major role in addressing mental illness in 20-30 years' time.

In a study comparing the use of psychotropic medication among people aged 16-64 identified through the Psychiatric Morbidity Surveys of Great Britain of 1993 and 2000 (Traolach et al, 2004), usage doubled in those designated as psychiatric cases, and in the non-case-status population antidepressant use rose from 0.16% in 1993 to 2.02% in 2000.

More recently, in a study looking at trends in prescriptions and costs of drugs for mental disorders in England between 1998 and 2010, Ilyas and Moncrieff (2012) found that prescriptions of drugs used for mental disorders increased by 6.8% per year on average, in line with other drugs, but made up an increasing proportion of all prescription drug costs. There were rising trends in prescriptions of all classes of psychiatric drugs, except anxiolytics and hypnotics (which did not change). Antidepressant prescriptions increased by 10% per year on average, and antipsychotics by 5.1%.

Trends: Psychiatric beds

Numbers of psychiatric beds have been dropping across the UK for many years.

In the mid-1950s, there were some 150,000 mental illness beds in England, in the old asylums. This fell to some 80,000 beds in the early 1980s. As at March 2012, there were 23,000 available beds. Fewer people spend time in psychiatric in-patient care. In the last decade the number of people spending time in NHS provider inpatient services has dropped from some 114,000 to 99,000 between 2003/04 and 2011/12; this was the lowest ever recorded, which appears consistent with a fall in the average number of occupied beds from 21,076 in 2010/11 to 18,924 in 2011/12 (NHS Information Centre, 2013). However compulsory admissions under the Mental Health Act 1983 in England have recently risen. Overall, beds are increasingly being used by people who have been sectioned under mental health legislation, squeezing out opportunities for patients to go into hospital voluntarily.

However the overall number of beds disguises a variation in type. For example in Scotland for General Psychiatry and Psychiatry of Old Age beds, there has been a steady decrease over time, with Psychiatry of Old Age falling from 3,992 beds in 2001 to 2,530 in 2011. But between 2001 and 2011 the number of staffed beds for Forensic Psychiatry has increased from 137 to 254 (Scottish Government, 2011).

The Call for Evidence: what we were told

We issued a Call for Evidence in December 2012, with a closing date of 30 May 2013. The Call was publicised through the Foundation's website and via professional and service user networks, such as the Royal College of Psychiatrists and the National Survivor and User Network (NSUN).

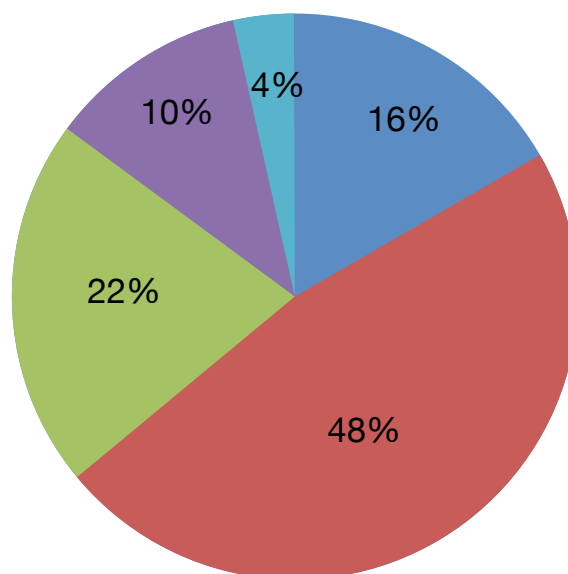
We received 1533 responses in total, broken down by respondent as follows (note, some respondents ticked more than one box):

Mental health service user (27.4%); carer / family member (15.2%); mental health worker (53.2%); health worker (5.5%); other (15.5%).

We asked five questions in order to capture a broad sense of whether mental health services were better or worse than 20 years ago, and what people thought about mental health in 20 years' time, to give us a springboard for our discussions.

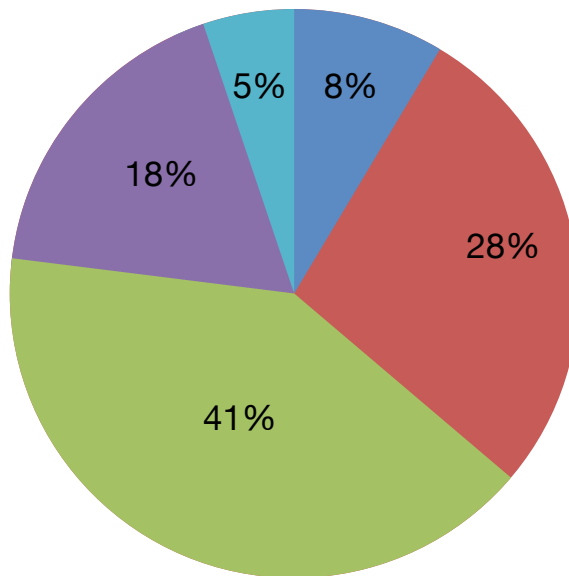
Q.1 Mental health services are better now than they were 20 years ago.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree



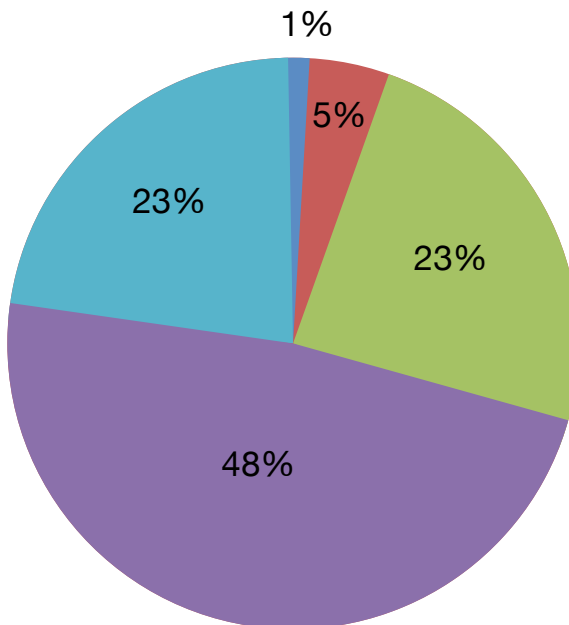
Q.2 Mental health services will be better in 20 years than they are now.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree



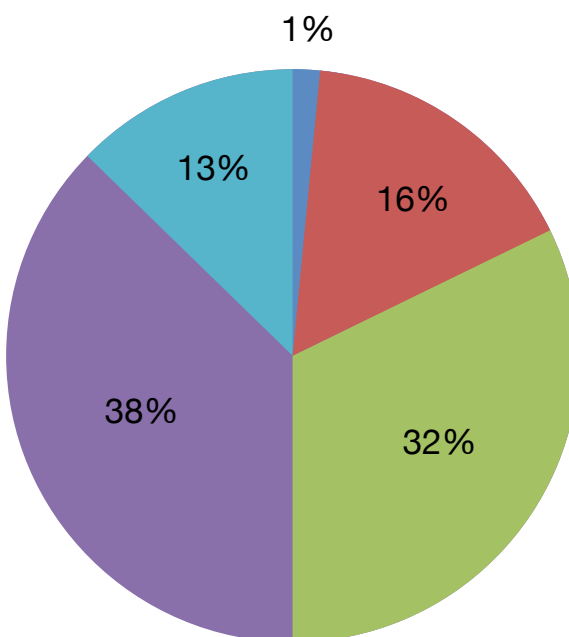
Q.3 In 20 years' time, children and young people will be more resilient and less likely to develop mental health problems.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree



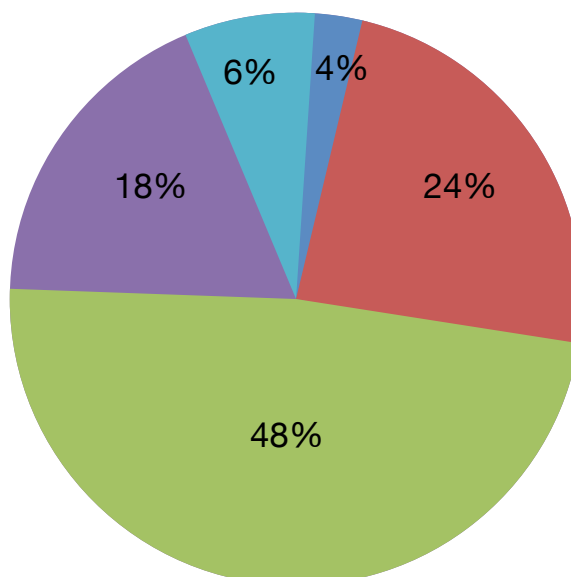
Q.4 In 20 years' time, more people in later life will experience good mental health than now.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree



Q.5 In 20 years' time, mental health services will be highly regarded by the public and respected by health professionals.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree



These were broad questions to ask, and we would not wish to over-interpret the message they gave. However it is noticeable that more than half (64%) of respondents thought mental health services are better today than they were 20 years ago, with only 14% disagreeing. Accompanying comments included

“The health services have improved so much, and some places are wonderful - I owe my life to mental health professionals and the services available.” (1.139)

“I want to be optimistic. My experience nationally over the past couple of years has been one of the most positive I have had ever experienced in the past 20 years. In the past we could barely get in the door of DH! I want to see that kind of will to work together trickling down to the local level and hope that a door is now opening for that to happen.” (6.1434)

This gives a fairly positive picture of the service developments that have taken place over this period, one that it would be hoped both national and local mental health interests might look to build on in the next 20-30 years. However when looking ahead 20 years, some of that positivity had waned – over one-third of respondents (36%) still thought that things would get better, but nearly a quarter (23%) disagreed.

“I’m hopeful of continuing slow improvements in mental health services and attitudes towards mental health but I’m not optimistic of huge improvements, even over a 20 year timescale. I base this on my experiences as a service user over the past 20 years and on where society is now regarding mental health.” (6.883)

“I am struggling to see how things are going to get better. But I don’t know, they have been getting better over the last 100 years, so why should that stop?” (6.1152)

“I would like to be more optimistic about the future of mental health services but my experience (not just as a health worker but as the daughter of a mother who is affected by schizophrenia) is not an improving one. With the ageing population it is more challenging than ever for workers to respond appropriately and provide an integrated approach to health and social wellbeing.” (6.1191)

“I’m very pessimistic about the future of mental health services. I believe things are going to get a lot worse as budgets are squeezed. People with poor mental health are not an easy sell - It might not go back to Bedlam but we don’t have a lot of public sympathy at the best of times so bureaucrats looking to save a buck or two will choose us knowing there will be no outcry.” (6.777)

“Things are really, really bad and it just looks like they are going to get worse. I have been a consultant for 10 years and am [named post] in a Specialist Mental Health Foundation Trust.” (6.798)

The picture was least encouraging when it came to children and young people. Only 6% thought that in 20 years' time children and young people will be more resilient and less likely to develop mental health problems, against a massive 71% who disagreed. While it is not possible to know why people responded in this way, it reflects very little confidence both in the support that children being born today will receive if they experience mental health difficulties as they grow into adulthood, and the support that children born in 20 years' time will receive. The message we took from this is that we need to do much more to develop demonstrably good and effective mental health support for children and young people, to build a sense of confidence in the future.

In terms of whether more people would experience good mental health in later life in 20 years' time, the response was again of concern. 51% of respondents did not think they would; only 17% agreed. This response may have been coloured by the widespread assumption that as more people live longer (which is a clear trend for the next 20-30 years) they have an increased risk of developing depression and dementia. Again, the message is that we need to ensure that the support we develop for people in later life is demonstrably effective.

Our final question, asking whether in 20 years' time mental health services will be highly regarded by the public and respected by health professionals, arose from the mixed response that mental health services attract today, both from patients and carers / families, from other (non-mental) health professionals, and from the public. The picture here was balanced. Around a quarter (28%) agreed; around a quarter (24%) disagreed, with half (48%) of all respondents not having a view.

We also asked six open questions, namely

1. What do you think mental health services should look like in 20 years' time?
2. How can this be achieved? What changes to models of care and methods of service delivery will be needed?
3. What might the mental health workforce look like in 20-30 years' time?
4. Where should mental health services focus their financial resources in the future?
5. How can better integration of physical and mental health be achieved in the future?
6. Do you have any further comments on the future of mental health services?

The response to the first of these questions we have already described in the section above setting out visions of the future – in short, integrated and holistic care, provided locally in the community and easily accessible when required, co-produced by mental health service users and carers and health professionals, with more self-management and better use of technology.

The other questions provided us with a treasure-trove of views and suggestions for developing mental health services fit for the future. The responses colour what we say in the rest of this report under our six key themes, and provide illustrative quotes.

The six key themes

The evidence we received and considered ranged far and wide. Very broadly, it fell into two categories. The first referred to existing services and models of delivery and how they could be improved in the future; the second looked at fresh ways of working and new models of delivery.

We inclined to agree with the response we received to our Call for Evidence that suggested

“Mental health policy needs to stabilise – there is a tendency to seek ‘magic’ solutions for intractable problems. Consequently... everyone goes rushing off in the direction of the latest idea, neglecting what was good or useful in previous practice.” (5.217)

Some things clearly do have to change. Technological advances will in any case dictate much of how we provide mental health care in the future. And we naturally want mental health services to be forward-looking and imaginative about fresh ways of designing and delivering services. However much of what in our view needs to be done is simply implementing the “good or useful” that already exists. Failure to provide good, integrated mental health care is not a failure of understanding what needs to be done, it is a failure of actually implementing good practice in organisational strategies and the day-to-day business of providing people with the care and treatment that they need and want – though accepting that some people, particularly when very unwell, can actively seek to avoid both care and treatment. We need to start today to rectify that.

There were many ways that we could have cut the evidence. In the end, although there was inevitably a good deal of overlap, we decided that the vast majority of responses and views

we received could be considered under six broad themes:

1. *Personalising services*
2. *Integrated care*
3. *Life span issues*
4. *Workforce development*
5. *Research and new technologies*
6. *Public mental health*

We have looked at all the evidence we received under these themes, and drawn from them a small number of key messages that we believe are crucial for mental health services to take on board, starting today, if they are to adapt to meet the demands of the future.

