

# **Whole-person care: from rhetoric to reality**

## **Achieving parity between mental and physical health**

Occasional paper OP88  
March 2013

'A Man's body and his mind, with the utmost reverence to both I speak it, are exactly like a jerkin, and a jerkin's lining; – rumple the one – you rumple the other.'

(Laurence Sterne, from *The Life and Opinions of Tristram Shandy, Gentleman*, 1761)<sup>1</sup>

'We are made by others and others are the making of us in every biopsychosocial sense.'

(DR Crossley, 2012)<sup>2</sup>

# Contents

Foreword	4
Authors and acknowledgements	6
Membership of the parity of esteem working group	7
Key recommendations	9
Introduction	15
Terms of reference and methodology	18
Definition and vision for parity of esteem	20
The funding gap: disparity in funding for mental health	23
The treatment gap: disparity in access to treatment for mental health problems	25
NHS Outcomes Framework Domain 1: Preventing people from dying prematurely	27
NHS Outcomes Framework Domain 2: Enhancing quality of life for people with long-term conditions	33
NHS Outcomes Framework Domain 3: Helping people to recover from episodes of ill health or following injury	41
NHS Outcomes Framework Domain 4: Ensuring that people have a positive experience of care	47
NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	52
A life-course approach: early intervention, children and young people and older people	55
Measurement and monitoring of parity: data, research, audit and inspection	63
A cross-government approach to parity	68
Annexe A1. Lester UK Adaptation: Positive Cardiometabolic Health Resource	72
Annexe A2. Programme for implementing the Lester UK Adaptation	74
Annexe B. Summary of recommendations for parity	75
Annexe C. Parity commitments from working group member organisations, Royal Colleges and others	84
References	88

# Foreword

I pen this foreword with a sadness that this report is needed, and a passionate determination that the inequities in healthcare it describes should no longer be experienced by people with mental health problems.

Over a professional life of more than 30 years, working with the most vulnerable children and families, I have seen positive changes, but the rate and pace of change is too slow.

In our society mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

However this has arisen, the consequences are severe. People with severe mental illness have a reduced life expectancy of 15–20 years, yet the majority of reasons for this are avoidable. This can no longer be tolerated in the 21st century.

At an international level, the Sixty-Fifth World Health Assembly in May 2012 highlighted the global scale of mental health problems and the need for a comprehensive, coordinated response from the health and social care sectors at the country level.<sup>3</sup>

In England, I am delighted that important progress is being made in this area. The Health and Social Care Act 2012 explicitly recognises the Secretary of State's duties in relation to both physical and mental health, and this has become synonymous with the principle of 'parity of esteem' for mental health. This principle informs and underpins *No Health Without Mental Health*, the mental health strategy for England, and the work of the NHS Commissioning Board through the NHS Mandate. This is reflected in the coalition government's mid-term review, which sets 'an ambition for the NHS to put mental health on a par with physical health'.<sup>4</sup>

However, the concept of parity in this context is not always well understood. I was therefore delighted to be asked by the Care Services Minister to lead an expert working group to define 'parity of esteem' in detail, and to examine why parity between mental and physical health does not currently exist and how it might be achieved in practice. This report is the result of this work, and I hope that it will be of practical value to all those concerned to improve both the mental and physical health of the population and to the NHS realising its ambition.

While it is much else, parity is essentially a mindset. At the heart of this report is the fact that a person's physical and mental health influence one another: deficiency in the care of one can lead to serious problems with the other. A shift in this mindset should lead to a narrowing of the treatment gap. I urge the government, policy-makers, service commissioners and providers, professionals and the public always to think in terms of the whole person – body and mind – and to apply a 'parity test' to all their activities and also to their attitudes.

When Public Health England and local authorities assume their new responsibilities for public mental health from April 2013 it is important that they should take a parity approach to their work. Public health programmes and local authority activities more broadly need to address population mental health problems and their social determinants, and ensure a focus on developing and measuring resilience, in individuals, in families and in communities.

The disparities in care described in this report are everybody's business. We all, including psychiatrists and others working in mental health, need to ensure that parity is the golden thread running through the whole of health and social care provision. All forms of care must consider

and value mental and physical health equally, if people are to have the treatment to which they have a right and are to be supported effectively in their recovery.

It will take time, and sustained focus, but if the recommendations in this report are accepted and followed through at national and local level, my hope is that there will ultimately be no need to argue the case for 'parity' for mental health, as the discrepancies set out in this report will be a thing of the past. Success will ultimately be judged by whether 'parity' in this context becomes a term of historical interest rather than one of everyday concern.

**Professor Sue Bailey, FRCPsych, OBE**

*President, The Royal College of Psychiatrists*

# Authors and acknowledgements

Professor Sue Bailey, President of the Royal College of Psychiatrists, led this work. The report was drafted by Lucy Thorpe, Head of Policy, and Greg Smith, Policy Analyst, at The Royal College of Psychiatrists.

With profound thanks for the hard work, invaluable expertise and contributions of members of the parity of esteem working group and other expert advisers (see pp. 7–8).

Thanks also to the civil servants in the Mental Health Strategy Team at the Department of Health for their comments and advice.

# Membership of parity of esteem working group

Chair: Professor Sue Bailey, President, RCPsych

Professor Mark Baker, Director, Centre for Clinical Practice, NICE

Professor Kam Bhui, RCPsych Lead for Public Mental Health

Dr Jonathan Campion, Director for Public Mental Health, South London and Maudsley NHS Trust, and RCPsych Specialist Adviser for Mental Health Strategy

Paddy Cooney, Interim Director, Mental Health Network, NHS Confederation

Professor Mike Crawford, Director, RCPsych Centre for Quality Improvement

Dr Shanu Datta, Chair, Psychiatry Subcommittee, BMA

Sandie Dunne, Head of Programmes, Local Government Association

Dr Shirley Gracias, Director/Consultant Psychiatrist, Families Inc CIC

Professor Tim Kendall, Director, National Collaborating Centre for Mental Health

Mat Kinton, Care Quality Commission

Richard Pemberton, UK Chair, Division of Clinical Psychology, British Psychological Society

Professor Sir Mike Richards, National Clinical Director for Cancer and End of Life Care, Department of Health, and Director for Reducing Premature Mortality (Domain 1), NHS Commissioning Board

Dr David Shiers, Chair of National Early Intervention Leads Network, IRIS

Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services

Greg Smith, Policy Analyst, Royal College of Psychiatrists

Professor Phil Sugarman, Independent Mental Health Services Alliance

Lucy Thorpe, Head of Policy Unit, Royal College of Psychiatrists

Michael West, Department of Health

## Medical Royal Colleges

Dr Sian Rees, Faculty of Public Health

Dr Marta Buszewicz, RCGP

Ian Hulatt, Mental Health Adviser, RCN

Sir Richard Thompson, President, RCP London

Dr Liz Didcock, RCPCH

## Voluntary sector

Lucie Russell, Director of Campaigns and Policy, Young Minds

Sophie Corlett, Director of External Relations, Mind

Sean Duggan, Chief Executive/Andy Bell, Deputy Chief Executive, Centre for Mental Health

Paul Jenkins, Chief Executive, Rethink Mental Illness

Simon Lawton-Smith, Head of Policy, Mental Health Foundation

Dr Andrew McCulloch, Chief Executive, Mental Health Foundation

## Service user and carer representation

Juliet Dunmur, RCPsych Carer Representative

Terence Lewis, MAGMHS Service User Representative

Mary Nettle, Mental Health User Consultant and Member of RCPsych Service User Recovery Forum

Lucy Rolfe, MAGMHS Service User Representative

## Other expert involvement

Dr Ruth Allen, Transitional Chair, Mental Health Faculty, College of Social Work

Dr David Branford, Chief Pharmacist, Derbyshire Healthcare NHS Foundation Trust

Dr Alan Cohen, Director of Primary Care, West London Mental Health Trust

Terry Dafter, Joint Chair, Mental Health Network, Association of Directors of Adult Social Services

Dr Josie Jenkinson, Clinical Lecturer, Old Age Psychiatry, Institute of Psychiatry, Kings College London

Professor David Oliver, National Clinical Director for Older People

Professor Sarah Stewart-Brown, Chair, Mental Health Committee, Faculty of Public Health, and Professor of Public Health, University of Warwick

Professor Graham Thornicroft, Institute of Psychiatry, King's College London

Interprofessional Collaborative for Mental Health

RCPsych Faculties, Sections, Service User Recovery Forum and Carers' Forum

## International perspectives

John Bowis, expert on parity issues in the European Union

Professor Steve Sharfstein, Hon Fellow of RCPsych (via email)



# Key recommendations

This report should be seen as the first stage of an ongoing process over the next 5–10 years that will deliver parity for mental health and make whole-person care a reality. It builds on the Implementation Framework for the Mental Health Strategy<sup>5</sup> in providing further analysis of why parity does not currently exist, and the actions required to bring it about.

A 'parity approach' should enable NHS and local authority health and social care services to provide a holistic, 'whole person' response to each individual, whatever their needs, and should ensure that all publicly funded services, including those provided by private organisations, give people's mental health equal status to their physical health needs.

Central to this approach is the fact that there is a strong relationship between mental health and physical health, and that this influence works in both directions. Poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems. Mental health affects physical health and vice versa.

The parity of esteem working group has identified a wide range of factors affecting the long-standing lack of parity between mental and physical health and this report makes recommendations for addressing these. It also presents a number of commitments that working group member organisations have made to achieving change in these areas.

This section sets out the recommendations that we believe will make the biggest contribution to achieving parity, and which should therefore be early priorities for action.

## 1. Leadership for parity

Political and managerial leadership, at both national and local level, is vital for achieving parity. Such leadership needs to recognise and understand not only the interrelationship between mental and physical health in the major health and adult social care policy priorities for which the Department of Health takes government responsibility, such as obesity, dementia and dignity in care. It must also recognise that population mental health can be worsened or improved by policies for which other government departments are responsible, such as early years, children's social care, education, welfare reform and criminal justice.