Theme 1 – Personalising services

“People should be regarded as individual, with symptoms individual to them that may bear similarities to others, but that each need very specific forms of treatment because every person’s experience of mental health problems comes from their own personal and unique life experience.” (5.1227)

“I know so many of my clients who talk about feeling like a ‘patient’ and not a ‘person’.” (2.266)

“Unfortunately, there appears to be an increasing trend in the use of diagnostic- or therapy-specific services, thus diluting the possibility that we can treat people as individuals. A more holistic approach, whereby we can consider the needs of service users from a biopsychosocial perspective is needed.” (2.166)

“Would like to see an increase in the uptake of personal budgets. Generally speaking the person supported and their circle of friends/relatives - people who do care and love them - know how best to spend money. As a relative of someone with a mental

health illness I have seen £s being wasted on services neither required nor helpful!” (4.1108)

Much of the evidence we heard in oral evidence sessions and from our Call for Evidence has referred to a greater personalisation of services (or, as it is sometimes referred to in parts of the UK, self-directed support or citizen directed support). By this, broadly, people mean having choice and control over the support they get, and a tailored approach to their care, not ‘one size fits all’. The Scottish Parliament, for example, has recently passed the Social Care (Self-directed Support) (Scotland) Act 2013, which aims to empower people to decide how much on-going control and responsibility they want over their own support arrangements. One witness in our evidence sessions suggested to us that “When people can choose what services and support they get, services will change – they will have to!”

We were told that this requires a significant shift in traditional mental health and social care thinking about staff’s relationship with mental health service users, and the sort of support they need to offer. Personalisation, including personal budgets, has been a widely-used concept in social care for some years, and has generally been welcomed, not least among people who use mental health services. This ties in with evidence we noted from the WHO Regional Office for Europe (2013) that “In some circumstances, service users and their families are in the best position to determine how to allocate resources effectively and efficiently, thus having opportunities to take responsibility for their own health and quality of life.” We did note, though, that, as one respondent told us, “personalisation through personal budgets does not sit neatly with top down commissioned care”, not least because the mental health services an individual might want to spend money on may not be the mental health services local commissioners have traditionally commissioned. This will require mental health service users to be much more involved in future commissioning decisions.

Although the extension of personal budgets across both social care and healthcare is still, relatively speaking, in its infancy across the UK, the existing evidence of its popularity, and reported effectiveness in terms of patient outcomes and satisfaction, is promising. We see a future where people who use mental health services are given greater control over their care, and are able to choose from a menu of evidence-based interventions, whether they have personal control over the amount of money spent or not.

We were also made aware, however, of the potential risks of personalisation for some people. Firstly, to exercise choice people need to have the best possible information about the available options in front of them, and to be able to make informed decisions about what would be best for their individual circumstances. Expert mental health and social care advice therefore still needs to be available, and decisions taken in partnership – something we talk more about below. Otherwise there is a danger that while some people benefit, others do not, widening inequalities. This is particularly the case where people may lack capacity, for example through dementia or an episode of severe mental illness. There is also a small but significant risk that some vulnerable people with personal budgets may be exploited or coerced by relatives or other acquaintances.

Secondly, we heard that some service users are resistant to the idea of personalised service approaches, not so much in theory but in terms of what it will mean in practice to them. One Inquiry Panel member pointed out that

“for some service users who have had to fight long and hard for services it’s worrying to feel that the landscape is shifting. It needs a change management process. We have found that many service users’ expectations can be low in relation to what they can aspire to in life or expect out of services. Also, after years of having service decisions made for them it can be daunting to take over control. This is a very real issue for us and you would have to hope that the changes that will come with a move to personalisation will be handled more sensitively than the hospital closure programmes.”

Co-production

Linked to the issue of personalisation, a number of responses referred to “user-led” services in the future. While we think there are opportunities in the future for many services to be led by service users, most responses on this issue pointed out that personalisation did not mean that service users should dictate everything, any more that health professionals have in the past. Rather, there should be genuine ‘co-production’ involving mental health and social care professionals and the people who they support (along with family and carer involvement as well) as equal partners in care.

We noted the views of the Royal College of Psychiatrists and Academy of Royal Medical Colleges (2009) that “Patients should be better informed about, and involved in, decisions about their treatment, discharge and self-care [and] patients and carers should be involved in designing and improving mental health services”. We concur with all these sentiments, not least in respect of carers. As one witness told us, “For us, mental health services really can’t survive until carers are fully included as equal partners, especially for people who do sit at that end of the spectrum where their condition is far more severe and far more disabling than somebody who experiences mild to moderate mental health issues”.

There was a view put forward in a small number of responses that services needed to remain clinically led, of which this is an example:

“There needs to be more made of the fact that psychiatrists are medically trained and, as a result, have a range of medical and leadership skills which have been eroded over the last 10-20 years. It’s not easy to list all of the required models of care but a theme should be that psychiatrists should lead in service development and delivery, rather than the current situation where they have almost no input.” (2.1287)

We do not wish to play down the skills that psychiatrists, and other specialist mental health staff, bring to the job, or the need for clinical leadership. We talk in a later section about the importance of not diluting specialist skills among the workforce. However this does not mean that services should be dictated by any one profession, paying little regard to either other professionals or patients or carers.

A number of respondents raised the linked issue of staff attitude. We were pleased to hear from respondents who praised staff attitudes.

“I hope that it might look like some of the wonderful nursing staff that I met when I was hospitalized last year. People who do not look down on you or hold any sort of social status over you. People that talk to you like a normal person and not like a child. And people that actually take a few minutes out of their day to get to know you, personally and as an individual. These were people who did not in any way judge me nor treat me any differently to the next person. I felt like I actually still existed, and I was not a child that had all responsibility and humanity taken away from me.” (3.127)

“The frustration for me was finding a doctor who would help. It has taken 13 years to

get a doctor that listens and understands. He put me in contact with all the relevant people and places and gave me a choice of different things to try. I never felt pressured into anything. We need more people like this.” (2.1076)

However we received many more responses that called for a significant improvement in staff attitudes. A common thread in these responses was a feeling that staff simply did not listen to what service users (or carers) had to say.

“Importance of not just ‘tweaking’ existing services but transforming attitudes.” (6.917)

“I work closely with community mental health teams. Having a mother with a severe mental illness I can see how her GP disregards her concerns, and her opinions over treatment are ignored by mental health professionals.” (6.1415)

“It would be good to think that inpatient services had become more therapeutic places with a more compassionate and more skilled workforce. This can only be achieved if recruitment into the nursing profession is overhauled to avoid appointing people who lack the necessary humane approach to their work. Currently, poor quality breeds poor attitudes in some facilities.” (3.1392)

“No medical school can teach you how it feels to want to end your life for example, so more listening to service users would be helpful.” (2.1511)

“Mental Health Services should employ staff members who have the right attitude to be working in health care; in my experience I have so often encountered staff members who speak to patients disrespectfully and are rude in manner, often due to their own stress as a result of staffing issues.” (1.22)

“Attitudes towards MH as a legitimate medical condition has to be worked on. Emphasis on empathy as a necessary characteristic for staff working within the MH sector is a requirement.” (1.215)

Some respondents acknowledged that the reason behind staff being abrupt and not spending time listening to them was that staff were themselves under a great deal of stress with very heavy work commitments and caseloads. This does suggest that in the future there will need to be clearly mandated minimum staffing levels and maximum caseloads for staff.

In England we noted that in response to the Francis report on Mid Staffordshire hospital, the Government is launching plans to ensure that patients are always treated with compassion and respect - at least in hospital (Department of Health, 2013). However if we are serious about creating 'the right attitude' among all staff working across the UK in support of people with mental health needs in coming decades, we need to develop a rigorous and effective recruitment, training and education, and continuing professional development (CPD) programme.

We noted evidence from one recent study that measured stigmatising attitudes and intended behaviour among medical students in respect of people with mental health problems (Freidrich et al, 2013). This found significantly greater reductions in stigma-related attitudes and intended behaviour, relative to the control group, at immediate follow-up. However at six months' follow-up only one attitude item remained significantly better:

"Although the intervention produced short-term advantage there was little evidence for its persistent effect, suggesting a need for greater integration of ongoing measures to reduce stigma into the medical curriculum."

The general consensus among those to whom we spoke was that creating genuinely co-produced mental health services across the UK would require a significant cultural shift among many mental health staff, including a more flexible approach to risk-taking and a willingness to value the input of patients, carers and other fellow professionals.

We accepted that there would be times when sharing risk might be both difficult and indeed inadvisable, for example when someone with a psychotic illness was very unwell or in the field of personality disorder. It is important to recognise that there are significantly different factors to be considered in, for example, addressing severe mental illness within forensic mental health services as opposed to mild to moderate anxiety disorder within primary care. This did not, however, deflect us from considering that co-production in terms of service development and service delivery should in principle be the default for all patients receiving mental health services in the future, regardless of diagnosis.

The early training of all health and social care staff, and their continuing professional development, should include as a core principle the need to provide patients with a personalised service, and to involve them, and their family and carers, as equal partners in decisions about mental health service design and service delivery. This means that we will need to recruit a workforce for the future that has a truly participative and listening approach to patient care, as well as skills helping people to make decisions who may lack capacity.

This message also applies to national and local commissioners of mental health services across the UK, who we would like to see review their commissioning processes to ensure the engagement of service users, families and carers.

Self-management

"Oh I just wish I could make other service users believe me when I tell them how much better life is for people with mental illness when they stop making it worse with alcohol, drugs and poor self-management. I ignored others who tried to tell me, but eventually I gave it a try and I now know that self-management is the only way forward." (6.1332)

"Empowering a person to manage their own mental health is surely more economical, ethical and desirable than having a person reliant on medication." (2.1377)

"Empowering service users to take responsibility for their own recovery using a partnership approach whereby they are supported, but professionals do not take over in a parent role." (2.199)

"Investment into lobbying for stress management, compassion, self-esteem and relaxation techniques to become a part of the national curriculum. After receiving treatment at a private psychiatric hospital I was awakened to how many basic skills I could learn to manage my own depression. If only I had been taught that in school." (4.1219)

"I have had twenty five years of experience working with people with mental ill health within forensic secure establishments... I am sure that the individuals themselves would prefer not to be labelled as they are through the medical model and be given the chance to show how they can support themselves much more through focussing the scant resources available into socially active and self-help models." (6.1488)

The issue of self-management and self-help as a core component of future mental health care came across strongly during our evidence sessions, and was supported in many responses to our Call for Evidence. We also noted the increasing evidence base for the effectiveness of self-management, primarily among people with long-term physical health conditions (LTCs), many of whom have comorbid mental health problems, as well as among people with a primary diagnosis of mental illness. This is alongside strong political backing, such as that set out in the Ministerial foreword to the new Scottish mental health strategy (Scottish Government, 2012) which states that “Self-help, self-referral, self-directed, self-management and peer to peer are all concepts that will only grow in importance and which demand a different mindset and approach to service design”.

We see self-management of mental health conditions and daily living as an essential part of future mental health care. Not only will this empower people, leading to a more appropriate balance in the relationship between professionals and patients, but it should remove a considerable amount of pressure on mental health services. We fully accept that it will not be possible for everyone to self-manage all aspects of their condition and their life all the time, although work by the Mental Health Foundation in Wales has demonstrated that even people with a severe mental illness can gain skills that improve their health and wellbeing and help them to achieve their goals. For example, people with dementia, especially during its later stages, may well need considerable support to self-manage, and for many people there will become a time when it is simply not possible for them.

We also heard evidence that self-management needs investment in proper training for service users, and in monitoring the risk that they may disengage from treatment unless there is some level of continuing professional support. We were told, for example, that self-managed Computerised Cognitive Behavioural Therapy (CCBT) doesn't always work – the number of people who complete courses is relatively small, unless moderated by a CBT therapist or tutor, or a case manager with a prompting function.

However the benefits of self-management on mental health conditions seem to us evident. It is the direction that management of long-term conditions is going, and we need to make sure that mental health service users are able to benefit from self-management developments and opportunities. These will

come in part from advances in technology that we discuss later in this report. As one witness at our evidence sessions said,

“We need to harness non-professional resources, both for financial reasons and because it is far more effective. We need to help people build networks themselves”.

We noted an increasing level of resources involving self-management in mental health available through websites, and the provision of self-management courses, such as those offered by Bipolar UK. The further development of self-management resources and training should be a win/win situation for patients and mental health services that we anticipate will be facing increasing levels of demand in years to come, providing effective cost-beneficial outcomes even in an atmosphere of restricted resources.

Mental health services need to build service users' capacity to safely self-manage their conditions. This will involve training service users both in their own care (whether it is, for example, adherence to prescribed medication, managing a comorbid physical health problem, self-help psychological therapy or improving diet and exercise regimes) as well as establishing ongoing monitoring and support that ensures people are self-managing their condition effectively. There may be an important role for peer support in this process.

Theme 2 – Integrated care

The Inquiry received a wealth of evidence about the disjointed nature of mental health care that was at present on offer across the UK, along with a range of suggestions for improving the integration of services for people in the future. The following quotations make up a small, but representative, sample.

“As a patient the most frustrating part of my treatment was how fragmented it was. My GP, consultant psychiatrist, psychologist and counsellor had no mechanism for actually talking together.” (5.1219)

“So many assessments point to other services that are overwhelmed or do not exist eg psychology, CBT, counselling, eating disorders, personality disorders. No point having a pathway when most of the stepping stones are missing. Just get patients returning again and again.” (4.1193)

“A better integrated system, with well-informed GP practices able to refer straightforwardly to and share information in both directions with a coherent NHS mental health provision, would also be very much worthwhile (and hopefully a short-term investment that would actually save money in the future).” (4.136)

“Multidisciplinary teams working in partnership and consultation with service users, their carers and health commissioners.” (5.991)

“If you want a team to be a team then they need to work in the same place in offices next to each other and have space to communicate. At the minute teams are separated throughout whole counties and do not ever communicate face to face.” (5.1371)

“Primary care and secondary care must work as a multidisciplinary team - too often physical health matters are overlooked as a result. A primary care team of General Practitioners, specialist diabetes nurses and lifestyle interventionists should be attached to every mental health community care team and inpatient services.” (5.14)

“I would like to see psychiatrists, therapists, counselling services and all other therapeutic services all available at local GP surgeries with shorter waiting lists and with more availability.” (5.203)

“I am lonely, scared, have no future and no way to make things better. In this I'm 100% sure I'm not alone. Only my GP helps with counselling at their surgery.” (6.1070)

“I have not seen a psychiatrist for over 2 1/2 years, my GP is good, but sometimes I feel I'd like to touch base with MH person from time to time. I have no CPN, the only healthcare support I get is via my GP. That's it. Nothing / no-one else.” (6.1264)

“Hopefully CPNs and support workers will be based nearer to their patients and not 30 miles away due to area boundaries.” (3.1093)

To bring the issue home to us, we heard in oral evidence about one young man who committed suicide, who in the three months prior to his death had contact with 17 different professionals, without any single person having an overall grasp of his condition, level of need and level of support.

We recognise that integrating mental health care is hardly a new issue. In a 34 year old collection of essays looking at various aspects of what were, at that time, “new methods of mental health care” (Mental Health

Foundation, 1979) many issues were raised that are identical to those told to us during oral evidence sessions and in responses to our Call for Evidence. These included shared personal involvement between members of multidisciplinary teams; shared facilities or resources; joint care planning between health and social services to make the most effective use of mental health resources; and joint financing and formally shared responsibility. The essays also raised the barriers that are again familiar to us today - effective collaboration being undermined by a lack of clarity as to who carries prime responsibility at any time; the challenges of professions working together; the relocation of specialist services into local settings; and a lack of organisational links between social work, multi-professional health teams and primary care services.

It is perhaps sobering that a key message about the importance of having the right staff attitudes towards integrated care was also part of the debate in these 34 year old essays:

“One of the most important changes often needed is in the personal attitudes of the staff concerned, and formal educative or re-educative programmes may have particular relevance.... personal acquaintance and contact between individuals are essential ingredients, and efforts must be made in both services to facilitate these.”

We must not still be recycling exactly the same concerns about how to improve staff commitment and attitude towards integrated care in another 34 years' time. At the same time we acknowledge the challenges that mental health and social care services, and other services used by people with mental health needs, will face in working together in the future.

We noted, and welcomed, the emphasis being given to better integrated mental health care across the UK: this emphasis has appeared in Government statements and mental health strategies. This political thrust is echoed by health professionals. For example, the Royal College of Psychiatrists (2013) sees integration of mental, physical and social care as an essential feature of a health system:

“Planning for integration - this requires movement away from mental health, physical health and social care ‘silos’; the consideration of mental health should be integral to all health and social care, at any point where someone with a mental or physical health problem comes into contact with a service.... Generic health and social care policy, planning and services will integrate mental health from the outset.”

However we consistently heard from witnesses that it is easier to find scattered examples of good practice across the UK than any systematic organisational or cultural integrative process that has led to significant improvements in the care and support given to people with a mental illness. There was a general consensus that the future will see a continuing fragmentation of services as health systems become more diverse - most particularly in England, which has already stepped down this road, although in time also across the rest of the UK. In view of this, it is all the more important to ensure we start the process today of putting in place the building blocks that will ensure mental health services, wherever they are provided and whoever provides them, give people all the support they need in the future.

Models of integrated care

We noted and agreed with the Royal College of General Practitioners' view that there is no one 'right' model of integration - "Different approaches will be appropriate depending for example on patient needs, geographical factors and organisational characteristics" (Royal College of General Practitioners, 2012). The College's definition of integration is summarised as "patient centred, primary care led shared working, with multi-professional teams, where each profession retains their autonomy but works across professional boundaries, ideally with a shared electronic GP record."

Having said that that there is no 'right' model, we noted very strong support for three particular approaches that people wanted to see in place in the future:

- specialist mental health care in primary care settings
- crisis support in the community
- one stop shops and community support.

Specialist mental health care in primary care settings

"Continual dialogue and joint working between primary health service and mental health services; psychiatrists working with GP practices, psychiatric nurses employed by GP practices as practice nurses, skilled psychotherapists working with GP practices." (2.1344)

"Psychiatry needs to become part of the team rather than leading teams and dictating treatment."(2.186)

"More mental health services co-located with primary care." (1.5)

"Have mental health teams as part of GP practices." (1.882)

"Other healthcare professionals should also be trained in talking therapies and easily accessible from the CMHTs and GP surgeries." (6.721)

"Make providers of primary care responsible for achieving the outcomes expected by people with mental illness, with the expectation that they will employ psychiatrists and other mental health staff to achieve this and to integrate mental health care into routine work of the practice, regardless of severity." (2.972)

"Specialist MH workers in primary care who may be nurses, social workers, psychologists or GPs are available to advise colleagues and to support people with complex needs in the community - backed up by relevant resources in the voluntary sector. This would include sufficient specialist workers to support teachers, foster parents and other staff who encounter children in mental distress and who currently receive no support and have nowhere to whom they can refer children." (3.222)

"Multi-disciplinary teams highly skilled in working in the community and less and less from hospitals. I think that workforce needs to have a stronger interface with primary care and can see specific roles in linking the two and joining more with the voluntary sector in providing much more integrated person-centred services." (3.39)

We received a clear message that in the future mental health services should be primary care led, with specialist interventions easily accessible, but only when strictly necessary. This is not to say that mental health specialists, such as psychiatrists, should surrender clinical leadership when they are involved in the care of an individual. Expert and experienced specialist staff will always need to maintain this vital role. But mental health services will certainly need more commonality with generic health services, as future challenges for most people with mental health problems will often be around multi-morbidity, requiring integrated and holistic primary care interventions.

This is different to the sense we received from witnesses that it is secondary care services, based on a primary diagnosis of a mental disorder, that drive the mental health system today, with primary care often offering only a fleeting, inexperienced and inadequate response for many millions of people across the UK, despite the best efforts of many GPs. This was reflected in the very large number of responses we received calling for GPs to

receive better training in mental health issues, and for primary care facilities, in particular GP surgeries, that could provide a much wider level of expertise and support for people with mental health needs – such as the example of social prescribing in Newcastle that one witness pointed us to.

CASE STUDY

Newcastle Bridges Clinical Commissioning Group

The project is led by the Newcastle Bridges Clinical Commissioning Group and aims to develop a single cohesive approach to social prescribing in primary care for the city of Newcastle that will improve the quality of life for vulnerable adults with the full range of LTCs and mental health issues.

Social prescribing supports GPs to refer and encourage people to take up activities instead of, or alongside, their medical prescription. This could include going to the gym, joining a reading group, or taking up a hobby. By developing a model to meet the range of needs of patients with LTCs the project will move away from a disease specific view of LTCs. The partnership's approach is underpinned by the recognition of the importance of non-traditional service provision as complementary to traditionally commissioned services. The ambition is for the social prescribing system to be embedded in all LTC pathways used across Newcastle, therefore enabling better responses to co-morbidity.

We were told by one witness that

“we need to get highly expert people in at the beginning, in primary care, to get an early diagnosis and treatment plan, because everything else depends on that. We must ensure we do not send people off on the wrong, ineffective care pathways when they first present”.

Another witness told us of a previous successful attempt to work more closely with local GPs:

“So we [psychiatrists] started liaising with GPs and they loved it. And they got to understand our role, we got to understand theirs, and we developed a common language which was around the tiered model and actually we then had something much more like a seamless interface because we all knew what we were doing.” We have mentioned the Royal College of General Practitioners' emphasis on integrated care being primary care-led. We believe that in the future GPs do need to become leaders in mental health care. This does not mean they need to become mental health specialists, but it does mean that they need to know as much about mental health as they do about physical health.

We recognise that many GPs might be reluctant to take on the risk associated with mental health care, but we do not think this insuperable if there is specialist mental health support attached to their practices and easily accessible. We noted research (Gask and Khanna, 2011) indicating that

“The therapeutic work of attached professionals is highly congruent with what patients and general practitioners (GPs) want; is strongly supported by current health policy; has a high level of accountability in the specific professions involved in delivery (psychologists, counsellors) and the confidence of those who request it (GPs). However, these professionals still work in a way that is essentially disengaged from primary care rather than integrated with it... Of particular importance [for psychiatrists] is the ability to communicate effectively with primary care and to provide support for front-line staff, including mental health workers and GPs. There is a potential opportunity for 'primary care psychiatrists' to play a key part in developing the interface with primary care. However, it will be necessary to provide training for this role.”

In the future mental health services should be primary care led, with specialist interventions and expertise easily accessible in primary care settings. This will involve professionals on both sides of primary and secondary care working together in a more collaborative way, alongside patients and family and carers. However the very language of “both sides” is unhelpful. What in effect we would like to see is a merging of primary and secondary care services so that the distinction (and many of the problems that arise from people being moved from one ‘box’ to the other) becomes much less evident.

This will assist a more accessible and holistic care regime for individuals, who will often have complex multiple needs, and should also help to facilitate a better coordinated care pathway for any patients who require hospital care, particularly on discharge. It will require psychiatry, and other mental health specialisms such as mental health nursing and psychotherapy, to establish themselves as primary care services within a primary care team.

Crisis support in the community

“Do we need to think again about offering ‘asylum’ in the community – safe havens for those with complex mental disorder – ie jointly funded/managed health/social work small community resources (rather than big institutions) which provide systemic person-centred treatment and rehabilitation. I have positive experience in working in this model of care.” (2.236)

“Also needs to be some substitution for the psychiatric hospitals that have been closed - safe houses, halfway houses, rehabilitation houses, and safe places for people who are suicidal. Care in the community isn’t working for people who have serious mental illness and who don’t have support of family or friends.” (4.1290)

One witness suggested to us that it was a “maelstrom of madness” to put people with very mixed experiences and disorders in the same psychiatric ward for long periods when they are unwell, suggesting that we needed to be designing future acute psychiatric inpatient

care along the lines of small, local intensive care units. In such units, people would generally stay only two or three days while they rode their crisis, with expert specialist staff managing the risk – “a crisis house in the future, somewhere we can self-refer with strong clinical support for a few days”.

We were not convinced that this sort of facility would be the only inpatient care required in the future, given that many people are likely to need longer term secure care and support. However we also recognised continuing concerns around the current provision of care in psychiatric wards, as evidenced by, for example, Mental Health Act Commission and more recently Care Quality Commission reports in England, the report from the Schizophrenia Commission (2012), and the desire to keep hospital admission as a last resort.

“My last hospital in-stay was in the early 1990’s. I am now working for a mental health trust that really is moving forward on the recovery concept but even here in-patient wards really not a health environment. Wish I could say they are better but saddened 22 years after my last admission little seems to have changed.” (6.937)

We do think that a community crisis model of this kind meets a need that was expressed to us by a number of people, and is a good model to continue testing and developing further in terms of future mental health care. Care for crisis in the community has a creditable track record to date, in terms of crisis houses and Crisis Resolution Teams, these being generally popular with people in crisis. But we also heard that access to crisis care can be a real problem. Mind (2011) found that excellent care exists, but that too often people are turned away and struggle to get help. It called for

“the defining concept of residential acute care [to] shift from that of a medical ward towards that of a retreat; providing humane, respectful, personalised care in a comfortable environment.... There should be more options for people in crisis – more gateways into help and more kinds of help so that the requirements of all groups and communities can be satisfied.”

We would not wish to prescribe a single model, but we were impressed when we considered the services provided by the Edinburgh Crisis Centre.

CASE STUDY

Edinburgh Crisis Centre

The Crisis Centre is open 24 hours a day 365 days of the year and provides community-based emotional and practical support at times of crisis – for example when people are feeling suicidal, actively self-harming or having psychotic experiences. Over 1300 people contact the Centre each year, over half making contact for the first time. Carers of people who have mental health issues can also fully access all the services at the Crisis Centre. Approximately 100 carers used the Centre in 2010.

The Crisis Centre has a free phone telephone help line as well as face-to-face support and access to a wide range of information. When the person feels ready staff can support them with computer access to a database of local statutory and community resources to inform the development of their crisis plan. The Centre aims to give people an alternative to hospital as well as working with people facing an acute crisis in a preventative way. People stay overnight at the Centre for a range of reasons. In the past, before the Centre was established, some people would have been admitted to hospital because there was a danger they would harm themselves. Now the Crisis Centre presents an alternative. There are times in people's lives when the Centre is a more restful and safer place for them to be than their own home.

'One stop shops' and community support

"Care should address the holistic care needs of service users in a much more meaningful way. Physical health care, suitable education, community presence, education, training and employment opportunities should be given as much priority as managing symptoms." (2. 212)

"The wider contributory factors to mental ill-health need to be considered in their widest sense particularly preventative measures that help to reduce actual mental ill-health and decline - substance misuse, poor housing, poor diets - mental health services need to work in partnership with community services at a local level." (6.990)

There was considerable support throughout our Inquiry for places in the community that people with mental health problems could go to which would be both a place where they could feel relaxed and unstigmatised, as well as somewhere offering a range of local support and local guidance. As one witness put it to us, observing that many mental health day centres had been closed in recent years, "Our service users have been screaming out for this – it's a nightmare for them". A particular example we were pointed to was Headspace - the National Youth Mental Health Foundation that operates 55 centers around Australia, advising and supporting young people on general health, mental health and counselling, education and employment, and alcohol and other drug services.

Closer to home, we looked at the example of community support provided by the Bury Involvement Group, that we were told provided an excellent response to local needs.

CASE STUDY

Bury Involvement Group

Bury Involvement Group (BIG) in Mental Health is a voluntary organisation located in Bury, Greater Manchester. It provides a broad range of accessible and responsive user led support services for individuals experiencing mental health problems. It is run entirely by volunteers who themselves have experienced a range of mental health issues.

BIG educates people about mental health in a non-judgmental and supportive way, whilst improving knowledge and understanding. It takes a holistic approach to mental health. Free and confidential support sessions offer a safe and welcoming environment for service users. They focus on a range of issues from recovery to anxiety and from general drop-in sessions to social activities. Service users can drop in and out of the sessions when it suits their individual needs. Through the support groups held in the local community, BIG provides opportunities for people to make friends, share experiences and gain mutual support. It also raises awareness through outreach work with professionals and employers alike.

Both these examples struck us as being just the sort of local, accessible, non-stigmatising and informative community mental health services that so many people told us they wanted to be widely available in the future.

People want good, local, expert community support, both when they are in need of crisis care and in helping them to cope with the problems and challenges of daily living. There are good examples of such services in the UK, but they are patchy, and under pressure from both demand and financial constraints. If mental health services in the future are to meet people's needs in these areas, then local commissioners across the UK need to learn from these models and discuss with mental health service users and their carers how they can be implemented more widely.