At national level, we recommend that mechanisms are identified for driving a parity approach to relevant policy areas across government. Options could include a cross-government committee under ministerial leadership and the development of some kind of assessment process to ensure that parity can inform all policy developments – across all areas of government – that have implications for mental health.

At local level, we recommend that:

- all local councils should have a lead councillor for mental health in recognition of the need for all local authority activities and commissioning to take full account of mental and physical health and their social determinants
- all providers of specialist mental health services should have someone at board level who leads for physical health

- all providers of physical healthcare should have a board member who leads for mental health.

At the level of service delivery, clinical leadership will be essential in securing a culture change in the provision of both physical and mental health services that refuses to accept second best for service users with mental health problems.

## 2. Policy changes to promote parity

To help drive change, the government and the NHS Commissioning Board should work together to:

- Make it clear, including as part of the NHS Constitution, that parity is expected between mental and physical health, in all relevant aspects of the work of the NHS.
- Give people equivalent levels of access to treatment for mental health problems as for physical health problems, agreed standards for waiting times for this treatment, and agreed standards for emergency/crisis mental healthcare.
- Continue to improve access to psychological therapies so that they are provided as a timely and appropriate response to assessed need for such interventions.
- Include a right in the NHS Constitution for service users, when it is judged clinically appropriate, to receive treatments that have been recommended by the National Institute for Health and Clinical Excellence (NICE) in clinical guidelines as well as in technology appraisals.

At present, the NHS Constitution confers this right only (if clinically appropriate) to drugs and treatments recommended by NICE technology appraisals and not to those recommended by NICE clinical guidelines. This is a parity issue, as in practice a greater proportion of mental health treatments than physical health treatments have undergone a clinical guideline assessment process rather than a technology appraisal process. This means that they are in practice less available to service users, as there is not the same legal imperative for mental health service providers to make them available. NICE clinical guidelines are the gold standard for evidence-based care. To use the example of mild depression, guidelines recommend talking therapies as a first-stage treatment and explicitly discourage the use of antidepressants. It is not equitable that a recommended treatment such as group cognitive-behavioural therapy does not have to be provided within the same reasonable time frame as the majority of treatments for physical complaints because it has been through a clinical guideline assessment rather than a technology appraisal. We recognise that as a first stage this may initially need to be a pledge rather than a right.

- Include a pledge in the NHS Constitution that patients with mental health problems, including people treated under the Mental Health Act, will be given information and support in making as many collaborative decisions about their treatment as possible.

## 3. Parity of professional and public respect: tackling stigma and discrimination

No part of the NHS should tolerate professional attitudes, behaviour or policies that stigmatise mental illness and thus contribute to the discrimination experienced by people with mental health problems. Unless such attitudes are challenged and changed, mental health will not gain parity with physical health. An element of this is showing the same respect to mental health professionals as to professionals working in other areas of health, as the stigma associated with mental health can also affect the esteem in which they are held.

We recommend that organisations providing NHS-funded care review their diversity and equality policies to ensure they include clear statements about non-discrimination in relation to mental health, and that a 'zero tolerance' approach is adopted in all health settings in relation to stigmatising and discriminating attitudes and behaviour towards people with mental health problems and their carers.

In every trust and hospital, non-discrimination policies should be supported, first by an encouragement to report episodes of discrimination and secondly by provision of reparative training.

The Department of Health should consider how for the next 2 years the work of the Time to Change initiative could improve the attitudes of mental health and other health professionals towards people with mental health problems and their carers.

The British Medical Association (BMA) and medical Royal Colleges should consider how doctors can adopt a more aspirational approach to the care of people with mental health problems, such as is found within physical healthcare, in relation, for example, to recovery. This would also have significant benefits for the employment prospects of people with mental health problems, given the established link between employment and mental health.

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) should consider how medical and nursing study and training could give greater emphasis to mental health. This would help to improve the care and treatment provided by non-specialists to people who present with mental health problems, and to those with physical health problems who develop mental health problems. Mental and physical health should be integrated within undergraduate medical education, with an emphasis on joint placements and on engaging with service users who have comorbid physical and mental health problems.

The working group strongly supports the proposed extra year for general practitioner (GP) training, which presents an important opportunity to teach more about child development and mental health, and the relationship between physical and mental health.

## 4. Parity of outcomes: preventing premature mortality

The NHS Outcomes Framework should complement the indicator of 'excess under-75 mortality in people with severe mental illness' with an additional indicator that measures excess mortality in people with mild or moderate mental illness. Without this, the picture of premature mortality is incomplete. There should be an expectation that the mortality differential will reduce year on year.

Efforts to reduce premature mortality must include a major focus on reducing smoking among people with mental health problems. Commissioners should require smoking cessation services to include a focus on smokers with mental health problems. They should also ensure that younger smokers receive early intervention, since most smoking has started by adulthood. In particular, smokers with emotional or conduct disorder require targeted intervention since they represent 43% of smokers under the age of 17.<sup>6</sup>

As a key primary prevention approach for reducing the increased mortality and morbidity experienced by those with severe mental illness, the NHS Commissioning Board and clinical commissioning groups (CCGs) should promote widespread adoption of the recently developed Lester UK Adaptation: Positive Cardiometabolic Health Resource. This is designed to help reduce the high rates of type 2 diabetes and cardiovascular disease in psychiatric patients treated with antipsychotic medication.

The Lester UK Adaptation resource is included in Annexe A1 and is also available at <http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#cmhresource>.

## 5. Parity of care and treatment

We welcome the requirement in the NHS Mandate for the NHS Commissioning Board to work with CCGs to quantify waiting times for mental health services, including for when people are in crisis, and to address unacceptable delays in access to such services. The subsequent development of access standards should result in the introduction of waiting-time standards for secondary care mental health assessment, diagnosis and treatment.

People with mental health problems who are in crisis should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems.

Clinical commissioning groups should ensure that they commission a sufficient mix of crisis services on the scale required by the needs and composition of the local population. These services should be staffed in accordance with national guidelines. Local communities should be meaningfully involved in the planning and review of such services.<sup>7,8</sup>

The NHS Commissioning Board should as an early priority extend the NHS staff 'family and friends' test, of whether they would recommend a health setting as a place for their family to be treated, to mental health in-patient wards.

## 6. Parity and integrated care: addressing co- and multi-morbidity of mental and physical health conditions

Commissioners need to regard liaison services as an absolute necessity rather than as an optional luxury.<sup>9</sup> NHS and social care commissioners should commission liaison psychiatry and liaison physician services to drive a whole-person, integrated approach to healthcare in acute, secure, primary care and community settings, for all ages, including multidisciplinary paediatric liaison services for children both in and out of hospital. This will not only improve patient outcomes but also save money.

All NICE guideline development groups for physical conditions should consider including representation from co-opted mental health experts to ensure that the mental health aspects of conditions are comprehensively considered. This will ensure that NICE quality standards have a sufficient focus on mental health.

## 7. A parity approach to public health

Public Health England and local authorities should take a parity approach to their work and support the development of local public health strategies and interventions which recognise and fully consider the mental health dimension of issues commonly conceptualised as physical health concerns, such as smoking, obesity and substance misuse. Public health programmes should also involve appropriately integrated work across health and social care in order to consider and address the wider determinants of mental health and mental illness, such as social isolation, parenting, violence and abuse.

This 'whole person' approach should apply across the life course.

Health Education England should as a priority support the development of core skills and competencies in public mental health for health and public health professionals.

## 8. Parity across the life course

All our recommendations apply to the whole population. In addition, action is required in the following areas affecting people of non-working age:

### Children and young people

All bodies with responsibility for training professionals working with children and families should review their curricula to ensure inclusion of the ability to understand and identify mental health problems, and factors that adversely affect mental well-being, at an early stage, including signs of abuse and neglect, and to respond to them effectively. This training should include child development, the importance of emotional resilience, the relationship between a child's physical and mental development, and the determinants and risk factors for poor emotional and mental health. This is a vital underpinning for an early-intervention approach both to children's mental health problems and to population mental health as a whole. The Children and Young People's Health Outcomes Forum has also highlighted such training as a priority for action.<sup>10</sup>

Commissioners should require that antenatal and postnatal education for parents includes a focus on the emotional well-being of both the infant and the parents. They should also invest in perinatal, or parent–infant, mental health services to work with families where there are parenting difficulties or with particularly vulnerable parents or babies. The provision and function of such specialist services are currently variable and inequitable, and there is significant unmet need in this area.<sup>11</sup>

Schools should implement the NICE public health guidance on mental health promotion in schools.<sup>12,13</sup> This aims to develop psychological, emotional and social skills to support resilience and coping mechanisms and will help to develop better mental health 'literacy' in children and young people. In the longer term, this has the potential also to contribute to reducing the prevalence of stigmatising attitudes to mental ill health in the wider population, as well as to earlier identification of and response to mental health problems throughout life, through educational and therapeutic means.

### Older people

Clinical commissioning groups should make flexibility of access a cornerstone of service contracts, so that someone being treated within adult mental health services (AMHS) does not become automatically ineligible to be treated by a service once they pass 65 years of age, and someone under the age of 65, with for example early-onset dementia, can access the expertise of comprehensive older adult mental health services (OAMHS). This is important for fulfilling public sector duties under the Equality Act 2010. CCGs should ensure they provide specialist age-appropriate services that have porosity with adult services to ensure the mental health of this disadvantaged population is appropriately addressed.

## 9. Parity and funding

Parity is about equal value being placed on mental health and mental healthcare, and responses being proportionate to need. Funding for mental health must be commensurate with its impact on children and young people, working-age adults, older adults and society as a whole.