Taking integrated care forward

Over and above these specific models of integrated care for people with mental health needs, we took on board a range of evidence about how better integrated mental health care could be delivered in the future.

Changing the mindset, and the importance of relationships

Underpinning our consideration was a desire expressed by a number of respondents for a new mindset in delivering services that acknowledged the indivisibility of physical and mental health. As a member of the Foundation's Policy Panel put it

"Recognition that physical and mental health are totally integrated within any one person and cannot be divorced from each other when considering the well-being of any individual."

"Change the entrenched mindset. Remove the differentiation. Take the caption, "physical and mental health" (as completely separate terms as it's meant in modern medicine) change it to "mind and body" or "wellbeing" as one term, because they are linked, inseparable and wholesome." (Policy Panel member, 2012)

"Training of doctors to address the unhelpful dichotomy of the mind/body divide." (5.1194)

We agreed that a better understanding across the health and social care workforce of the indivisibility of physical and mental health is important if future generations are to get the best possible response to their needs. However what came out most strongly from the evidence was that it is people and relationships that secure good integrated care. The evidence we heard made it clear that we need both leaders who will drive forward integration at a strategic level and staff who understand and respect the roles and responsibilities of other professions and are willing to work with patients and across organisational and professional boundaries.

"Relationships are the way in which integration occurs, not elaborate models or new ways of working. Focusing on allowing people in teams to build relationships would go a long way to enabling integration." (5.1371)

"A motivated workforce will improve the services more than a carrot and a stick. There is good practice in some teams, almost certainly this will be because they are working as a team, and have a skilled manager who engages with them all." (6.925)

Alongside this, and as a crucial element of helping staff in different disciplines to work in a more integrated way, we received numerous calls for more and better joint training and joint practice across the health care workforce.

“GPs and emergency care doctors need more mental health experience.” (5.1522)

“Provide training in physical health to mental health practitioners and vice versa, also train GPs more in mental health so they understand and can get the relevant teams involved.” (5.962)

“Nursing training should regroup and no longer keep mental and physical training separate. Consultant psychiatrists should train alongside other doctors and work within general hospitals. Their training should change to encompass more experience of managing “physical” illness. The specialty needs to realign itself with physicians to improve expertise, academic achievement and recruitment.” (3.1213)

“By adopting a holistic approach to mental health care; by joint training of mental health and physical health workers.” (5.160)

“By targeting medical and nursing staff particularly whilst in training at university.” (5.248)

“Training and education, I have always advocated a rotation of for example RGNs through mental health, LD services.” (5.227)

“Joint clinics with GPs and physicians. More cross over experience both at training level and professional levels with all staff spending time in each other’s departments.” (5. 342)

“Cross training of mental health and medical personnel beginning at earliest level and continuing throughout careers.” (5.374)

“We would also welcome joint training of the nursing workforce so specialisation into general or mental health comes later and there is recognition that the health workforce doesn’t focus on one without the other. This also applies to mental health staff more widely who often take no interest the physical experiences of their service users whether they are psychologists, social workers etc.” (5.395)

“Dual training like Occupational Therapists for more professions.” (5. 621)

“As mental health nurses I feel we should have more training on physical health problems.... There needs to be more generic training to incorporate physical health training and vice versa with general nurses.” (5.712)

“I plan as a professional in my own right to try and network and build bridges with professional colleagues within the CAMHS team and adult mental health teams. Education of each other’s roles and responsibilities being paramount.” (5.635)

We were pleased to note that in England, the Department of Health’s Mandate to Health Education England included the improved integration of the health and social care workforce, including staff being equipped to treat mental and physical health conditions with equal priority (Department of Health, 2012a):

‘Mental health is a matter for all health professionals and HEE should develop training programmes that will enable employers to ensure that staff have an awareness of mental health problems and how they may affect their patients. This should include an awareness of the links between patients’ mental and physical health.... and the impact of co-morbidity as well as the actions they can take to ensure that patients receive appropriate support.

‘Training should also raise awareness of the increased likelihood of mental health problems presenting themselves in those people with long-term conditions and the need for care to address both issues concurrently.’

We were also pleased to see that the Mandate calls on the HEE to work with the General Medical Council (GMC), the four UK Health Departments and the Royal College of General Practitioners to agree an approach for implementing a revised GP training programme, including much more emphasis on child health, mental health and care of the elderly. Separately, we welcomed the recommendation from the Schizophrenia Commission (2012) to extend GP training in mental illness to improve support for those with psychosis managed by primary care.

We may not be able to do much about changing human nature in terms of natural collaborative instinct. What we can do, though, is to maximise opportunities for both the current and future health and social care workforce to be better informed about the indivisibility of physical and mental health and the value of collaborative working and the skills that colleagues in other disciplines can bring to patient care. These issues need to be a core element of early basic training of all health and social care staff. There should also be an expansion of continuing cross-boundary inter-professional training and education. All professional bodies should make such training a requirement of continuing professional development for their members.

Structural factors that facilitate good integrated care

Based on the evidence it received, the Inquiry identified a number of structural factors that helped to establish a framework for good integrated mental health care, namely

- Information-sharing systems
- Shared protocols
- Joint funding and commissioning
- Co-located services
- Multidisciplinary teams
- Liaison services.

Information-sharing systems

We heard from a number of sources about the problems caused by a lack of Information Technology (IT) co-ordination across different organisations, and parts of organisations. This hindered the sharing of information and made integrated care much harder to achieve. As one witness put it, when asked what the single key thing that needed changing to establish integrated care, “A decent IT system that works! We’ve got to try to resolve our computer systems not talking to each other.”

As the whole question of IT was one of the key themes of our Inquiry, we deal more fully with this issue later in this report.

Shared protocols

Although care needs to be taken to ensure staff ‘buy-in’ to shared protocols, where they have been established the evidence suggests they work well. We commend the development of shared protocols within and across the range of statutory, independent and voluntary organisations that support people with mental health problems.

Joint funding and commissioning

“Shared formulation rather than diagnosis to drive resource allocation and pathways to care.” (1.1527)

“Many of the barriers come from different funding streams so there is no joint working.” (5.486)

We heard from a number of witnesses that the allocation of resources and funding into organisational and specialist silos militated against good collaborative working, as there was a natural defensiveness for managers, especially at a time of very constrained funding, not to want to share their pot of money.

We recognise there are opportunities across the UK for health and social care services to share budgets (especially in Northern Ireland, where health and social care are joined formally at Departmental and regional level) and know of a number of instances where this has led to innovative and cross-boundary working. However the evidence we saw did not suggest that merging organisations necessarily improved the sharing of budgets.

We see a greater need for funding in the future to be directed more towards individual integrated care packages rather than single, isolated interventions along a care pathway. By the same token, combining health, social care and other (eg education) budgets at a local commissioning level provides the opportunity to mirror the service delivery requirements of people who need a coordinated approach to manage their mental health condition. Future commissioners should focus on the integrated care that people need rather than individual services, and to use their leverage to encourage joint planning and service provision.

Co-located services

“The mental health workforce needs to be spread across GP surgeries, specialist mental health services and primary care and social services.” (3.1240)

“It may be that physical and mental health services can be combined relatively quickly into bigger integrated trusts but that won’t mean that the different groups of staff will automatically work together – the split will still exist under the surface of the Trust logo.”

We have already noted the many responses we received suggesting that specialist mental health services need to be available in primary care settings, and in particular accessible within GP surgeries. One witness told us “Only when practitioners work with others do they recognise others’ skills. Their eyes are opened”. We heard that co-location can improve access for patients and reduce stigma, as well as improving relationships between staff from different disciplines and organisations. However we found no convincing evidence that in itself co-location guarantees better integrated working. It still requires staff to understand each others’ respective roles and responsibilities and work willingly and collaboratively together.

Multidisciplinary teams

“There also needs to be a radical shift away from the medical model, with the psychiatrist in charge, to a multi-disciplinary shared decision making approach, where people with mental health problems are listened to and feel in charge of their own care.” (1.532)

“Emphasis on multidisciplinary working, that allows clinical expertise to be used effectively to provide interventions.” (1.1417)

“My worry is that what we will be left with are services which have been de-professionalised and fragmented. But people in distress often have complex overlapping needs, and it is really important to maintain and protect ‘coherent’ service structures, which can provide multi-disciplinary support.” (3.936)

“Over the last 10 years we have been asked in mental health to do more with less. We can’t keep doing this. If there were multiagency mental health teams, I could come back from a visit and ask my social work or home care colleague to visit the patient that afternoon or the next day which would be a much better service for patients and staff.” (6.742)

Many of the responses to our Call for Evidence spoke of the benefits of multidisciplinary teams and the need to ensure they are an integral part of mental health support that people receive in the future. We felt that there was a good reason why such models had survived for so many years as an integrated response to people’s needs, despite evidence that they did not always work as effectively as they should. We believe improvements in how these models work could be effected by the better interprofessional education and training of staff working within multidisciplinary teams, as advocated in this report.

Liaison services

“Locally we majorly need an investment in liaison services and for commissioners to support the work underway.” (6.1343)

“GPs and associated staff need to be better trained in mental health. Liaison psychiatry needs to be developed and accepted as an essential component of acute care. The physical health of patients with mental health problems needs close attention and care.” (5.216)

“Liaison psychiatry being a transparent service within adult psychiatry, not a hidden specialism.” (5.242)

“The increased presence and funding of mental health liaison services within the general hospital, with improved relationships between the teams.” (5.823)

“By promotion of liaison services, which can highlight the cross-over between physical and mental health. Re-examining how mental health is taught across the undergraduate curriculum of health care professionals. Promoting joint workshops relevant to physical and mental health.” (5.1187)

The message we received on liaison services is clear. There are significant benefits to establishing both psychiatric liaison services in physical health care settings, and physical care liaison services in mental health settings. Commissioners need to be better aware of the evidence for such services, the improvements to integrated patient care and the cost savings that can be made through more effective care and more rapid recovery.

There are a number of structural arrangements that can help to establish effective integrated care for people with mental health needs. Among the most important are having effective information-sharing systems, the ability to pool funds from different funding streams into a single integrated care budget, shared protocols and partnership agreements, co-location of services, multidisciplinary teams and liaison services. All these should be further developed so that future mental health services can be based on proven and effective service delivery mechanisms.

However while these are all necessary and helpful, it is the quality of people involved that makes or breaks integrated care – leaders with a determination to drive forward integrated care at an organisational level as a way of improving patients' experience and outcomes, and staff who understand the holistic nature of health care and have no professional defensiveness about working closely with colleagues in other disciplines, and with patients and families.

The future of effective integrated care therefore lies primarily in recruiting, training, maintaining and developing a workforce, both in health and social care, that is passionate and committed to the principles and practice of holistic care and partnership working.

Theme 3 – Lifespan issues

“Where the effect of the relational environment on children is fully acknowledged, so that child protection and subsequent mental health issues are clearly linked intellectually and in terms of service provision across the life span.” (5.322)

“There should be a balance of support for long-term and acute conditions with a range of interventions that will support folk to lead full and satisfying lives from adolescence to old age.” (5.593)

We did not especially look to identify specific age groups in respect of the key messages that we wished to draw out from all the evidence we received during our Inquiry. We noted the Office of Science and Technology report on Mental Capital and Wellbeing across the UK (Office of Science and Technology, 2008), which had looked at the best available scientific evidence on the factors that

influence an individual's mental development and wellbeing from conception until death. It concluded that a lifespan approach was required, but that there was some way to go before the UK could claim to have a long-term and strategic perspective that spans an individual's life course.

In principle we agree that mental health services of the future need to cover individuals from conception to death, and we welcome that the Equality Act 2010 means that mental health services cannot discriminate against people on age grounds. However we also knew as we started our work that there were major concerns about the mental health of children and young people, and of older people. Particularly in the former case, these appeared to be borne out by the very pessimistic view of survey respondents when we asked them what they thought about the future mental health and resilience of children and young people.

Early life

We received a considerable volume of responses to our Call for Evidence urging mental health services of both today and the future to focus on infants, children and adolescents.

“I think that currently mental health services are reactive to a problem that has already developed - very often adults with moderate-severe mental health problems began to develop these difficulties in very early childhood. I would like there to be more help for parents from the day their children are born, and for schools, to help promote the development of psychological wellbeing - in particular for parents with their own mental health problems.” (1.51)

“Focused support to all first time mothers to ensure their babies get a good start. Widespread parenting classes.” (5.1068)

“On prevention and much more that is to do with pregnancy, parenting and childhood. The evidence shows money spent in this period is many times more effective in changing outcomes when compared to money spent on adults. The cost effectiveness is well demonstrated with projects like the Family Nurse Partnership and schools based interventions for children with challenging behaviour. Mental health issues cost over £67 billion to society per year, and yet we don't do any long-term planning to reduce the incidence in future generations or later in the lifespan.” (4.705)

“I worked with countless young women who were single mothers with up to 4 children who were desperately struggling mentally, financially and emotionally; the children start to drop out of school and then the mothers drop out of MH services because they are scared their children will be removed by social services. They then become more isolated and the children get even less help and support.” (4.725)

“I worked as a secondary school teacher before re-training to become a psychologist, and from what I saw in schools and what I see within society I think we are sitting on a time bomb.” (6.984)

“I will say as a CAMHS clinician that money spent on parental mental health will pay back fivefold in the mental health of the next generation, throughout their lives and the lives of their dependants.... the argument is unquestionable in my view.” (4.1474)

Alongside these many responses, we took into account the established evidence that points to a child’s early years being crucial to their mental wellbeing and a major determinant in their chances of experiencing mental illness as an adult, with half of those with lifetime mental health problems first experiencing symptoms by the age of 14, and three-quarters before their mid-20s. We considered that Graham Allen MP’s two reports on early years (Allen, 2011a; Allen, 2011b) set out much of this evidence very convincingly, as does the Munro review on child protection (Munro, 2011). It is clear that work on promoting attachment and managing emotions of both parents and child provides the best form of prevention, reduces mental distress and the number of looked after children, decreases the use of the juvenile and criminal justice system, and is cost effective. We further discuss the importance of a public health approach to early years later in this report.