The NHS Commissioning Board and CCGs should allocate funding in a way which supports and promotes parity. This should include ensuring that any person with mental health problems (including comorbid mental and physical health problems) can expect the same access to services and the same quality of care and treatment as people who have only physical health problems.

Consideration should be given to the percentage improvement in overall health outcomes that could be achieved if investment were to be reallocated into mental health, community and dementia services from the acute physical healthcare sector.

## 10. Parity and research

The Department of Health should continue the adult psychiatric morbidity survey to underpin its commitment to achieving parity. Without it, we lose the most comprehensive, and therefore important, information we have about the prevalence of mental health problems and our efforts to treat them. This information will be vital for measuring the impact of actions to achieve parity for mental health.

The Department of Health should also consider reinstating the child and adolescent national psychiatric morbidity survey and should repeat its survey of psychiatric morbidity among prisoners in England and Wales (the latest available data are from 2005 and 1998 respectively).

The Department of Health should consider a refocusing of research on to areas of co- or multi-morbidity, involving mental health and physical health problems, rather than single diseases/disorders. This would help to demonstrate the interconnectivity of mental and physical health, and to underpin the developments of evidence-based treatments that address all an individual's health needs, not just their primary diagnosis.

The Department of Health and NHS Commissioning Board should examine how existing and future data registers can be utilised to learn more about comorbidity of physical and mental health problems.

To improve the evidence relating to models of support for individuals' recovery, it would be beneficial to promote more social care research in mental health, to include not only clinical resolution, but also social recovery and self-management when problems persist. Social recovery often enables people to maintain themselves in communities, thus reducing demand on formal services (and acute services in particular).

To help understand why mental health does not enjoy parity of esteem at present, there should also be a greater research focus on health and social care staff culture, attitudes and behaviour towards service users with mental health problems; and further research to investigate why people with more serious mental health problems are at higher risk of dying earlier from treatable diseases.

# Introduction

The long-standing and continuing lack of parity between mental and physical health evidenced in this report is inequitable and socially unjust. This 'mental health treatment gap', exemplified by lower treatment rates for mental health conditions, premature mortality of people with mental health problems and underfunding of mental healthcare relative to the scale and impact of mental health problems, falls short of government commitments to international human rights conventions which recognise the rights of people with mental health problems to the highest attainable standard of health; yet it can be argued that this lack of parity is so embedded in healthcare and in society that it is tolerated and hardly remarked upon. It also affects people with physical health problems who also have mental health needs that may not be recognised in more physically healthcare-orientated settings. The poorer outcomes that result are considered by many, both within and outside mental healthcare, as all that can be expected.

In England, section 1 of the Health and Social Care Act 2012 states that:

The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement –

- (a) in the physical and mental health of the people of England, and
- (b) in the prevention, diagnosis and treatment of physical and mental illness.

Section 4 of the Act states that the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.<sup>14</sup>

The amendment to the Health and Social Care Bill which secured an explicit recognition of the Secretary of State for Health's duty towards both physical and mental health has become synonymous with the concept of parity of esteem.<sup>15</sup> In conjunction with a clear legislative requirement to reduce inequalities in benefits from the health service, these place an obligation on the Secretary of State to address the current disparity between physical and mental health. They also present an important opportunity to drive changes in professional training and practice, attitudes, knowledge and priorities in order to address the continuing inequities in healthcare provision experienced by those with mental health problems.

This in effect enshrines in law the commitment made in the English mental health strategy, *No Health Without Mental Health*,<sup>16</sup> to 'parity of esteem between mental and physical health services'. The concept of 'parity of esteem' is relevant to all six of the mental health strategy objectives, and is of particular relevance to improving the quality of all service users' care and experience, improving the physical health of those with a mental health problem, the mental health of those with a physical health problem, and reducing the stigma and discrimination experienced by those with mental health problems.

The current system needs to change in order to fulfil international human rights obligations, such as the United Nations Principles for the Protection of Persons with Mental Illness,<sup>17</sup> adopted in 1991, which state that:

All persons have the right to the best available mental healthcare, which shall be part of the health and social care system. [Principle 1]

All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person. [Principle 3]

Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the UN Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic,

Social and Cultural Rights, and in other relevant instruments ... all persons have the right to the best available mental healthcare. [Principle 5]

These inequities have been highlighted by the UN Committee on Economic, Social and Cultural Rights in its recent report on the UK's adherence to the UN Convention on Economic, Social and Cultural Rights. This stated that, in relation to article 12 – the commitment to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – people with mental health problems experienced 'significantly poorer health conditions' than those without.<sup>18</sup>

At a global level, the Sixty-Fifth World Health Assembly in May 2012 highlighted the global scale of mental health problems and the need for a comprehensive, coordinated response from health and social care sectors at the country level.<sup>3</sup> The Assembly called on the Director-General of the World Health Organization (WHO) 'to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes, based on an assessment of vulnerabilities and risks, in consultation with and for consideration by Member States, covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community'. This calls explicitly for inclusion of a number of specific provisions, including 'equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system'.<sup>3</sup>

The importance of parity of esteem for mental health has been emphasised consistently, by both government ministers and key mental health organisations. It is a principle that is as important for professionals working in social care as in health, and for those predominantly treating physical health problems as it is for those whose main focus is mental health.

There is evidence of the benefits of a parity of esteem approach from the USA. The core principle is that behavioural health should be treated equally with physical ill health. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in the USA<sup>19</sup> has brought forward concrete evidence of benefits by legislating for parity for mental health.<sup>20</sup>

The law in the USA was constructed to address the concerns about healthcare for large numbers of people with long-term conditions which could be improved by better integrating mental health support with primary care and chronic disease management programmes.<sup>21</sup>

This report sets out the rationale for a parity approach to mental and physical health, and makes recommendations for how parity can be achieved, largely in health and social care, although it also includes some broader recommendations.

It should be seen as the first stage of an ongoing process over the next 5–10 years that will deliver parity for mental health and make whole-person care a reality. It builds on the implementation framework for the mental health strategy<sup>5</sup> in providing further analysis of why parity does not currently exist, and the actions required to bring it about.

It is important, however, to recognise that effecting such change will be especially challenging at a time when the NHS and local authorities are operating in a climate of significant structural change, combined with requirements to make major efficiency savings. It is vitally important for people with mental health problems that relationships and trust across whole systems are maintained during this very difficult economic time.

## Structure of the report

During the development of this report the working group agreed it would be helpful to link the work to the domains of the NHS Outcomes Framework.<sup>22</sup> In doing so, we wish to note the inevitable and considerable overlap between the domains, as many of the factors affecting parity are cross-cutting issues.



The issue of parity is also of key importance to the Public Health<sup>23</sup> and Social Care<sup>24</sup> Outcomes Frameworks.

The report presents evidence on a range of factors affecting disparity between mental and physical health, and includes case studies and examples of good practice to illustrate some of the key issues and solutions.

## Note on terminology

For consistency with *No Health Without Mental Health*, the English mental health strategy, this report predominantly uses 'mental health problems' as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Exceptions to this are for the purposes of accurate citation of evidence. The term 'mental health problems' is defined in the mental health strategy as follows:

Mental health problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest themselves in different ways at different ages and may present as behavioural problems (for example, in children and young people). Some people object to the use of terms such as 'mental health problem' on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative.<sup>16</sup>

# Terms of reference and methodology

In April 2012, the Royal College of Psychiatrists was asked by the then Minister of State for Care Services, Paul Burstow, in partnership with the Department of Health and the NHS Commissioning Board Authority Medical Directorate, to advise the Ministerial Advisory Group on Mental Health Strategy ('the MAGMHS') on how to achieve parity of esteem between mental and physical health in practice. The following terms of reference were agreed for the work.

## Terms of reference

### Aims and scope

The working group was asked by the Minister to:

- Consider how parity of esteem can be operationalised in outcomes/funding frameworks and in service design/commissioning structures.
- Consider: access to mental health treatment, including for long-term conditions; structural issues such as funding/research relating to mental health; undergraduate, postgraduate and continuing medical education of staff working in either mental or physical health settings in either primary or secondary care; adequacy of treatment of physical health problems for people with mental health problems (including issues of reduced life expectancy and poorer physical health outcomes); public health interventions; clinical guidelines; stigma among the public and within the medical profession; organisational, cultural and legislative barriers to achieving parity of esteem in practice.
- Consider and collate national and international examples which demonstrate how parity of esteem can be achieved in practice.
- Present recommendations in such a way that distinguishes what different organisations can realistically achieve and to what timescales.

### Key outputs

The key outputs for the group have been agreed as:

- A vision for, and definition of, parity of esteem between physical and mental health, including concrete examples of behaviour changes which 'parity' would bring about. In developing this, the group will consider how to ensure this vision and definition can be influential in a variety of professional, policy and public spheres.
- Based on this, an analysis of why parity does not exist at the moment, examining all aspects of the system, including commissioning.
- Recommendations for change.
- Actions which group members agree to take in order to further this agenda.

In September 2012 the new Minister of State with responsibility for mental health, Norman Lamb, affirmed the government's continuing commitment to this work.

## Methodology

A core working group was established representing different population groups, mental health charities, professional bodies, service users and carers, and individual professional experts. The group met three times, in May, July and September 2012. These meetings were supplemented by individual contact and virtual working. In addition, the College had detailed individual discussions with other experts and organisations to discuss particular aspects of parity and how these might be addressed.

A full list of working group members and others who have advised on parity is provided on pp. 7–8. A summary list of commitments towards achieving parity from working group member organisations, medical Royal Colleges and other bodies, is included in Annexe C.

# Definition and vision for parity of esteem

## Definition

The *Oxford English Dictionary* defines 'parity' as: 'the state or condition of being equal, or on a level; equality'. 'Esteem' is defined as 'to attach value (subjectively) to; to think highly of; to feel regard for, respect'.