Yet despite all this evidence, as one witness told us, “We keep talking about early years, but don’t invest in it”.

“Early prevention of MH problems in infancy/childhood makes most sense, but specialist MH services are not usually the people providing this sort of intervention (and needs involvement of several agencies anyway). Specialist care therefore needs to focus on the care of those people who most require specialist mental health care.” (4.358)

We believe that many, if not almost all of the factors that lead to poor child and adolescent

mental health can be modified. Some of the ways this can be done fall outside the scope of this Inquiry, such as reducing inequalities in society and ensuring decent housing for all families and tackling domestic violence. But as far as mental health services go, two issues stand out for us. The first is around the need to focus mental health support more intensely on the mental health of parents, infants and children who are identified as having mental health difficulties, with services working in close collaboration with other agencies supporting families. This might take place in homes, or in the community as appropriate.

Secondly, a number of witnesses told us about the need to strengthen mental health work with schools, primary schools in particular. They considered that children with difficulties that were likely to develop into mental health problems were identifiable very early on. Accordingly, alongside universal interventions led by teachers to maintain and improve children’s mental and emotional wellbeing, trained mental health workers also need to be widely available to respond to any identified needs. CAMHS policies exist across the UK, but we heard that many CAMHS services were under intense pressure and many children were not receiving the support that they should.

We see benefits in continuing to develop CAMHS expertise working with families and in schools across the UK, although, as one witness put it to us, “A big shiny CAMHS centre is not what children and young people want”.

Infants and young children growing up today, many in damaging environments, are the young parents of children growing up in 20-30 years’ time. It is essential that mental health services both today and in the future are geared up to intervene early when problems are identified, and support parents and their children to break any generational cycle of poor mental health and mental illness. Investment in early years support is likely to repay its costs many times over by reducing use of health and other public services, and will also significantly improve the health, educational and social outcomes for children of the future as they grow into adulthood.

Later life

We noted earlier in this report the demographic changes to the UK population

that suggest there will be at least 6 million more older people (aged 65 plus) in the UK by 2030 than there were in 2010.

“Older population with greater morbidity will put strain on services.” (6.1403)

“The demand from the older adult population will grow because of an increase in longevity with resultant increase in dementia.” (4.68)

“Dementia care to help people stay in their own homes with high quality treatment and support for them and their family.” (4.987)

“Catering for the needs of dementia sufferers and investing in dementia research.” (4.998)

“Services for older people should be more accessible to them, especially non-pharmacological interventions.” (5.1118)

Older people experience a range of mental health problems, some of which may have started earlier in life (indeed, in childhood), others which may become a problem only in later life, perhaps due to life circumstances such as the loss of a lifelong partner. These include depression, anxiety, delirium (acute confusion), schizophrenia (70,000 older people across the UK), eating disorders and bi-polar disorders. Yet levels of awareness and understanding about them remain low (National Development Team for Inclusion, 2013).

Perhaps reflecting this low level of understanding, the majority of responses that we received touching on old age referred to dementia, and the potential health and economic challenge that larger numbers of people with dementia will cause in 20-30 years' time. This issue is also raised in the Office of Science and Technology report (2008) that we refer to above, which sets out what it believes are the two major challenges in terms of the future demographic shift in the UK to an older population:

- how to ensure that the growing number of older people maintain the best possible mental capital, and so preserve their independence and wellbeing. Dementia will be a major problem and will have a substantial and increasing impact on individuals, carers and families.
- how to address the massive under-utilisation of the mental capital of older adults, and how to reverse the continued negative stereotyping of older age.

We also took account of the recent report from the House of Lords Select Committee

on Public Service and Demographic Change (2013), looking at whether the UK is ready to cope with an ageing population. This report points out that an estimated 83% increase in the number of people with dementia by 2036 will place substantial extra demands on formal and informal care networks, and that

“The doubling by 2030 of the number of people aged 85+ will have a substantial impact on those public services that are particularly important for older people, an impact for which they are worryingly ill-prepared... The primary care GP workload incurred by those aged 75 and over is roughly three times that of the 45-64 age group”.

Clearly the expected growth in the number of older people with dementia is one of the biggest mental health challenges in the future. We noted that governments across the UK have published dementia strategies and have set in motion actions to address the challenge. This is all well and good, but the evidence we have looked at suggests that the challenge will not be adequately met without a significant increase in both the skills among health and social care staff who support people in later life, and – given the very large increase in numbers of people suffering from dementia – an equivalent increase to the workforce supporting people in later life.

The attention being given to dementia cannot be said of the other mental health challenges facing older people in the future. The Foundation has recently published work on the mental health of the baby boomer generation, who will in 20-30 years' time be the cohort of people in their 80s and 90s with high levels of both dementia and, linked to increasing physical health frailty and loneliness, depression (Mental Health Foundation, 2102a). The report calls for adult mental health care services to continue working to integrate services across all ages, and for treatment for both common mental disorders and severe mental illness to be available on the basis of need, not age. This specifically includes the development of drug and alcohol services to meet the needs of older substance misusers. It also highlighted the need for more research into the current service patterns and treatments that work best for older people.

It is equally important, in terms of tackling ageism, that older people are fully engaged in decisions and choices about the mental health care they get. The evidence we looked at shows that having a voice and feeling in control are important in maintaining the mental health of older people. Staff must continue to be trained not to make assumptions about older people's ability to engage in discussions and decisions about their care.

The increasing numbers of people across the UK who are likely to experience dementia is a major challenge for the future. Current initiatives to address this challenge need to be actively pursued. However, there is less focus on the many other mental disorders that older people will face, such as depression. Mental health services of the future need to recognise the prevalence of these disorders among older people and provide a comprehensive response to need. Older people must also have a voice in future mental health services. This will require the future mental health workforce to increase its skills around mental health in later life, as well as having a better understanding of older people's ability to make informed choices about their care.

The balance between generalist and specialist

“Move AWAY from very specialist teams being responsible for a portion of the patient pathway, eg integrate home options, assertive outreach, early intervention into one community service. Remove as many interfaces as possible.” (2.474)

“Fewer specialist teams and therefore boundary disputes when it comes to providing a service.” (2.338)

“Much more generic and not so disparate in professions as this tends to set up the need for further communication which slows the service down. Also tends to repeat assessments when one would do. eg Psychology assessment, OT assessment, nursing assessment, Dr assessment etc.” (3.1193)

“The future of mental health services needs to be taken out of psychiatrists' hands. The current strong emphasis on the medical model does not ring true with either practitioners, users or the public. There needs to be a change to the hierarchy so that the social model is much more at the heart of how mental health services are focused.” (6.1322)

“If we continue to focus down on a medical model and retain purely our doctors and nurses this will have a very negative impact on any progress which has been made over the last 20 years. However if we look at creating community capacity by making the use of the resources we have available to us already and use this to create more capacity and if we listen (with open minds) to what our service users tell us we could make huge and very positive changes.” (6.1323)

One theme running through the evidence we received and heard was that there was far too much emphasis on expensive and 'silo' specialist care, and what we need in the future is a far greater range and number of staff with more generalist skills that will help people to live fulfilling lives in the community rather than just moderate their clinical symptoms. One witness suggested that

“We must have more provision in community and primary care, primary care clinics, screening in primary care. We need to unlock mental health services and decommission, for example, a 20-25% reduction in secure care. DSPD [Dangerous Severe Personality Disorder] doesn't work though costs millions of pounds”.

Theme 4 – Workforce development

We received many suggestions during the Inquiry as to what the workforce of the future should look like, in terms of both roles and attitude. We noted the view of the National Clinical Director for Health and Criminal Justice that “In the end, mental health reforms are about workforce roles” (Appleby, 2012).

In general, witnesses and survey respondents wanted a workforce that consisted of skilled practitioners and communicators; was local, and easily accessible when needed, 24 hours a day, 7 days a week; worked better across professional boundaries and hospital / community boundaries, rather than in silos; had the professional competencies to deal with the problems people had; and had the time to just talk to patients about their lives rather than simply provide a (sometimes insufficient or ineffective) clinical input.

Two particular issues that we thought worthy of attention in terms of workforce development in the future were

- the balance between generalist and specialists
- a potential role for peer support and navigators.

Other witnesses suggested that “There will be a change in the workforce. We simply will not be able to afford the current balance of staff, the balance between specialists and others”; “We want a lot of generalists, with a few specialists; but at the moment we have the opposite.”; “We get wound up about our own professional identity, but service users don’t care”. One suggested that arguments for specialism were “The death-knell of professionals as they scrabble around on the head of a pin.”

These are all heartfelt responses that might be seen in the context of the progression of mental health services over the last hundred years, from authoritarian and paternalistic treatment largely in places of detention, through the move to care in the community, into the current focus on social, recovery-based, service models, personalisation and patient choice.

However, we also heard a vigorous defence of specialist mental health services from respondents to our Call for Evidence (some 50% of whom were mental health professionals) and a number of individual witnesses. One witness put it to us that we would not just need to maintain specialisms, but that we should in fact be developing more ‘super-specialisms’ to address those people who required very complex and intensive care, often within a forensic setting.

“A generic nightmare with nobody able to help the service user make a rational decision. OR... Clear roles based on specialist professional knowledge and experience, providing recovery-based support to service users.” (3.213)

“There is a great danger that the move towards generic workers underestimates what each profession contributes from its own heritage, underlying ethos and diverse research traditions. Whilst we need to work together in the best interests of service users, families and carers none of us can be all things to all people and we need to value and appreciate professional skills and abilities.” (3.1460)

“Community services have already undergone enormous change with more and more lower grade and unqualified staff. Whilst some aspects of specialist community mental health worker roles can be taken on by unqualified staff, clinical experience and specialist skills are, of course, necessary to deliver skilled interventions to people with complex mental

health issues. We need to ensure that the downgrading of the mh workforce doesn’t continue beyond the tipping point.” (3.1392)

“There is a role for generic mental health workers to provide care and support but if they replace expert staff who have an expertise in effective assessment and in developing and helping to deliver effective management plans patients with severe mental disorders will suffer.” (3.474)

“More accredited specialists offering better range of therapies, of which drugs will be a part. More access to specialists than we currently have, eg perinatal services. Routine access to specialist mental health pharmacists.” (2.320)

“While prevention and early intervention must be the focus of future services, this should not be at the cost of providing high quality specialist services for those who need them.” (4.1419)

We see merit in both sides of the argument and conclude that a balance between (properly trained and skilled) generalist care and specialist care will be required in the future. This was, in fact, the overall conclusion from many respondents to the Inquiry.

“All staff will be skilled and confident in supporting people through general mental health needs in order to avoid frequent changes and onward referrals. However, they will also be enabled to maintain and develop expertise so that people who use services are able to access a range of highly skilled workers at the appropriate points of their journey.” (3.1419)

“Very varied - lots of support workers/ volunteers/peer mentors rather than necessarily people with qualifications. Psychiatrists & CPNs will certainly be needed too as well as therapists of many types. We need to use people’s skills sensibly eg psychiatrists know about drugs but not about work, social workers understand the mental health legislation but are not (mostly) clinical experts.” (3.1139)

“My fear is that the workforce will have a lot of ‘low-intensity’ workers with high caseloads and relatively little training... My hope is that it will consist of multi-disciplinary teams of a range of high/low intensity and specialist/general qualified staff.” (3.991)

We did not see any over-riding evidence for any significant future shift in the balance of generalist and specialist staff providing support for people with mental health problems. This is not the same as saying we have the right numbers of each today, or will do in the future – but that will depend to a great extent on the availability of future funding, which is not an issue that we looked at. Nor do we think there is convincing evidence to suggest major role changes among existing mental health staff. We think all the various professions involved in mental health care today – psychologists, psychotherapists, mental health nurses, CAMHS staff, occupational therapists, psychiatrists, social workers and others – will have significant roles to play in future mental health care.

We would welcome staff in any professional group expanding their knowledge and skills beyond what is expected of them today – a number of witnesses spoke of ‘role shifting’ within mental health teams – but agree with witnesses and survey respondents who pointed out the danger of diluting the specialist skills that at times mentally ill people both require and want.

“a combination of ‘professionals’ and peer workers in all roles. (3.412)

“A mix of Peers and others with a genuine wish to understand and support those who go through mental health difficulties.” (3.1227)

“More people with lived experience of having had mental health problems themselves and professionals who are empowered to share their own recovery journeys if they have them.” (3.1405)

The Inquiry heard of widespread support for more people with lived experience of mental distress (peers) to be employed in the mental health workforce. We heard from one witness that putting a peer supporter in his local primary care team had been remarkably effective. We were told that peer support workers were highly valued by recovery services because of the practical nature of their interventions, and that they should be involved early on in the treatment and care process. Indeed, garnered from among the responses we received, it was suggested that in 20-30 years’ time the proportion of peer support workers in the mental health workforce might be 10, 20, 30 or even 50%.

The Mental Health Foundation (2012b) has summarised the research evidence on peer support and concluded that there are significant benefits not only to the people who are supported, but to the peer support workers themselves. The development of peer support within the mental health workforce has its challenges, including the importance of not losing the value of informal, voluntary peer support alongside the formal role taken by peer support workers as part of local mental health teams. In addition all formal peer supporters, whether voluntary or paid, must receive appropriate levels of training and support in order to carry out their role effectively and safely. Nor must peer support ever be seen as simply a cheap option for replacing skilled and experienced mental health staff. Their value comes from working beside such staff.

A potential role for peer support workers and navigators

We were much taken by evidence that presented a strong case for the development of the future workforce through an increased role for peer support and navigators.

Peer support workers

“I think more help needs to be available in the field. People available to take phone calls. To call round to houses. To have a coffee. To chat. To have group meetings. Maybe to become a friend - someone to be trusted - someone who will be there to help and not pass judgement. To maybe meet and talk to other people suffering from the same illness. I find people suffering from mental health problems are very isolated. No one wants to talk about it.” (4.440)

“There should be a greater presence of peer support within services, and an accent on recruitment of people with direct experience of recovering from mental ill health.” (3.202)

“It will still be multidisciplinary but with the potential for peer workers in addition.” (3.206)

Navigators

“Perhaps by using an individual coordinator who can support & liaise with other agencies & professions.” (5.1491)

“Care navigator roles in place to enable focussed professional interventions.” (3.1436)

“There will be a heightened health care navigator/coordinator role for primary care staff.” (1.557)

“Is there a booklet that can tell you what help there is out there so that you can try different approaches or at the very least know what help there is available. In my experience I still do not know what help is available to for me to quickly access when I feel overwhelmed and in need of some support. I have never felt so alone in my life yet I have a family and friends who I know love and care about me. But they cannot always reach out to me in the way that a professional can.” (2.285)

Linked to the idea of ‘one-stop shops’ is the role that a navigator could play as a core worker within future mental health services – someone who would help people with mental health problems, and family and carers, navigate their way through complex systems of health and social care support, and understand their rights, as well as linking them to opportunities in their communities around welfare benefits, housing, training, employment, leisure activities and so on.