The following definition of parity has been used in the US literature:

The overarching principle of the parity movement is equality – in access to care, in improving the quality of care, and in the way resources are allocated.... If we stay true to the principle of treating each person with dignity and respect in our health care system, then we should make no distinction between illnesses of the brain and illnesses of other body systems.<sup>25</sup>

In essence, 'parity of esteem' is thus best described as: 'Valuing mental health equally with physical health'.

More fully, and building on the US definition, parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by:

- equal access to the most effective and safest care and treatment
- equal efforts to improve the quality of care
- the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.

For simplicity, and to shift the focus from equally valuing mental health and physical health to the next stage, of taking action to achieve parity, this report refers simply to achieving 'parity' in order that mental health has equal status with physical health. Inherent in this, however, is the need to value mental and physical health equally.

The group has identified the following as key features of a parity approach:

- It should apply to people of all ages, including preconception care, and to all groups in the population, including those at increased risk of mental health problems, such as people with intellectual disabilities, asylum-seekers, people in the secure estate, lesbian, gay, bisexual and transgender people, some Black and minority ethnic populations at greater risk, children in care, care leavers and others.
- Equal access to health and social care, including: comparable waiting times; equitable treatment for all, according to their need; the provision of equivalent levels of choice and quality regardless of condition.
- Holistic care – the mind and the body should not be regarded separately but integrated: professional and public education, public health programmes, social care and treatment approaches need to reflect this; an open-minded approach to whole-person care is essential.

- 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.
- Investment in the prevention of mental health problems, and the promotion of mental well-being, in proportion to need.
- Investment in mental health research, in proportion to need.
- Investment of both funding and clinical/managerial time and attention should be proportionate to the prevalence of mental health problems and scale of mental health need.
- Aspirational outcomes and an expectation that mental healthcare should continuously improve (as is the case for other areas of healthcare).
- Respect and dignity for those with mental health problems across all areas of health and social care.

## Vision

A parity approach will both require and influence positive changes in attitudes to mental health, and in knowledge, priorities, professional training and practice, all of which are necessary to reduce the stigma experienced by those with mental health problems and to improve the assessment and care they receive.

Parity should pervade all aspects of mental and physical health policy, including research and development, NICE guidance and quality standards, and the planning, commissioning and delivery of mental and physical health services and public health activity. Appropriate commissioning of health and public health services should result in improved health and well-being and mean that:

- A parity approach is adopted for all health and social care provision from pre-birth and throughout the life course.
- People with mental health problems will receive timely and appropriate treatment, as is expected for those with physical health problems.
- People with mental health problems will have parity of life expectancy and no higher rates of physical illness than those without these problems.
- Mental health problems will be recognised as a risk factor in physical illness and vice versa.
- People with mental health problems will receive the same quality of physical healthcare as those without a mental health problem.
- People with mental health problems will express the same levels of satisfaction with their health and social care services as people with physical health conditions, including experiencing the same levels of dignity and respect from health and social care staff.
- People with mental health problems will receive appropriate intervention and support to address the factors affecting their much higher rates of health risk behaviour.
- People who present with a physical health problem will receive assessment to identify potential mental health problems, and appropriate intervention to prevent escalation of any existing mental health problem.
- Public mental health and well-being will be an integral part of both national and local public health services, programmes and campaigns.
- Commissioners will give the same priority to addressing and preventing mental health problems as they do to addressing and preventing physical health problems.
- Commissioners will understand that physical and mental health are inextricably linked, and that it is not possible to treat or support one without affecting the other.

- Service providers will be expected to have and to fulfil aspirations for the recovery of people with mental health problems that are the same as those for people with physical health conditions.
- Generic health and social care policy, planning and services will integrate mental health from the outset.
- Continuity of care will be a guiding principle for the commissioning and provision of both mental and physical healthcare.
- Mental health research will receive funding that reflects the prevalence of mental health problems and their cost to society.
- People with mental health problems will receive social care on the same basis as people with physical health problems – according to the impact on the quality of their day-to-day life, the risk of further deterioration in health and the need for further health or social care.
- People with mental health problems will be given the same level of choice and control over their care, including discussions about choice of treatment and access to personal budgets. Where necessary, advocacy will be provided to enable this to happen.

Giving mental health equal status with physical health will result in major improvements in the health and wealth of the nation, and is achievable through interventions that can save money in both the short and the longer term.

## Commitments

The Academy of Medical Royal Colleges (AoMRC) will ensure that work programmes are designed appropriately to achieve the aim of parity of esteem.

At its meeting on 22 November 2012 the European Psychiatric Association Council of national psychiatric associations agreed to set up a working group on parity of esteem. This will be led by Professor Sue Bailey, President of the Royal College of Psychiatrists. Its first product will be an article in a journal of international psychiatry which includes a questionnaire seeking information from other countries.

# The funding gap: disparity in funding for mental health

There is significant, and historical, underinvestment in mental healthcare relative to its impact on individuals, their families and society as a whole.<sup>26</sup> This is one of the key issues that a parity approach should aim to address.

Mental illness is responsible for the largest proportion of the disease burden in the UK (22.8%), larger than that of cardiovascular disease (16.2%) or cancer (15.9%).<sup>27</sup> Overall, the economic and social costs of mental health problems were estimated at £105 billion in 2010.<sup>28</sup> In comparison, the wider annual UK cost of obesity is £15.8 billion<sup>29</sup> and the wider annual UK cost of cardiovascular disease is £30.7 billion.<sup>30</sup> However, only 11.1% of the NHS budget – £11.9 billion – was spent on NHS services to treat mental health problems for all ages during 2010/11.<sup>31</sup>

The funding gap for older-adult mental health services is particularly large, not just in terms of the funding available compared with disease burden but also in comparison with the level of service provision (also underfunded) in adult mental health services. It was estimated in 2008 that around £2 billion of additional funding would be required to eliminate the inequality in service provision between middle-aged people (aged 35–54) and people aged 55 or over.<sup>32</sup>

Further, the level of funding received by child and adolescent mental health services (CAMHS) is highly incommensurate not only with the colossal level of undertreatment, but also with the missed opportunity to prevent considerable future suffering and expense. In 2010/11 CAMHS funding was £760 million (or roughly 0.7% of the total NHS budget),<sup>31</sup> and it is widely acknowledged that mental health services for children have been chronically underfunded relative to need.<sup>33,34</sup>

There is also a disparity in research spending on mental health. A review of the 2004/05 research portfolios of the largest UK funders of health research showed that mental health research received 6.5% of total funding, compared with 25% for cancer, 15% for neurological diseases and 9% for cardiovascular conditions.<sup>35</sup>

Addressing this funding gap will be challenging, as such underinvestment tends to be exacerbated during times of economic downturn, when mental health services risk being cut in preference to physical health services, in part because of the lack of a national tariff for mental health.<sup>36</sup> In practice, mental health spending has followed an erratic pattern nationally, with cuts in some areas and investment in others.<sup>37</sup> It should be borne in mind that population mental health is thought to be more negatively affected than population physical health during economic downturns, and this can put additional pressure on already underfunded services.<sup>38</sup>

Parity is about equal value being placed on mental health and mental healthcare, and responses being proportionate to need: funding must be allocated as required to achieve parity so that those with mental health problems can expect the same access to services and the same quality of care as those with physical health problems.

Achieving true parity for mental health will thus require an approach consistent with 'proportionate universalism', as defined by Marmot,<sup>39,40</sup> with actions matching the degree of disadvantage.

## Recommendations

Parity is about equal value being placed on mental health and mental healthcare, and responses being proportionate to need. Funding for mental health must be commensurate with its impact on children and young people, working-age adults, older adults and society as a whole.

The NHS Commissioning Board and CCGs should allocate funding in a way which supports and promotes parity.

This should include ensuring that any person with mental health problems (including co-morbid mental and physical health problems) can expect the same access to services and the same quality of care and treatment as people who have only physical health problems.

Consideration should be given to the percentage improvement in overall health outcomes that could be achieved if investment were to be reallocated to mental health, community and dementia services from the acute physical healthcare sector.

## Commitment

The Royal College of Psychiatrists will continue to advise the Department of Health on the development of payment by results for mental health, with a view to refining the cluster system so that payments can be more clearly linked to treatments that are recommended by NICE guidelines.



# The treatment gap: disparity in access to treatment for mental health problems

## Proportion of people receiving treatment

Only a minority of people with mental health problems in England, with the exception of those with psychosis, receive any intervention for their problem. This is true across the life course, for children and young people, working-age adults and older people.

An estimated 25–40% of people with intellectual disabilities also have mental health problems,<sup>41</sup> and often present with very different mental health needs. Access to both mental health and non-mental health services is a common problem for these vulnerable groups.

### Adults

Analysis of the most recent national psychiatric morbidity surveys found the following figures for treated prevalence of mental health problems in the UK for adults:<sup>42</sup>

- 24% of people with a common mental disorder
- 28% of people with post-traumatic stress disorder
- 65% of people with psychotic disorder in the past year
- 14% of people with alcohol dependence
- 14% of people with dependence on cannabis
- 36% of people dependent on other drugs.

In contrast, data on treated prevalence in comparable high-income countries for physical health conditions are:<sup>43</sup>

- 94% of people with diabetes
- 78% of people with heart disease
- 51% of people with asthma
- 91% of people with high blood pressure.

### Children and young people

In relation to children and young people, the level of treatment of childhood mental illness is, at only 25%,<sup>6</sup> very low, nearly identical to the adult level.

The last major comprehensive survey of children and young people's mental health in Great Britain found that 28% of parents of a child with conduct disorder (the most common disorder in childhood) sought advice from a mental health specialist and 24% from educational services such as psychologists.<sup>6</sup> Levels of impairment or symptoms are undetected in 55% of children with autism and 57% with Asperger syndrome.<sup>44</sup>

**The following sections of the report consider the factors influencing this treatment gap and make recommendations for how to address these. A key overarching factor affecting all these factors is stigma and the discrimination it can lead to. This is discussed in detail under Domain 4, 'Ensuring that people have a positive experience of care'.**

# NHS Outcomes Framework

## Domain 1: Preventing people from dying prematurely

The life expectancy of those with severe mental illness is on average 20 years less for men and 15 years less for women, when compared with the population as a whole.<sup>45</sup> People with severe mental illness are significantly more likely to have worse physical health than people without; for example, those aged under 50 are three times more likely and those aged 50–75 are 1.9 times more likely to die from coronary heart disease.<sup>46</sup>

Efforts to reduce premature mortality must include a strong focus on increasing the life expectancy of people with mental health problems, many of whom die younger and experience significantly worse physical health than those without such problems. Ensuring that efforts to reduce mortality include a strong focus on those with mental health problems can contribute significantly to achieving a reduction in deaths across all aspects of Domain 1.

Early intervention can also result in cost savings. For example, early intervention for psychosis leads to total returns of £17.97 for every £1 invested, with net savings starting by year 1.<sup>47</sup> The mental health strategy estimated that extension of current early-intervention services to cover the total population in England would cost the NHS £57 million over 10 years but result in net NHS savings of £290 million, increasing to £550 million if wider economic savings are taken into account.<sup>48</sup>

The 2012/13 NHS Outcomes Framework renames the previous 'under 75 mortality in people with severe mental illness' indicator as 'excess under 75 mortality in people with severe mental illness'. As the 2012/13 Outcomes Framework acknowledges, this reflects the fact that 'people with serious mental health problems are more likely to die prematurely, and through better quality of care these deaths could potentially be avoided'.<sup>22</sup>

As well as evidence that severe mental illness dramatically reduces life expectancy,<sup>45,49,50</sup> it is becoming increasingly clear that common mental health problems such as anxiety and depression also cause significant premature mortality.<sup>51–53</sup>

Research consistently shows that people with mental health problems have higher rates of physical ill health and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors such as smoking, obesity, substance misuse and inadequate medical care.<sup>54</sup> These factors lead to reduced life expectancy and higher levels of physical ill health several decades later (relevant also to Domain 2).

## Reduced provision of evidence-based interventions

However, people with mental health problems are less likely to receive interventions to address or prevent such health behaviour. This is despite clear evidence of the increased risk they experience and the availability of evidence-based interventions. For example, people with severe mental illness appear to be prescribed significantly lower quantities of several common medications for physical health conditions (largely cardiovascular problems).<sup>55</sup>

The Lester UK Adaptation Positive Cardiometabolic Health Resource has been developed by the Royal College of General Practitioners (RCGP) in collaboration with the Royal College of Nursing (RCN) and the Royal College of Psychiatrists' Centre for Quality Improvement to provide a simple framework for identifying and treating cardiovascular risks and type 2 diabetes risks in patients with psychosis receiving antipsychotic medication. This supports collaborative practice across professional disciplines and service settings. It has been sent to every member of the RCGP and RCPsych, with the aim of embedding it into practice.

The Lester UK Adaptation Resource is included in Annexe A and is also available at <http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#cmhresource>.

## Smoking

People with mental health problems smoke more than the general population. Indeed, they consume almost half of all tobacco in England, with 42% of tobacco consumption being by adults with mental disorder;<sup>56</sup> they therefore experience disproportionate tobacco-related harm. Further, adolescents with conduct or emotional disorder are four to six times more likely to smoke and represent 43% of all smokers under the age of 17.<sup>6</sup>

Smoking is the largest cause of health inequality in people with mental disorder yet only a minority of this group receives smoking cessation intervention, and they are less likely to receive help with their smoking than the general population, despite being as motivated to stop.<sup>56–58</sup>

Further, NHS stop smoking services do not record whether someone (a) has a mental health problem or (b) is taking medication for a mental health problem, despite national guidance requiring up to 50% reduction in doses of some medications for mental health problems within 4 weeks of cessation, to prevent the risk of toxicity (relevant also to Domain 5).

Since increased levels of smoking are responsible for the largest proportion of health inequality among people with mental health problems, supporting people with mental disorders to stop smoking will have an even larger impact on health outcomes and directly reducing health inequalities.<sup>59</sup> However, health inequality experienced by people with mental disorder will widen if investment in smoking cessation services for this group is not greater than for the general population.

The working group is pleased to note that the Royal College of Physicians' Tobacco Group will publish a report on smoking and mental disorder in 2013.

## 'Diagnostic overshadowing'

Despite significant levels of physical ill health and premature mortality, physical illnesses in people with mental health problems are frequently inadequately addressed.

A significant factor in this disparity is 'diagnostic overshadowing', which is strongly thought to account for some of the disparities in the physical health outcomes experienced by people with mental health problems. This describes what happens when healthcare staff incorrectly attribute symptoms of physical ill health to a mental health condition.

For example, studies have shown that people with ischaemic heart disease who required hospitalisation were less likely to have a revascularisation procedure if they also had a mental illness,<sup>60</sup> and people with diabetes who present to accident and emergency departments are less likely to be admitted to hospital for diabetic complications if they have a mental illness.<sup>61</sup>

### Case example: The 'diagnostic overshadowing' of severe mental illness

A woman in her mid-40s with a diagnosis of severe bipolar affective disorder who was an in-patient on the mental health rehabilitation ward suddenly started to have recurrent episodes of loss of consciousness, falling into a deep, unrousable sleep. The mental health nurses called an ambulance after recording her oxygen saturation to be below 90%. She was seen in the accident and emergency department (A&E) and was returned to the ward, awake and recovered, within a few hours, with no diagnosis or advice. These episodes continued, with increasing frequency over subsequent days, culminating in a particularly intense and stressful night when an ambulance was called to the ward on three separate occasions. On each occasion she was seen in A&E but sent back to the psychiatric ward without a diagnosis or recommendation for any intervention, despite the ward and duty psychiatrist attempting to gain further information and requesting that she be admitted for further investigation. The following day, she had another episode but this time a member of the on-call medical team who happened to be in A&E caught sight of her electrocardiogram (ECG), although he had not been asked to review her, and diagnosed heart block. She underwent emergency surgery to install a pacemaker and subsequently remained in intensive care for a number of weeks before recovering adequately to return to the mental health unit. The impression was that she was inadequately assessed on her previous A&E visits and the junior psychiatrists who attempted to liaise with A&E were treated with a lack of respect. She had a lucky escape and could easily have died during one of her collapses had it not been for the medical team member inadvertently noticing her abnormal ECG.

What can be done to address these kinds of incidents?

The problems seem to result from a lack of confidence and skill among acute care staff when dealing with people with mental health problems and, to varying degrees, a stigmatising attitude towards this group. However, it is also important to note how lacking in confidence most non-medically trained mental health staff are when confronted with medical emergencies and less urgent medical scenarios.

Responses might include:

- Mandatory continuous professional development in psychiatry for all doctors and nurses, reviewed through appraisal, similar to the annual mandatory resuscitation training for psychiatrists.
- Mental health nurses being required to complete some general medical training prior to specialising in mental health.

Composite case study provided by the RCPsych Faculty of Rehabilitation and Social Psychiatry.

## Venous thromboembolism

A physical condition that has so far received little attention in mental health patients is venous thromboembolism (VTE). This is a potentially fatal condition that has been the subject of a national focus over recent years as part of overarching aims to improve quality of care within the NHS. In relation to mental health, it is possible that this is a significant and preventable cause of in-patient morbidity and mortality, as strategies to lower the rates of hospital-acquired VTE have so far been focused on acute trusts. One of these is a national commissioning for quality and innovation (CQUIN) payment, which is exclusive to acute trusts, and national reporting required as part of this CQUIN can be viewed as a performance measure for VTE prevention. Possibly more importantly, the NICE guideline for VTE prevention<sup>62</sup> refers to all hospital in-patients but makes no mention of psychiatric patients.

However, there is an increasing body of evidence that people with severe mental illness are at increased risk of VTE.<sup>63</sup> There is also a growing awareness that a number of deaths on mental health units remain unexplained.<sup>64,65</sup> One study found that individuals prescribed antipsychotic drugs had a 55% increased risk of VTE. The authors conclude that the new risk-prediction algorithm developed and validated by this study could be used when considering medication that might increase the risk of VTE, such as antipsychotic drugs.<sup>66</sup>

There is also clear evidence of variation in the use of and access to appropriate pathology tests for people with mental health problems (personal communication from the President of the Royal College of Pathologists, 10 September 2012) and widely variable use of some tests specifically indicated for care of those with mental health problems. This variable and inadequate

use is likely in part to be a reflection of inadequate management of physical illness, and also of the difficulty in diagnosing physical health problems in people with a mental illness and in recognising the interactions of physical and mental illness (pathology testing issues are also relevant to Domains 2 and 5).

This lack of attention to the physical health of people with mental health problems amounts to systemic discrimination and should be addressed as a key priority for tackling the discrimination experienced by people with mental health problems, including in the NHS itself.<sup>67</sup>

In primary care, a recent study has found a four-fold reduction in the rate of consultation in primary care for people with severe mental illness, from rates of 13–14 per annum in 1992 to an average of only 3 per annum in 2008/9, which is only slightly higher than the annual consultation rate of the general population, at 2.8. Given their higher risk of a range of physical health problems, this is a matter of concern. The same study found that practice nurses, key providers of cardiovascular risk screening and health education in primary care, consulted with this population on average only once a year, compared with the general practice population rate of 1.8 consultations per year; nor was health education a common feature of these consultations. The authors conclude that practice nurses appear to be an underutilised resource.<sup>68</sup>

## Recommendations

### Reducing excess mortality in those with common mental health problems

The Department of Health should clarify the roles of the NHS Commissioning Board, Care Quality Commission (CQC) and the NHS Information Centre in relation to collating data on the physical health morbidity of people with mental health diagnoses.