To a degree this role is already being undertaken variously within a wide range of befriending, advocacy and information initiatives across the UK, some of which are specific about the navigating role. It should be noted that, as envisaged, this role is not the same formal role as a public service key worker or care co-ordinator under the Care Programme Approach (CPA), who has the important responsibility to join up the support given to a patient being cared for within secondary services – although the navigation function could be provided by such workers.

National Voices, the coalition of organisations across England that supports the voice of patients, service users, carers and their families, highlighted this as an issue across the whole of healthcare (National Voices, 2011):

“People know they may need a variety of professionals and support services, but within this they want a single trusted point of liaison, to which they can have recourse as necessary, where the above knowledge is held. They expect this person/service to advise them on how to take next steps and, ideally, to co-ordinate their care or to help the patient/carer to co-ordinate it.”

This navigator would in effect hold a ‘tube map’ of all available local services which professionals (such as GPs and social workers), patients, family and carers alike could use, and would be able to point people in the right direction and, possibly, negotiate with services on an individual’s behalf. One witness put it as

“the analogy I’ve got in my head is I use the tube and I don’t want a single point of contact because I want to go from all sorts of different places on the tube. But I want the same map every time I get there so I know exactly where I am and where I’m supposed to be going. And it seems to me the same principle, let’s not pretend we can have a single point of contact, [but] make sure there are consistent aids to navigation.”

Such support would be sensitive to the needs of particular groups, such as people from Black and Minority Ethnic (BME) and Lesbian, Gay, Transgendered and Bisexual (LGTB) communities. We received very positive views during our Inquiry about this sort of role, both in responses to our Call for Evidence and from witnesses, one of whom stated that “We need a clearer articulation of what the network of local services really is. We cannot leave people and carers just to navigate themselves”.

Many respondents felt that this was a role where the voluntary sector could lead, and in particular peer support workers. We would concur with this, although would not wish to restrict such a role to the third sector, having considered what seems to us an excellent example of such work undertaken by the NHS in Sandwell.

CASE STUDY

Sandwell Esteem Team

The Esteem Team is part of an integrated primary care and wellbeing model. It consists of Gateway and Link workers who act as care co-ordinators and navigators for clients with complex needs and underlying mental health issues. The Team are diverse and work across Sandwell to enable people to cope with the challenges in their everyday lives. The Team was developed to work within primary care services and to work in close partnership with other statutory agencies to offer a seamless service without barriers.

The main aim of the service is to support people in Sandwell to improve and maintain their wellbeing. It works closely with Welfare Rights, talking therapies, advocacy and many others to ensure all clients get the services which are right for them, and to help them access services that will help them in dealing with their everyday issues.

The mental health workforce of the future needs a balance of specialist and generalist staff, with clearly defined skills and roles, but able and willing to work collaboratively in support of individual patients. While we would urge an increased knowledge and understanding of mental health issues among generalist staff, and particularly GPs, as we would physical health issues among specialist mental health staff, it will be important not to water down the specialist skills that at times mentally ill people both need and want.

Peer support

The very strong backing that peer support received during our Inquiry convinces us of the need to develop both formal and informal arrangements to increase opportunities for people with lived experience of mental illness to play a role within the future mental health workforce. We are not prescriptive about the precise role that trained peer support workers could play. This would need to be decided by local services, based on local expressed needs and choices.

Navigators

Again without being prescriptive about the details, and recognising the potential overlap with formal key workers and care coordinators, we strongly support the principle of a single individual within the future mental health workforce who can help people navigate their way through complex systems across health, social care, housing, employment and education (among other services) and access integrated care packages. In our view this would go a long way to ensuring that people not only receive the best support, but also allow them to play as full a role as possible in their community. This should be a priority area for research in terms of effectiveness and patient outcomes.

Theme 5 – Research and new technologies

It is not possible to know where research and new technologies will take us in 30 years' time. We have made an assumption that clinical research, although vital to the future of better mental health care, will not have found a 'cure' for mental illness, whether it be through the development of new drugs or understanding of how the brain works, or through a genetic breakthrough. We expect advances in all these areas, but we are not convinced that, for example, a 'schizophrenia gene' will ever be discovered, isolated and safely removed, or, indeed, whether it would be ethical to do so even if we could. If we had assumed a 'cure', this report would not need writing. On the technological side, we can at least be fairly sure that today's 'smart' phone will no longer be considered smart, without knowing exactly what will have taken its place.

The Mental Capital and Wellbeing report we have cited above (Office of Science and Technology, 2008) looked at new science and technology and concluded that these will create substantial opportunities for improving how we develop our mental capital and promote mental wellbeing:

“For example: new understanding is already leading to new ways of addressing learning difficulties and mental disorders; advances in new technology for learning has the potential to play an important role in personalisation of education; and new technology could help everyone to flourish by changing how we socialise, work, learn and communicate.”

Based on the evidence we received, we looked at this area of evidence under three headings:

- **research**
- **sharing information and patient data**
- **using new technology.**

Research

We received a large number of survey responses urging more clinical and social research in mental health. Many called for research into particular aspects of mental health – for example, on the links between physical and mental health; the use of exercise professionals on psychiatric wards; alternatives to hospital; awareness raising among the public; peer support; talking therapies; prevention of mental illness; the role of spiritual leaders and faith communities; how families can be taught to cope with mentally

ill children; psychotherapy for people with psychosis; and “on anti-psychotic medication as that is the elephant in the room”.

If there were particularly strong trends among these suggestions, they were research into creating better drugs with fewer debilitating and dangerous side-effects; and research into non-medical (ie social) interventions that help people to cope with their condition and get on with their lives.

Spend on mental health research is disproportionately low in relation to the burden that mental ill-health places on society. We noted that mental illness causes 15% of the disease burden but receives only 5% of total health research spending. This prompted the Institute of Psychiatry and the Mental Health Foundation to launch a UK-wide Research Mental Health website and Declaration (Institute of Psychiatry and the Mental Health Foundation, 2009) pointing out that

“Mental ill health is a leading cause of suffering, economic loss, social problems and death in the UK. Our understanding of mental illness has not improved as fast as that of cancer or heart disease. Only proper investment in mental health research will bring the major breakthroughs that are possible in the next 20 years. These could dramatically change our understanding of mental illness and our ability to prevent and treat it.... They could also change our understanding of how mental health affects physical health enabling us to improve both.”

This imbalance in mental health research funding must be addressed, as a matter of urgency, and starting today. The good news is that this message has already been heard and acted on through the establishment of the new mental health research charity, MQ, which plans to fund projects “from basic bench research to clinical studies to the social sciences, with a remit to focus on the big challenges in mental health: depression, anxiety, bipolar disease and schizophrenia” (MQ, 2013). We have also noted that the Department of Health in England has earlier this year opened two new competitions with a total of £5million funding available to develop technologies and innovative solutions that can improve experience for people with mental health illnesses.

However, in view of the increasing numbers of people across the UK who will experience poor mental health, and mental disorders, in the next two or three decades, and the negative health, social and economic impact, we believe that these initiatives can only be the first payment into a much longer-term investment in research into both preventing

mental illness and supporting people with mental health problems, whether it is by clinical means or social means.

Clinical research

We received some isolated demands to get rid of all drug-based treatment in the future, but the majority of evidence that we heard called rather for 'less, but better' medication.

"I hope that psychiatric drugs will improve and that brain scanning and gene testing might help also." (5.1206)

"Better understanding of the brain will lead to better medications (especially in dementia) and 'talking therapies.'" (5.1499)

"Research into genetic links for conditions." (2.402)

"More research and better funding for it and more commitment from pharmaceutical companies." (2.470)

"It needs more funding, both from a research perspective and staffing our services. Dementia for example will become one of the big three killers in the next 20-30 years. We have to start looking at ways in which we will understand and treat mental health for the future generations." (6.993)

"Funding sustained development of neurological research should be used to attract an enthusiastic and expanding cohort of young people into this exciting field." (2.376)

"For better drug treatments we need research and to attract researchers and funding." (2.176)

Discussions with witnesses suggested that a number of pharmaceutical companies were disinvesting in researching new psychiatric medications, as there had been no 'breakthrough' drug for many years. Nor did any witnesses feel that one was likely in the near future. We heard that the vast majority of drugs prescribed today were created over a decade or ago. The 'big ticket', we were told, was finding more effective medication for dementia and depression.

The area that we were advised would dramatically improve was rather around the delivery of medication, for example through depot injections that will last 3 months, and medication that works in hours rather than weeks or months.

Research into social interventions

"Research into the effectiveness of interpersonal and social interventions, both qualitative and quantitative." (2.322)

"They should invest their money in researching objectively and strategically what (including various types of spirituality, culture, aspects of recreational activity etc) really improves people's lives, without playing safe by investing in what has already been found to be beneficial, and keeping within the NHS." (4.828)

Many respondents made it clear that, while they would welcome better clinical interventions to help them manage their symptoms and recover from episodes of mental illness, it was equally, if not more, important for them to have access to support, evidence and guidance that would help improve their daily lives, at home and in the community.

There is already a growing research literature demonstrating the benefits to people with mental health problems of a range of social interventions, such as social networks, exercise, access to green spaces, improved diet and reduced alcohol consumption. We agreed that to help the future workforce better understand the role that social interventions can play in addressing mental illness, more published and peer-reviewed evidence in this area, along with clear guidance on 'what works', was necessary.

The mental health workforce of the future needs to know what are the best, evidence-based clinical and social interventions they can offer to people. However this knowledge will not be available to them unless there is a significant investment in mental health research over the coming years, to redress the current imbalance between low investment and the high burden of disease caused by mental illness.

Sharing information and patient data

“I speak particularly about my own son who has Borderline Personality Disorder, and who specified that his parents should not be told when he made a suicide attempt. The Community Psychiatric Nurse was unable or unwilling to discuss our son with us because of so-called confidentiality, despite the fact that he clearly needed help from us, and we needed to be fully in the picture about him. He is now estranged from the family, which is tragic for him and for us and there is no help available to try to mediate.” (1.379)

“You will not be passed from pillar to post and you can see at a glance from someone’s records what somebody has had or is going to receive.” (3.630)

“There are various internet-based resources for keeping contact with people and trying to support them in the long term, with consistency in contact, rather than variable people involved.” (2.303)

“Better Communications and IT systems to capture and store data, increase front line workers’ knowledge of alternative services if clients cannot be seen by them.” (2.457)

“Seamless provision from primary to tertiary care with all agencies communicating with each other to share information in the patient’s best interest.” (1.6)

“IT systems need to communicate across boundaries - at present CAMHS workers, paediatric therapies, social workers, GPs and school nurses each use different systems although we may all be involved in a child’s care. This is wasteful, confusing for families and works against attempts to share skills/ resources to work more effectively.” (5.1419)

A key element of the mental health service of the future, expressed throughout our Inquiry, was an effective computerised system for sharing patient information both within the NHS and across boundaries with other organisations. We also noted the recent House of Lords report looking at our ageing population (House of Lords Select Committee on Public Service and Demographic Change, 2013), which makes its view very clear:

‘If health and social care systems cannot easily share data about an individual, the result is inefficiencies, delays, duplications and suffering. Enabling more data to be shared is crucial. Constraints must be

removed, risk-averse attitudes must be reduced, and myths which result in people feeling unnecessarily restricted must be challenged. If necessary, legislation must be introduced.’

A similar message about the wider public benefits of sharing data has already been espoused by the Department of Health In England under its new Digital Strategy (Department of Health, 2012b):

‘The impact technology can have in healthcare is profound and transformative. More open access to quality data increases our understanding of how diseases develop and spread. Linking data – to industry and research as well as to patients, service users and the public – gives us insight into the whole patient journey, not just isolated episodes of care.’

Technical compatibility

We heard that the problem of information sharing is two-fold. First, there is a lack of technical compatibility. We heard not just of different services (such as those used by GPs, hospitals, social workers and the police) being unable to establish effective links to exchange data, but even different systems within the same service.

We do not imagine it is easy to establish compatible systems that cover the records of 64 million adults and children across the UK. We noted the history behind recent attempts to establish computerised patient record systems in England, starting with the commitment made in the NHS Executive’s information strategy of 1998 to develop electronic patient health records, and finishing in 2011 with the scrapping of the National Programme for IT at a reputed cost of over £12 billion.

We do, however, think it essential that any future mental health service must have this ability to share relevant data on individuals quickly and effectively, to ensure good, safe, joined-up care. This includes patient access of, and contribution to, the record. As one witness put it, “Organisations transform themselves by sharing information across boundaries – they reduce time between decisions and get closer to their customers - and save money.” We also heard about the tragic cases of the death of a child and a homicide by someone with a mental illness where a lack of information sharing among professionals had contributed largely to the outcome.

We noted that there are a number of promising initiatives across the UK to develop such an integrated patient record system, one example that we looked at being SystemOne. For effective future care, it will be important for such information-sharing technology to be driven forward specifically in respect of patients who use mental health services.

CASE STUDY

SystemOne

SystemOne's 'one patient, one record' model for electronic patient records (EPR) aims to ensure that clinicians always have instant access to a complete, up to date record at the point of care. Through a shared EPR, clinicians from multiple care settings access and record patient information, saving time and resources, avoiding duplication and providing the most appropriate care for the patient.

Staff also benefit from using SystemOne. Processes are streamlined and standardised; resources are easily managed and reporting helps organisations to monitor their work. Mobile solutions mean that clinicians can access the information they need in any location, enabling them to provide informed and timely care. The continuity of the EPR over the years supports the continuity of patient care, and more efficient care handover.

A shared EPR can also help empower patients, allowing them to take a more active role in their care through the ability to view their own record, access healthcare apps, contribute to their record and benefit from online resources, as well as controlling who has access to their records.