The NHS Outcomes Framework should complement the indicator of 'excess under-75 mortality in people with severe mental illness' with an additional indicator that measures excess mortality in people with mild or moderate mental illness. Without this, the picture of premature mortality is incomplete. There should be an expectation that the mortality differential will reduce year on year.

### Smoking

Efforts to reduce premature mortality must include a major focus on reducing smoking among people with mental health problems.

All secondary and primary care services should make minor, inexpensive changes to primary/secondary care electronic records so that both smoking status and any smoking cessation intervention offered to people with different mental disorders are recorded. An alert about the need for certain medication dosages and potential toxicity would then automatically come up (relevant also to Domain 5).

The Quality Outcomes Framework indicator for smoking status in people with severe mental illness should be modified so that it records not only an individual's smoking status but also what action is taken to address smoking behaviour, such as provision of or referral for smoking cessation intervention(s).

Commissioners should require smoking cessation services to include a focus on smokers with mental health problems. They should also ensure that younger smokers receive early intervention, since most smoking has started by adulthood; smokers with emotional or conduct disorder in particular require targeted intervention.

## NHS services

All NHS staff working with people with mental health problems should be required not to smoke in their presence.

## Venous thromboembolism

Action should be taken to detect, monitor and reduce the incidence of VTE on in-patient mental health wards.

The national focus on VTE in medical and surgical in-patients should be expanded to include psychiatric in-patients, who should be subject to the same national guidelines as other in-patients. Specifically:

- The NHS Commissioning Board and CCGs should consider an annual mortality review being included as part of the contract for mental health trusts.
- More research should be undertaken on hospital-acquired VTE in psychiatric in-patients so that its actual incidence is better understood.
- NICE should consider making specific reference to mental health patients when the VTE guideline is reviewed.
- Improved guidance should be given to mental health trusts on which NICE guidelines are relevant to them, and mental health trusts should be included in the national programme for VTE prevention.
- The NHS Litigation Authority (NHSLA) should review its standards to include VTE prevention for mental health in-patients.

At a local level, mental health trusts should include a reduction in incidence of VTE and implementation of the policy as part of their clinical strategy. In addition, they should:

- Develop and implement a VTE prevention policy for subsequent auditing, with the involvement of clinicians throughout.
- Ensure that existing local incident reporting procedures incorporate VTE as a significant incident, to enable effective monitoring of incidence.
- Develop and implement an educational programme to raise awareness among all staff of VTE as an issue for mental health.

## Primary prevention

### Reducing rates of type 2 diabetes and cardiovascular disease in those with severe mental illness

The NHS Commissioning Board and CCGs should promote widespread adoption of the Lester UK Adaptation Positive Cardiometabolic Health Resource. This newly developed clinical algorithm for reducing the high rates of type 2 diabetes and cardiovascular disease in psychiatric patients treated with antipsychotic medication is a key primary prevention approach to reducing the increased mortality and morbidity experienced by those with severe mental illness. (See Annexe A1 for the Lester UK Adaptation and Annexe A2 for a proposed programme for its implementation.)

The Department of Health and NHS Commissioning Board should explore the potential of the Quality and Outcomes Framework (QOF) to provide improved incentives for GPs to give their at-risk psychiatric patients an annual healthcare check.

## Pathology tests

The Department of Health should fund a programme of research that will lead to better physical care and treatment of people with mental health problems.

## Commitments

The Faculty of Public Health (FPH) is developing interactive tools to disseminate both the evidence base for public mental health and examples of good practice to its membership.

The FPH will take an active stance in promoting the public health importance of mental health and well-being in continuous professional development for members and in the current review of the public health training curriculum.

The NHS Confederation Mental Health Network and the RCPsych will work towards the ambition that NHS non-smoking should be the norm for both staff and service users in mental health trusts, on the basis that all smokers (staff and service users alike) should receive smoking cessation intervention, including assistance with temporary abstinence (including for staff smokers at work).

The RCGP is working with Time to Change to provide a master class in reflective practice specifically for GPs – to raise awareness of mental health problems and management of patients with chronic mental illness within primary care.

The RCN will work with the RCGP to explore the role of practice nurses in primary care in providing health assessments for people with severe mental illness. This will take the form of a series of workshops to be held in 2013.

The Royal College of Physicians (RCP) and RCPsych will jointly publish a report about public health and drug, alcohol and tobacco use aimed at government, medical Royal Colleges, CCGs and health and well-being boards.

The RCPsych, RCPsych and RCP will explore how variations in the use of and access to appropriate pathology tests for people with mental health problems could be investigated and create both educational material and clinical guidelines to address any agreed problems.

The RCPsych will draft and propose improvements to the current smoking-related QOFs.

The RCPsych will engage with NHS stop smoking services with the aim of improving the information available to people with mental health problems (including the Quit Kit), ensuring that mental health status (including current medication) is routinely recorded and that access to smoking cessation interventions for people with mental disorder is greater than for the general population.

The RCPsych will update and disseminate its current medical education materials on smoking and mental health.

The RCPsych, RCGP and RCN will continue to make efforts to embed the Lester UK Adaptation: Positive Cardiometabolic Health Resource into clinical practice.



# NHS Outcomes Framework

## Domain 2: Enhancing quality of life for people with long-term conditions

### Co- and multi-morbidity of mental and physical health problems

There is a strong relationship between mental health and physical health, and this influence works in both directions.

Poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems.<sup>69</sup> Significantly, having both physical and mental health problems makes the treatment of both more expensive – it is the interaction between the mental and physical health problems that drives up the cost of treatment.<sup>70</sup> For example, the additional cost of treating long-term conditions for those with depression and other mental health problems is 12–18% of all NHS expenditure on long-term conditions in England – that is, between £8 and £13 billion each year.<sup>71</sup>

#### Case example: Positive experiences of care for co- and multi-morbid conditions

##### Case 1

As a diabetic I have received an excellent service on both levels. I can highly recommend the Ropewalks Surgery in Liverpool. They do their utmost and more to give me all the help I require both physically and mentally.

##### Case 2

I have been quite lucky in that I have had very good responses to physical health problems from my GP. I mainly deal with my consultant and my CPN [community psychiatric nurse] for mental health problems but my GP is aware of my problems. I feel my concerns have always been taken seriously. When I had treatment for breast cancer, the breast care service got in touch with my mental health team to make sure they had information about my medication (lithium and depixol) to take into consideration when using anaesthetics.

##### Case 3

I have had excellent treatment for both mental and physical health issues. When I was first diagnosed with schizophrenia, I had an excellent general practitioner, who knew exactly what the problem was right away, and arranged for me to have all the essential treatment in hospital.

These case studies have been provided by Mind.

Major public health issues, such as cardiovascular disease, cancer and obesity, have complex presentations, encompassing both mental and physical health, and health and social care interventions must be designed to respond to this complexity.

For example, depression is associated with:

- a 50% increased mortality from all disease<sup>52</sup>
- a two-fold increased risk of coronary heart disease<sup>72,73</sup> and diabetes<sup>74</sup>
- a three-fold increased risk of death in the subsequent 4 years.<sup>75</sup>

One London study identified a reduced life expectancy of 10.6 years in men and 7.2 years for women with depressive episode or recurrent depressive disorder.<sup>53</sup>

The mental health strategy estimates that national screening and treatment of depression in people with type 2 diabetes would cost £140 million but result in net savings to the NHS and social care of £10 million, with a further £10 million savings from improved productivity. However, intervention also results in £1.9 billion QALY (quality-adjusted life-year) gains and estimates do not include savings from averted complications, including productivity losses due to premature mortality.<sup>48</sup>

Schizophrenia is associated with:

- a two-fold increased risk of diabetes and a two- to three-fold increased risk of hypertension
- a two and a half times increased rate of mortality from all disease<sup>49</sup>
- reduced life expectancy of 20.5 years for men and 16.4 years for women<sup>50</sup>
- increased likelihood of death from coronary heart disease.

People with severe mental illness aged under 50 are three times more likely and those aged 50–75 are 1.9 times more likely to die from coronary heart disease.<sup>46</sup>

People with long-term physical conditions have a several-fold increased incidence of depression<sup>69</sup> while within a year of diagnosis of cancer there is a 20% rate of new onset of depression or anxiety.<sup>76</sup> A child who experiences a physical illness is two to five times more likely to develop an emotional disorder.<sup>77</sup>

## Integration: the role of liaison psychiatrists and liaison physicians

The new commissioning focus on long-term conditions presents important opportunities for the integration of mental and physical health, addressing co- and multi-morbidities, and achieving parity between mental and physical health services.

The concept of recovery from mental health problems needs to be more widely understood, as does the need for integrated care to help achieve it. Integration of primary and secondary care and of health and social care is important, as people with mental health problems move between these settings and the care received in all these settings can significantly affect treatment and recovery.

The importance of access to psychiatrists has been acknowledged by other disciplines within medicine. Psychiatrists have been described as 'essential and central in the treatment of cancer' (J. Barrett, President of the Royal College of Radiologists, personal communication, 2011) and the President of the Royal College of Physicians has stated that 'people presenting to hospital may develop mental health problems as a complication of their illness or people with an underlying mental illness may worsen if they are admitted to hospital with a physical illness ... there is therefore a particular need for prompt access to expert psychiatric opinion for patients

in the general hospital' (R. Thompson, President of the Royal College of Physicians, personal communication, 2011).

Parity would mean that patients in general hospitals or primary care with physical health problems receive the same level of access to a consultant psychiatrist as they would from a consultant specialising in physical health problems.<sup>78</sup>

Access to mental health teams within physical health settings is particularly important given the several-fold increase in rates of mental health problems in people with long-term physical illness, although this should not mean that other staff lose mental health skills through lack of use.

Interventions delivered by liaison psychiatry services can improve both physical and psychological health outcomes and reduce healthcare costs in the management of long-term conditions and medically unexplained symptoms. Liaison services thus have a significant role to play in integrating the management of co- and multi-morbid physical and mental health problems; while they have tended to work in general hospitals, they are increasingly also working in the primary care setting.<sup>79</sup> Such services can also have a significant role in training acute care staff and give them confidence in dealing with patients with comorbid physical and mental health problems, including how to assess risk.

### Case example: Role of the liaison psychiatrist – the RAID team

Liaison mental health services have the potential to work across the divide between physical and mental health. This potential is well demonstrated by the Rapid Assessment Interface Discharge (RAID) team in Birmingham, which offers comprehensive mental health support to all people aged over 16 within the hospital at all times. A study by the Centre for Mental Health found that 'based on a comparison of lengths of stay and rates of re-admission in similar groups before and after RAID was introduced in December 2009, in place of a previous, smaller liaison service, the internal review estimated that cost savings are in the range of £3.4–£9.5 million a year. Most of these savings come from reduced bed use among older adults.'<sup>80</sup> Extrapolating from these figures, it is estimated that similar models could annually save the NHS up to £1.2 billion, and could annually save a typical 500-bed hospital up to £5 million.<sup>9</sup>

The liaison psychiatry model of working across physical and mental healthcare for adults, both in hospitals and in primary care, has significant potential to provide the same benefits in other settings and in other aspects of medicine.

A liaison psychiatry service can save up to £5 million in a typical hospital every year. And even greater savings could be made if liaison psychiatry services were made available in the community to prevent hospital admissions and emergencies in the first place.<sup>9</sup>

A clear direction and strategy for the delivery of physical healthcare, built on lessons learnt from primary care and targeting resources at the most vulnerable within a robust reporting procedure, can deliver significant health benefits. The West London Mental Health Trust has created the role of liaison physician, who advises on physical healthcare within a mental health trust. This innovative role applies principles learnt from mental health services in developing the liaison psychiatry role. Its use in Broadmoor has demonstrated benefit in the delivery of physical healthcare and subsequent health outcomes for patients with a high-end need for care.

Paediatric liaison services are also important for providing good integrated care for children and young people but are not comprehensively available. A recent survey of 170 CAMHS in the UK, to which 52% of services (a total of 88) responded, found that only two-thirds provided a paediatric liaison service; of these, only a third were dedicated paediatric liaison services – the other two-thirds were provided by tier 3 CAMHS. Teaching hospitals and children's hospitals were more likely to have dedicated paediatric liaison services, although only 50% of children's hospitals surveyed had dedicated paediatric liaison services. (This survey covered both the UK and the Republic of Ireland, but the latter provided only one response.)<sup>81</sup>

We welcome the College of Emergency Medicine's national training day on mental health in the emergency department.

## Case example: Role of the liaison physician in a high secure service

### Context

West London Mental Health Trust (WLMHT) is one of the largest and most diverse mental health services in the UK. It provides care and treatment for around 20 000 people each year and serves a local population of around 700 000. The high secure services at Broadmoor Hospital in Berkshire are internationally recognised. With the West London Forensic Service, they make the Trust a leading national provider of secure and specialist mental healthcare.

People with severe mental illness die 15–20 years earlier from natural causes than those without mental health problems. Although there is a significantly raised rate of suicide, the main causes of this excess mortality are higher rates of obesity, respiratory, cardiovascular and infectious diseases, diabetes, and some cancers.

### Issue

Planning and providing physical healthcare for these patients is considered to be both a national and a local priority. The Trust has therefore appointed a full time Director of Primary Care, to lead on the development and implementation of a Trust-wide strategy to meet their physical health needs. This role is that of liaison physician, who advises on physical healthcare within a mental health trust.

### Aims

There is a clear aim that the physical healthcare service should be able to demonstrate that the outcomes of care are the same as they would be if the person had not had a mental illness. To that end, a model of care has been introduced based on the organisation and learning of general practice in the community, but applied to the most at-risk and vulnerable group of patients within the Trust – those who are long-term residents of the Trust and entirely dependent on it for all of their healthcare.

### Benefits

Using this model, and taking a proactive approach to long-term physical health conditions, considerable progress has been made:

- There is an understanding that a greater level of care and intervention is needed for most physical long-term conditions and that it is more complex and sophisticated to achieve the same outcomes than it would be for a population group that does not have a mental illness. For example, in diabetes, usually between a third and a half of people in the community can be managed by diet alone. To achieve reasonable levels of diabetic control, none of the diabetics in the high-risk group are managed by diet alone; all require medication.
- All the patients at Broadmoor have been assessed for their cardiovascular risk. A scoring system, QRISK2, has been used, and a multidisciplinary team approach taken for those patients who are considered at high risk (above 20%) of suffering a cardiovascular event in the next 10 years. Using this approach the proportion falling into the highest category of risk has fallen:

	2010	2011	2012
QRISK2 score			
High risk (>20%)	6.99%	2.96%	2.11%
Medium risk (15–20%)	6.45%	1.48%	2.82%
Low risk (<15%)	86.5%	95.5%	95.1%

The multidisciplinary team consists of a dietitian, exercise therapists, nursing and medical input. NICE guidelines are very effective management guidelines for setting targets and providing medication advice.

- Smoking. At Broadmoor Hospital, where smoking has been banned, there have been no admissions to an acute hospital in the past three years for a respiratory complaint, and despite screening with spirometry, there are no cases of chronic obstructive pulmonary disease (COPD). Antibiotic prescribing for respiratory complaints is low.
- Guidelines have been introduced for managing hyperprolactinaemia, Vitamin D deficiency, and identifying patients at risk of venous thrombosis.
- The mental health care programme approach (CPA) process has been supplemented by a physical health CPA, which includes a routine set of bloods, an ECG, a physical examination and an assessment of health education and health promotion needs. Linking the physical and mental health CPA processes allows a holistic approach, and ensures that physical health needs are not omitted.
- Clinical governance. A standard primary care computer system is used to record consultations, and calculate Quality and Outcomes Framework (QOF) scores on a monthly basis. The QOF scores are used as targets to identify long-term conditions, and manage these proactively. National QOF scores act as benchmarks to compare the service provided at the Trust to that delivered in the community. The service is reviewed annually by an independent external GP, a local QOF assessor. The service also reports the QOF scores to the Trust Board – the service believes it is the first Trust to do so.
- Nurse Training and MEWS. The Modified Early Warning Score (MEWS) has been introduced Trust-wide to support nursing staff to record and interpret physical health observations. MEWS is a scoring system used extensively in acute hospitals to identify deteriorating health, but the structured format is particularly useful for mental health nurses to support their interpretation of observations. Training in MEWS is linked to Basic Life Support skills, so reaches all nursing staff.

## Public health

Lack of mental well-being that falls short of mental illness plays a critical role in the development and deterioration of chronic illness. It is thus a risk factor for mental health problems, reducing resilience to life events and capacity to cope in adversity.

The capacity to live healthily requires a measure of agency, autonomy and self-esteem, which are key features of mental well-being. The capacity for self-care in chronic illness similarly calls for a measure of mental well-being.

Policy, strategy and practice must ensure that mental health and well-being are considered as integral to physical health when interventions are proposed. This is essential both for ensuring that physical and mental health improvements are achieved, and for tackling the stigma attached to mental health. Thus, well-being and good mental health should be considered both on a population-wide basis and as essential components of work on cardiovascular disease, smoking, cancer, obesity, alcohol, drugs, parenting, education and health promotion.

Public mental health should be core to public health programmes. For example, efforts to reduce smoking, the largest single preventable cause of death and long-term conditions in the UK, need to include a strong focus on people with mental health problems who smoke (relevant also to Domain 1).

Given the nature of mental illness and mental health as markers of social exclusion, poverty, unemployment and multiple social and family difficulties, how public health interventions are mapped, commissioned and delivered must also consider the potential for universal intervention not to reach those most in need, and thus to widen inequalities. Public health interventions should be equally available to all citizens, including those most excluded, whether in relation to housing, age, gender and/or ethnicity.

## Prescribing practice

Safe prescribing for people with mental health problems is an important aspect of ensuring they receive effective and appropriate care, which can be long term. There are particular issues that need to be addressed in the prescribing of mental health medicines, which are set out in the later section on Domain 5.

## Recommendations

The integration agenda needs to be widely promoted for different audiences, subdivided into structural, educational and individual clinical practice considerations. The NHS Commissioning Board and local health and well-being boards should ensure representation from people and groups who can champion the integration of mental and physical health and social care in primary and secondary care.

### Commissioning

Commissioners need to regard liaison services as an absolute necessity rather than as an optional luxury.<sup>9</sup> NHS and social care commissioners should commission liaison psychiatry and liaison physician services to drive a whole-person, integrated approach to healthcare in acute, secure, primary care and community settings, for all ages, including multidisciplinary paediatric liaison services for children both in and out of hospital. This will not only improve patient outcomes but also save money.

There is strong support from the Royal College of Physicians (RCP) for all acute trusts to have a liaison psychiatrist.

Commissioners should ensure that service specifications include the treatment of co-morbid health issues as well as addressing primary diagnoses, and might call for year-on-year improvements in recording comorbidity.

CCGs should ensure integrated commissioning of physical and mental health services for long-term conditions in children. All contracts for paediatric services should include measurable outcomes for mental health.

CCGs should ensure that providers of mental health services have a physical and procedural infrastructure in place to enable monitoring of people's physical health in accordance with NICE guidelines. This should be audited regularly as part of the commissioning process.

CCG commissioners should require that assessments at all stages of the pathway to care and recovery should include questions on both physical and mental health.

## Quality and Outcomes Framework

Routine screening for depression, anxiety and other common mental illness in people with long-term physical conditions such as diabetes, cardiovascular disease and chronic pain should be extended under the QOF.