Confidentiality

The second problem with information sharing is the concern that staff have about breaking confidentiality. We understand staff concerns and take patient confidentiality seriously, not least because of the immense stigma that still surrounds a diagnosis of mental illness.

"Could you make it more known that going to the doctor to say you are suicidal will not appear on your work record please. I thought that my medical record and my work record were linked somehow and I was terrified of being unable to ever work again." (2.1206)

It is of course important to respect people's rights to privacy and organisations' duties of confidentiality. We expect such rights and duties to still be enshrined in UK legislation in 20-30 years' time. However we also noted that almost all of those mental health service users who responded to our survey were as keen for information to be shared by professions (not least to counter having to tell the same story to different staff over and over again), as professionals were to share it. One witness told us, "We need to grow up and share data. There is no reason why we should not share information across the police, probation services, courts, health and social care. I was a nurse and shared information, unless it was damaging to the patient, with the police". Other witnesses suggested that many staff were confused about when they could and couldn't share information.

We noted a commitment from the Secretary of State for Health in England that by 2015 every patient will have online access to medical records held by their GP, while by 2018 digital records will cover health and social care services. This is fine as far as it goes, but is limited in scope compared to what sharing of information in respect of patients with mental health problems is needed in the longer term. We also noted that good guidance did exist on sharing information, such as that from the Royal College of Psychiatrists (2010a), and the Caldicott review (Caldicott 2013), aiming to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care.

It is essential for good, safe and effective mental health care in the future that we develop systems across the UK to share patient data more freely, involving patients themselves in decisions to do so. This is both in terms of information about an individual patient, so that the best integrated and holistic care can be provided, and in terms of anonymised collated data to allow better research to be undertaken into cohorts of people with a mental illness.

We cannot countenance a situation in 20-30 years' time when a failure to exchange relevant data leads to the death, or even serious harm, of a patient or any other individual as a result of a mental illness. IT systems that allow comprehensive information sharing must be developed both within health and social care, and across relevant organisations such as schools, housing organisations, prisons and the police, while still ensuring that people's legally-enshrined rights to privacy remain protected.

Using new technology

Everyone we spoke to agreed that new technology will radically change the way we deliver mental health care (indeed, all health care) in the future, even if we do not know exactly what form it will take. We think there are likely to be tremendous possibilities. We have noted above the potential improvements to medication delivery mechanisms, but it is likely that new technology will also help people with mental health problems simply to lead the sort of lives they want through 'tools for living well'.

However at the same time we also acknowledged an important point put to us by one witness, who cautioned, "Get away from new technologies, just give people what we know works – humanity, compassion, dignity, respect, social contact". Another witness told us that "Technology has its uses, but it is only a small part of it – the challenge is clinical attitude to what the patient should get", suggesting that in the future we need to offer people "basic principles and a supportive culture – technology is not a panacea....We must not forget the importance of face-to-face contact for patients with people they trust".

We completely agree with the sentiment that values-based human contact will always be an essential part of future mental care. Nevertheless, we heard many positive views around the way new technology might help deliver improved mental health care in the future.

"Lots more IT based programmes..... Much more virtual working together – the equivalent of video conferencing, but via mobile devices and with patients at home." (5.733)

"More use of technology to keep in touch with clients rather than face to face contact for everyone, only those who need it." (2.457)

"Using new technologies to keep in touch with clients - but not at expense of more face to face (therapeutic) encounters." (3.282)

"Many more psychological therapies will be delivered by computer systems and there will be the provision of psychotherapy over the internet (e.g. video calls). Mental health staff will routinely make use of smart technology (e.g. mobile phone apps) to help patients monitor their symptoms and improve their wellbeing. This may result in fewer specialists and more people who can be peer supporters and experts by experience." (3.395)

"My hope is that the workforce will be able to take advantage of technology to enable more personalised services, therefore I imagine that they will be more dispersed and supporting people remotely." (3.1402)

"Having been responsible for running depression support groups in Yahoo for some years I am well aware of their supportive power. Members have reported that these are a real lifesaver enabling them to survive the worst of crises. They create a non-judgmental inclusive atmosphere where people feel free to share giving appropriate constructive advice on symptom management where possible and other problems and also it avoids tendency to isolate." (1.1528)

Two survey responses specifically suggested that care in the future would be provided by robots. While this image might appear more suited to a science fiction film, we accepted the likelihood that more care would be delivered by machines (such as through apps, computerised self-help resources, electronic reminders to take medication and body and brain sensors that allow people to monitor their own mental health daily) rather than by humans. This is not necessarily a bad thing in itself and it ties in to our earlier message around the benefits of more self-management in future mental health care.

The potential of technology did lead to some divergent views. One Inquiry Panel member thought that "The image of a service user skyping their therapist/counsellor, possibly on the other side of the globe à la Big White Wall, is a very powerful one", while another suggested that even if future technology allowed conversations between patients and holograms of mental health professionals (effectively a 3-D version of Skype), what patients needed was "not just a hologram of a random Australian psychologist at 3am".

Whatever the pros and cons, it is inevitable that social media and virtual communication will continue to expand, allowing patients to use these developments increasingly as a source of support. We noted that Leeds and York Partnership NHS Foundation Trust (2013) had recently published a report setting out 'online network tools for recovery and living well' and we see the strong potential in using social media in the future to support people with a mental illness. We also, of course, recognise the dangers inherent in any unregulated and uncertified system of social media, as evidenced by the recent cases of young people who had taken their own lives after being bullied online. In the future we need to make sure these dangers are addressed firmly and clearly.

We are not alone in seeing the potential of new technology. We noted that the King's Fund (2013) takes the view that

'Technological innovation will also undoubtedly have a major impact on how the workforce is shaped and how it operates. The use of mobile techniques is already challenging the traditional lag in communication, making geography a much less relevant factor in care and potentially speeding up diagnosis and in some cases (depending on your access to the web) communication with and between multi-professional teams and patient. These advances will change the dynamic between professionals and patients and require a new set of skills'.

There is no argument that in 20-30 years' time there will be a range of astonishing (to our present-day eyes) technology available to provide better mental health care than we are able to offer today. However, we were mindful of the cautionary note sounded by the Office of Science and Technology (2008):

"Arguably the biggest challenge will not be the development and implementation of these new technologies, but rather, in ensuring equality of access to the benefits. This will be critical if they are to reduce social inequalities in the future, rather than fuelling further divisions."

We also heeded the view from the House of Lords Select Committee on Public Service and Demographic Change (2013) that

"New technologies are not a panacea—they have to be used carefully to work well and be cost-effective. Caution is needed to ensure that older people do not feel increasingly marginalised by digitalisation and automation, and to ensure that an expanding reliance on telecare does not increase loneliness."

A number of witnesses did tell us that we should not worry about future accessibility to new technology – it would be affordable to all, and everyone would have the technical competence to use it, patient, carer and mental health worker alike. While we commend such optimism, we do not think that we should take it for granted that all people using mental health services in the future would have such competencies, at least not all the time – we are thinking of people who become very unwell, or who do not have English as a first language, or may be living in poverty, or may have a learning disability.

Our message about new technology in future mental health care is twofold. First, while new technology will almost certainly bring improvements to the delivery of mental health care, and help people self-manage their condition more easily, it is not a panacea. One-to-one human contact, a smile and kind words have a timeless benefit to people with mental health problems.

Second, we should not assume that the benefits of new technology will automatically apply fully and equally to all those who use mental health services in 20-30 years' time. Many people will continue to need active support to gain equal benefit from new technology, and this support must be available from within the future mental health workforce.

Theme 6 – Public mental health

"Given that mental health difficulties are largely if not entirely the result of the conditions under which society forces people to live, I believe mental health services, governmental social services, local communities, voluntary organisations, and businesses should be integrated in such a way as to promote together the wellbeing of everyone in society... Where is the joined-up thinking? Where is the concern for an individual's wellbeing?" (5.41)

"The wider contributory factors to mental ill-health need to be considered in their widest sense, particularly preventative measures that help to reduce actual mental ill-health and decline - substance misuse, poor housing, poor diets - mental health services need to work in partnership with community services at a local level." (6.990)

There is much published evidence (for example, Friedli, 2009) pointing out that both poor mental health and the development of mental illness result from a combination of biological, psychological and social factors, many of which are well beyond the range of mental health services, at least by themselves, to address. The report on mental capital and wellbeing from the Office of Science and Technology (2008) cites debt and unemployment as two key risk factors associated with mental disorders, and we have already touched on the risks involved in experiencing a damaged childhood and a lonely old age.

The call for a more preventative approach to mental illness in the future was extremely strong in the evidence we received.

We have already touched on the need to bolster this element of future work when discussing early years, such as through parenting and school-based initiatives, although it applies to all ages and we need to be just as passionate about preventing mental illness in adult and later life as we do in early life.

“We need universal mental health promotion services – educating children, young people and young adults about the common nature of ups and downs, stress and difficult mental health periods in almost everyone’s life.” (5.1198)

“More money spent on mental health research and looking at preventative treatment.” (2.648)

“Much more effort and resource should be put into identifying methods of preventing mental ill-health in vulnerable populations, and in early intervention to prevent exacerbation and deterioration in mental health.” (4.395)

“Focus at least 20% of resources on developing better models for prevention. Otherwise it is going to be a losing battle all the way.” (4.572)

“I would love to see more focus upon prevention of poor mental health and upon the development of healthy psychological wellbeing.” (5.51)

We heard from public health specialists that the most important evidence-based public mental health approaches relate to parenting and school-based interventions, issues we have already referred to when looking at mental health in early life. Good parenting in particular was put to us as the number one public mental health priority, but closely followed by other interventions known to reduce risk across the life course.

The case for more preventative work is undeniable. Indeed, lacking a ‘cure’ for mental illness, and assuming that mental health services will not have unlimited funding in the future (whether public or private), a reduction in the number of people across the UK developing mental disorders appears to us to be the only way that mental health services will adequately cope with demand in 20-30 years’ time. We concur with the widely-held view that mental health is ‘everyone’s business’ and that there should be ‘mental health literacy for all’ - in other words, better education about mental health among the public, and better

training about mental health among all public sector staff (including generalist health and social care staff) and in schools, workplaces, prisons, care homes and hospitals, to name just some settings. Certainly we would want to see, as was suggested to us, all front line staff understanding key concepts like the ‘five ways to wellbeing’ (new economics foundation, 2013) and having an opportunity to go on mental health awareness / Mental Health First Aid training.

But what is the role of mental health services – as we have defined them in this Inquiry - in the prevention of mental illness? Clearly good early interventions for people who develop mental health problems can prevent disorders becoming more serious. This could include advice on issues such as reduction of alcohol intake or guidance on diet and exercise. However it was pointed out to us that primary prevention, involving a range of both universal and targeted interventions, is generally delivered by midwives, health visitors, teachers, people providing parenting support, play leaders, employers, faith groups and so forth, and not mental health professionals.

However, this does not mean that mental health services, today or in the future, can wash their hands of responsibility for helping to promote good mental health and prevent mental illness. We noted that the Royal College of Psychiatrists (2010b) has urged mental health professionals to adopt the public mental health agenda:

‘It is important that psychiatrists and other mental health professionals be aware of strategies related to prevention at all levels, whether on the primary, secondary or tertiary level. As psychiatrists, we must take the lead in educating the public, patients and their carers about these issues.... Clinical engagement in commissioning for public mental health is essential to ensure that effectiveness, quality and safety are prioritised and waste of resources is avoided. Psychiatrists could have a key role as advocates and leaders for public mental health.’

We also noted that the Joint Commissioning Panel for Mental Health (2012), in its guidance to commissioners of public mental health services, points out that collaboration is at the heart of public mental health interventions across a wide range of organisations, including education, criminal justice services and environmental planners. It places primary and secondary care services (including community-based mental health professionals) at the centre of this partnership process.

We would agree with this assessment. Mental health professionals have an important role to play in public mental health, and must be ready to deliver advice and support as required. This means that excellent working relationships will be required between mental health services, public health services and other services that have contact with the general public, of all ages, across the UK. Mental health professionals need to be aware of how to promote good mental health, and prevent mental illness, and to consider this as part of their role and responsibilities.

The public health workforce and mental health

The Royal College of Psychiatrists (2010b) has pointed out the importance of placing mental health at the core of future public health work:

‘Public health strategies concentrate on physical health and overlook the importance of both mental illness and mental well-being. Positioning mental health at the heart of public health policy is essential for the health and well-being of the nation. It will lead to healthy lifestyles and reduce health-risk behaviours, thereby both preventing physical illness and reducing the burden of mental illness.’

We also commend the UK Faculty of Public Health’s emphasis on mental health being vital to public health (Faculty of Public Health, 2013). However it is clear from the evidence we received that, despite best efforts of both mental health and public health staff, too little is being done to promote good mental health and prevent mental illness across the UK.

We want to see reduced prevalence and incidence of mental illness in the future. As we have indicated above, this may be the only way that mental health services can cope in the future. Partly this can be achieved through tackling society’s ills, such as unemployment, debt and domestic violence. Partly it is about increasing mental health awareness and skills among a range of public and private sector staff, such as health visitors, teachers, employers and prison officers. But we think there is an important role for the public health workforce as a whole - rather than just those within that workforce who specialise in public mental health - to have a good understanding of the indivisibility of mental and physical health, and knowledge of effective mental health promotion skills and resources. We have argued for all health and social care staff to develop a good basic understanding of

mental health and mental illness. Exactly the same applies to the public health workforce.

As we have indicated earlier, based on data from the past 20 years, we have assumed that prevalence rates of all the major mental disorders among adults and children across the UK will remain broadly stable over the next 20-30 years. We do not think this is inevitable, but it will require significant investment in public mental health, early years support and early intervention services if we are to improve the situation. Such investment has been insufficient in the past.

The training, education and continuing professional development (CPD) of all public health staff need to have mental health as a core component, and Directors responsible for public health across the UK should prioritise public mental health in their work programmes. This will bring benefits to individuals, families and the wider community, in terms of mental, physical and social health.

Addressing stigma and discrimination

A very large number of respondents to our Call for Evidence talked of a future with no stigma or discrimination. Comments around stigma fell into two areas – stigma from the public, and stigma from health professionals, which could negatively impact on patients and staff alike.

Stigma from the public

“I have taken a cautiously optimistic view of services in 20/30 years’ time as I think services are much better than 20 years ago and I believe they are gradually improving - although we still have a long, long way to go. I think the key issue... is stigma, stigma, stigma. If we can drive changes here, we can shift the balance and create the change we need.” (6.725)

“Until a shift takes place that allows mental health to emerge from the twilight of people’s own lives, the services that help people will remain in the twilight of the NHS.” (1.291)

“I would like to see it like when I go to the dentist. No-one gives me funny looks when I say I have an appointment to see the dentist, whereas it stops conversations when I say that I am having counselling! My dentist is in a parade of shops, but the counsellor was in a converted house that kind of looks like

offices and in another period of my life was even in an old building that was originally a hospital. There is still the stigma attached to this area and having 'mental' in the title certainly does not help other people's perception of this." (3.285)

It is unquestionable that the public stigma attached to mental illness blights lives. Although we have looked at good work in tackling this stigma - such as Scotland's 'See Me' campaign and the Time to Change initiative in England - it is clear that changing public attitudes and public behaviour towards people with a mental illness is more likely to be a matter of decades of hard work rather than just a few years.

Most respondents who raised the issue of stigma talked about educating the public, and in particular teaching children at school about mental health, so that as they grow up they understand the 'normality' of fluctuations in how they feel, and do not consider it shameful or unusual. We have referred to this above, both when considering early years and mental health promotion.

We see the merit of this, and have noted research findings which show that both educational interventions and interpersonal contact with people with mental health problems can reduce stigmatising views (for example, Couture and Penn, 2003; Pinfold et al, 2003). We also noted evidence from the Anti-Stigma Programme European Network (ASPEN) that, with respect to the stigma attached to depression, the key active ingredient most often identified is direct social contact with people with mental health problems, yet such contact is not at present a core feature of most depression programmes. Educational interventions, by contrast are more common.

What we can be sure about is that the public stigma attached to mental illness will continue to blight lives in 20-30 years' time, and hinder recovery from mental illness, as it does today, unless we continue forcefully to address it through the best evidence available, and undertake more research into effective approaches.

Stigma from professionals

"Colleagues still appear to remain uncertain and unconfident in addressing mental health issues and I [have] experienced that my clients still receive a lot of stigma from colleagues in that any report of symptoms [is] often related to mental health issues.

Eg cancer was missed! "It's a mental health issue." Slipped disc was missed. "It's a mental health issue." I am sure you get the picture." (6.793)

"People shun patients with mental health problems because they do not know how to handle them. Unless there is more education in this field nothing will change." (6.955)

"The general public will also have a much greater appreciation of what mental health professionals do as mental illness will no longer be stigmatised. This will help staff feel more appreciated and valued by society." (3.304)

One witness told us a story about a senior physician's comment to a trainee doctor who had decided to go into psychiatry – "You can do much better than that!" And this extract from a presentation made in 2012 by a witness who was GP with a special interest in mental health was also brought to our attention:

"I went to a very interesting lecture last year where the speaker started by asking us (and there were about 200 doctors in the room) to put our hands up if we had personal experience of mental illness. No one put their hand up - which made us either a very unusual group of doctors, liars or, most likely, worried about other peoples' reactions to a raised arm."

Many of our witnesses who work in mental health services confirmed the low status accorded to, in particular, psychiatry and mental health nursing. We noted research (Brown et al, 2007) from Scotland which concluded that "perceived low status of psychiatry among other doctors, and among the general public, and the belief that individuals with psychiatric disorders are difficult to deal with, emerged as the two most important factors seen to affect recruitment". This suggested "that anti-stigma campaigns may not have adequately targeted attitudes among other healthcare professionals and students, and that improved undergraduate teaching in psychiatry was deemed important in enhancing recruitment".

We were also pointed to another study, albeit from Canada (Bolton, 2012), in which three-quarters of 72 psychiatric liaison staff surveyed had experienced stigmatising attitudes towards mental illness by general hospital colleagues at least monthly. Two-thirds reported instances where stigmatisation had an adverse impact on patient care, and over a quarter reported stigmatising attitudes towards mental health professionals.

We have already made the point that all health and social care professionals need to have a good understanding of mental health issues in their basic training, and should be educated in the value of collaborative working and the skills that colleagues in other disciplines can bring to patient care. If this agenda is taken on board, starting today, we would have a reasonable expectation of considerably less professional stigma around mental health services in 20-30 years' time.

People, carers and mental health professionals want a future without stigma and discrimination. Children and adults who are better informed about mental health issues would help to create a future environment in which the stigma of mental illness will gradually fade away, though this may be a matter of decades rather than years. Current evidence-based education and interpersonal contact initiatives need to be expanded, and more research undertaken into effective activities, so that the future mental health and public health workforce knows what works best to tackle negative attitudes and behaviour.

The professional stigma that surrounds mental illness is a significant factor in hindering the effectiveness of mental health interventions and people's recovery, establishing psychiatry and other mental health services as the 'poor relation' within the health workforce, and deterring new trainees from specialising in mental health. Basic early education of all healthcare staff in mental health and more interprofessional education and continuing professional development would help overcome this problem in the future. Allied to this, psychiatry, and other mental health services, need to start to 'sell their successes', in particular getting across the message that many people, even with severe mental illness, can, and do, recover.

Annex: Participants in the Inquiry

Inquiry Advisory Panel members

Lord Carlile of Berriew (Co-chair); Professor Dinesh Bhugra (Co-chair), Chair of the Mental Health Foundation and Institute of Psychiatry; Professor Kamaldeep Bhui, Professor of Cultural Psychiatry and Epidemiology, Queen Mary University of London; David Brindle, Public Services Editor, The Guardian; Professor Mike Crawford, Director of Centre for Quality Improvement at the Royal College of Psychiatrists; Terry Dafter, Director of Adult Social Care, Stockport Council; Professor Lindsey Davies, President, Faculty of Public Health; Paul Farmer, Chief Executive, Mind; Isabella Goldie, Head of Mental Health Programmes, Scotland, Mental Health Foundation; Dr Iona Heath, past President, Royal College of General Practitioners; Albert Johnson, Chair of Trustees, Rethink Mental Illness; Prof Keith Lloyd, Dean and Head, College of Medicine, Swansea University; Catherine McLoughlin, Trustee, Mental Health Foundation; Professor Ian Norman, Deputy Head, Florence Nightingale School of Nursing and Midwifery, King's College, London; Professor Paul Salkovskis, Professor of Clinical Psychology and Applied Science, University of Bath; Chris Thompson, Chief Medical Officer, The Priory Group; Andy Hockey, Head of Public Affairs, Lundbeck UK; John Williams, Head of Neuroscience and Mental Health, Wellcome Trust; Sarah Yiannoullou, Managing Director, National Survivor User Network (NSUN).

Witnesses who gave evidence at oral evidence sessions

Sessions 1/2 (voluntary sector and mental health service user focus) 22 January 2013

Anne Beales, Director Service User Involvement, Together; Dr Dawn Edge, Research Fellow at the University of Manchester, Afiya Trust, Trustee, Non-Executive Director of Pennine Care Foundation Trust; Alisoun Milne, Reader in Social Gerontology and Social Work, School of Social Policy, Sociology and Social Research, University of Kent; Sarah Brennan, Chief Executive, Young Minds; Bill Walden-Jones, Chief Executive, Hafal, Wales; Suzanne Hudson, Chief Executive, Bipolar UK

Sessions 3/4 (primary care focus) 7 February 2013

Dr Mark Boulter, Chair, Wales Association for Mental Health in Primary Care (WAMH in PC); Sharon Blackburn, Policy & Communications Director, National Care Forum; Jeremy Clarke, National Clinical Adviser for NAPT, National Professional Adviser for IAPT, Chair of the New Savoy Partnership; Dr Alan Cohen, Director of Primary Care, West London Mental Health Trust; formerly Primary Care Advisor to the IAPT programme; Melba Wilson, Independent Consultant; Dr Charles Alessi, General Practitioner and Chair, National Association of Primary Care and Executive Member Kingston Clinical Commissioning Group; Claire Perry, Independent consultant.

Sessions 5/6 (researcher / thinktank focus) 18 February 2013

Chris Naylor, Fellow, The King's Fund; Martin Prince, Professor of Epidemiological Psychiatry at the Institute of Psychiatry and Co-Director of the KHP/ LSHTM Centre for Global Mental Health; Ivan McConnell, PA Consulting Group; Suky Kaur, BACP Policy & Public Affairs Manager; Heather Hurford, Care Quality Commission; Martin Knapp, Professor of Health Economics and Director of the Centre for the Economics of Mental Health at the Institute of Psychiatry, King's College, London; Philip Colligan, Executive Director, NESTA Public Services Lab.

Sessions 7/8 (service provision focus) 26 February 2013

Dr Hugh Griffiths, National Director for Mental Health, Department of Health, London; Jane Wells, Adult Community Services, Oxleas NHS Foundation Trust; Jay Stickland, Senior Assistant Director (Care Management), Adult and Older People's Services, Royal Borough of Greenwich; Gregor Henderson, Public Mental Health Advisor, Department of Health; Geoff Shepherd, Centre for Mental Health, IMROC Recovery Programme Lead and Senior Policy Adviser, Recovery Programme; Ruth Hannan, Policy and Development Manager (Mental Health), Carers Trust; Loy Lobo, Director of Strategy and Innovation, BT Health; Philip Sugarman, Chief Executive, St Andrew's Healthcare.

**Sessions 9/10 (secondary care focus)
6 March 2013**

Ian Hulatt, Royal College of Nursing; Dr Stuart Carney, Deputy National Director, UK Foundation Programme Office and Vice Dean Education, University of Exeter Medical School; Dr Gillian Mezey, Training Programme Director, Forensic Psychiatry, SWLSTG NHS Trust; Wendy Wallace, Chief Executive of Camden and Islington Mental Health Trust; Patrick Gillespie, Hospital Director, The Cambian Group; Anne McDonald, Deputy Director, Mental Health Care Pathways, Department of Health; Martin Price, Director of External Affairs and one of the Board of Directors, Janssen UK.

Session 11 (Scotland) 19 March 2013

Joyce Mouriki, Chairperson, VOX (Scotland); Geoff Huggins, Head of Mental Health, Scottish Government; Margaret Maxwell, Deputy Director of NMAHP Research Unit, Stirling University; Dr Susan Miller, Associate Postgraduate Dean (Mental Health), NHS Education for Scotland.

Session 12 (Northern Ireland) 26 April 2013

Dr Stephen Bergin, Chair, Regional Autistic Spectrum Disorder Group, Public Health Agency; Martin Daly, Service User Consultant; Molly Kane, Regional Lead Nurse Consultant, Mental Health and Learning Disability, Public Health Agency; Dr May McCann, Board Member, Patient and Client Council, Belfast; Prof Gerry Leavey, Professor of Mental Health and Wellbeing and Director of the Bamford Centre for Mental Health and Wellbeing, University of Ulster; Peter McBride, Chief Executive, NIAMH; Dr Philip McGarry, Chair, Royal College of Psychiatrists NI; Colin McMinn, Mental Health Unit, DHSSPS; Angela Meyler, Carer Advocate, Belfast Health and Social Care Trust, Cause; Aidan Murray, Assistant Director for Mental Health, Health and Social Care Board; Dr Maria O'Kane, Chair of Policy Committee, Royal College of Psychiatrists NI.

Individual interviews

18 March 2103: Professor Graham Thornicroft, Institute of Psychiatry

24 April 2013: Sean Duggan, Chief Executive, Centre for Mental Health

23 July 2013: David Behan, Chief Executive of the Care Quality Commission

**24 June 2013 Expert seminar
/ one day event**

Malcolm Basing, Trustee, Mental Health Foundation; Anne Beales, Director, Service User Involvement, Together; Andy Bell, Deputy Chief Executive, Centre for Mental Health; Professor Dinesh Bhugra, Chair, Mental Health Foundation and Professor of Mental Health and Cultural Diversity at the Institute of Psychiatry, King's College London; David Brindle, Public Services Editor, The Guardian; Mark Brown, Director, Social Spider; Laurence Bradley, Programme Director, eHealth, BT Global Services; Hannah Bullmore, Policy Officer, Mental Health Foundation; Lord Carlile of Berriew; Sophie Corlett, Director of External Relations, Mind; Professor Lindsey Davies, President, Faculty of Public Health; Margaret Edwards, Head of Strategy and Communications, SANE; Paul Farmer, Chief Executive, Mind; Patrick Gillespie, Hospital Director, Churchill Hospital, Cambian Group; Andy Hockey, Head of Policy and Access, Lundbeck UK; Karen Hooper, Carer, The Collaborative; Suzanne Hudson, Chief Executive, Bipolar UK; Ian Hulatt, Mental Health Adviser, RCN Nursing Department, Royal College of Nursing; Simon Lawton-Smith, Head of Policy, Mental Health Foundation; Chris Leaman, Media and Public Affairs Officer, Young Minds; Ann Leitch, Chief Executive, The Insight Network, Spire Healthcare; Prof Keith Lloyd, Dean and Head of College of Medicine, Institute of Life Science, Swansea University; Dr Andrew McCulloch, Chief Executive, Mental Health Foundation; Barbara McIntosh, Head of Children and Young People's Programmes, Mental Health Foundation; Catherine McLoughlin, Trustee, Mental Health Foundation; Dr Alison Milne, Professor of Social Gerontology and Social Work, School of Social Policy, Sociology and Social Research, University of Kent; Joyce Mouriki, Chairperson, VOX; Kevin Mullins, IAPT National Programme Director, Department of Health; Chris Naylor, Fellow, Health Policy, The King's Fund; Professor Ian Norman, Deputy Head, Florence Nightingale School of Nursing & Midwifery, King's College London; David Pink, Chief Executive, UKCP; Martin Price, External Affairs Director, Janssen; Nancy Rowland; Director of Research, Policy and Professional Practice, BACP; Ian Smyth, Head of Janssen Health Care, Janssen; Lucy Thorpe, Head of Policy, Royal College of Psychiatrists; Marjorie Wallace, Chief Executive, SANE; Wendy Wallace, Chief Executive, Camden and Islington NHS Foundation Trust; Sarah Yiannoullou, Managing Director, NSUN.

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