## NICE quality standards and guidance

NICE quality standards and guidance could play a central role in establishing parity, by considering integrated physical and mental healthcare in respect of the particular disease or disorder that is being considered. This is not to downplay the importance of setting out the evidence of best treatment for a particular disorder, nor auditing, monitoring or researching treatment of specific disorders. However, the standards and guidance should address prevalence and treatment of comorbidity and guide clinicians towards a holistic approach to care. This should apply as much to the physical health needs of someone with, for example, depression, as to the mental health needs of someone with, for example, chronic obstructive pulmonary disease (COPD).

All NICE guideline development groups for physical conditions should consider including representation from co-opted mental health experts to ensure that the mental health aspects of conditions are comprehensively considered. This will ensure that NICE quality standards have a sufficient focus on mental health.

## Public health

A parity approach should be adopted for addressing major health and social care priorities such as dementia, obesity and dignity-in-care issues. The report on obesity from the Academy of Medical Royal Colleges<sup>82</sup> models this approach.

Public Health England and local authorities should take a parity approach to their work and support the development of local public health strategies and interventions that recognise and fully consider the mental health dimension of issues commonly conceptualised as physical health concerns, such as smoking, obesity and substance misuse. Public health programmes should also involve appropriately integrated work across health and social care in order to consider and address the wider determinants of mental health and mental illness, such as social isolation, parenting, violence and abuse.

This 'whole person' approach should apply across the life course.

Health Education England should as a priority support the development of core skills and competencies in public mental health for health and public health professionals.

## NHS trusts

To help ensure that mental and physical health work together:

- all providers of specialist mental health services should have someone at board level who leads for physical health
- all providers of physical healthcare should have a board member who leads for mental health
- all providers of specialist mental health services should have a liaison physician who focuses on physical health
- all providers of physical healthcare should have a liaison psychiatrist who focuses on mental health.

## Local authorities

All local authorities should have a lead councillor for mental health in recognition of the need for all Local Authority activities and commissioning to take full account of mental and physical health and their social determinants.

The Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services should work with local authorities to ensure that mental health is given parity with physical health in the areas for which they are responsible, including in their new responsibilities for public health and the commissioning of addictions services.

All local authority activities and commissioning should recognise the social determinants of mental and physical health, and the importance of housing, education, social care eligibility, green spaces, access to leisure activities and employment for mental health resilience and recovery in the following ways:

- Local authorities should consider the mental health and well-being impact of all their policy decisions, including decisions about cuts to services. The Mental Well-being Impact Assessment (MWIA) toolkit developed by the National MWIA Collaborative (England) can assist this process, and its use should be widely adopted (available at: <http://www.apho.org.uk/resource/item.aspx?RID=95836>).
- People with mental health problems should receive social care on the same basis as people with physical health problems – according to the impact on the quality of their day-to-day life, the risk of further deterioration in health and the need for further health or social care.
- Mental health social work should be jointly commissioned by CCGs and local authorities to promote an integrated approach to health and social care.
- Local authorities should demonstrate their active commitment to parity through health and well-being and commissioning strategies.
- Health and well-being boards should benchmark their activities against the Mental Health Strategy Implementation Framework.
- Health and well-being boards should ensure that more common mental health problems are included in the Joint Strategic Needs Assessment (JSNA), not only severe mental illness.
- Health and well-being boards should also take an asset-based approach to needs assessment to determine the resources available locally for promoting good mental health and well-being.

## Commitments

The College of Emergency Medicine (CEM) has identified a lead for mental health, with responsibility for liaising with the RCPsych and other relevant bodies. They will continue to report as a standing agenda item to every meeting of the College Clinical Effectiveness Committee.

The CEM is creating a management 'toolkit' to promote mental health services in the emergency department. This includes a range of resources, including current standards and guidelines, sample business cases for service development, staff and patient resources, and a range of materials that will assist in working towards parity between mental and physical health in the emergency department.

The CEM and RCPsych are developing a set of mental health standards for emergency departments.<sup>83</sup> They will then proceed to complete a national audit against these standards during 2013/14.

The NHS Confederation Mental Health Network actively supports the principles of recovery and social inclusion for mental health service users. It will work with the RCPsych to collate and disseminate examples of best practice (at trust or service level) in improving the physical health of people with mental health problems.

The Royal College of Physicians (RCP) Future Hospitals Commission includes a representative from the RCPsych and is considering both physical and mental health issues. The Commission is expected to report in summer 2013.

The Royal College of Paediatrics and Child Health (RCPCH) and RCPsych will explore the development of paediatric liaison services, with production of a joint document for commissioners.

The Royal College of Physicians of Edinburgh (RCPE) will continue to include mental health as a cross-cutting issue within its work streams.

The RCPE will, on occasion, hold full events with a sole mental health focus. Extracts from such meetings will be recorded and uploaded to the RCPE website.

The RCPsych will develop draft CQUINs and QOFs which might also be used to reward improvements in recording and treating physical and mental comorbidity.

The RCPsych and Centre for Mental Health are exploring the development of a network of local authority 'mental health champions'. It is anticipated that other mental health charities will also be involved in this project.



# NHS Outcomes Framework

## Domain 3: Helping people to recover from episodes of ill health or following injury

### Waiting times for services, including crisis care

People with mental health problems have lower levels of access to evidence-based or recommended treatments; this is a significant aspect of disparity. For example, despite NICE recommendations that psychological therapies be offered to a wide range of people with depression, and despite funding being made available from central government for this purpose, these services have not been universally commissioned and many people go without.<sup>84</sup> This state of affairs would not be tolerated in other areas of healthcare.

People with mental health problems can face unacceptable waits of months or even years for psychological therapies, which are not included in the 18-week maximum treatment time outlined in the NHS Constitution. Of 527 people who responded to a Mind survey for people who had attempted to access psychological therapies in the previous 2 years, one in five had been waiting over a year to receive treatment and one in ten had been waiting more than 2 years to receive treatment,<sup>85</sup> by which time the illness may well have become more severe.

There is widespread evidence that people with mental health problems can wait a long time for secondary care services, even in a crisis. People can be turned away on the grounds that they are not sufficiently ill to qualify for emergency care, or 'crisis' services can be closed out of working hours, leaving people with nowhere to turn except in the worst cases to the police.<sup>86</sup>

#### Case example: Crisis service

There was a 999 'concern for welfare' call during the night concerning a woman in her late 70s with bipolar disorder. An ambulance rapid response vehicle was sent. The woman was 'highly agitated' and anxious, saying she did not have a community psychiatric nurse and only saw her GP. She may not have taken her lithium for a few days. There were no injuries apparent.

The paramedic noted some paperwork for another area's community mental health team (CMHT). The woman denied any CMHT involvement but did say that she had a flat in the area. The paramedic called the number on the paperwork and got an out-of-hours number which said the service worked only from 9–5 and gave no alternative contacts.

The paramedic then called the local CMHT out-of-hours number, believing it was appropriate for this woman to be assessed at home. The reply from CMHT staff was that the woman was 79 and too old for their service, and she would need to call social services herself.

The paramedic therefore requested an ambulance to collect the woman and take her to the emergency department.

The emergency department staff told the ambulance crew that they 'don't do mental health' but did accept the woman eventually, after some persuasion from the crew.

This anonymised case study was provided by an ambulance service manager.

Recent research conducted by Mind has uncovered: ten-fold variations between English mental health trusts in terms of access to crisis care services (and subvariations related to ethnicity); limited alternatives to the staples of in-patient care and home treatment; and crisis resolution home treatment (CRHT) team understaffing, that is, below the levels recommended by Department of Health guidance, in 40% of trusts.<sup>7</sup> These are all extremely worrying findings.

Preliminary analysis of existing waiting time measures undertaken by the Centre for Mental Health suggests the following implications for mental healthcare (A. Bell, Centre for Mental Health, personal communication 28 September 2012):

- Waiting time targets, especially where they are enforceable, appear to have a very strong influence on providers' behaviour.
- Watchfulness is needed to avoid 'gaming' but this can be managed, for example by separating out diagnostics and in-patient care and by measuring trolley waits.
- It may be useful to focus on a range of waiting times throughout the system, including delayed discharges.
- It will also be important to distinguish emergency and elective waiting times, for example admissions in a crisis (including from prison) compared with CMHT or CAMHS referrals and access to psychological therapies.

## Choice and shared decision-making

Choice is also less available in mental healthcare than in physical healthcare, in relation to both choice of treatment and choice of provider. The perception has been that choice is more difficult to exercise because of, for example, detention under the Mental Health Act or long-term relationships with services requiring people to 'choose' the nearest service. However, the Mental Health Act Code of Practice requires that staff pay attention to choice and the capacity to choose/consent to treatments, and it is important that they should be enabled to optimise service user choice even in this context.

The developing personalisation agenda should provide further opportunity for exercising choice but, to date, direct payments in social care have been much less available to people with mental health problems, despite evidence that they are one of the groups most able to benefit.<sup>87</sup>

The organisation of primary care, where some services can require the booking of separate appointments for different problems, makes it difficult to deliver holistic care.

The 'choose and book' approach to care is currently not used in mental health, and while it may not itself be the most appropriate mechanism for referrals to specialist mental health services, how mental health patients can be afforded greater choice in their care has long required attention. The government's recent announcement that, from April 2014, mental health service users will be able to choose which team they are referred to for secondary care is therefore very welcome.<sup>88,89</sup>

### Case example: The importance of choice for service users

It's imperative to be given a choice – apart from anything else it makes you feel good about yourself and improves your self-image. This is particularly important. Plus, if there is no choice but an action is rather forced upon you, then you may well rebel against it. To give you a vignette – had my alcohol treatment centre initially forced me to become abstinent (rather than going with my wish of controlled drinking and helping me with that) I would definitely have walked out. As it was, the way I insisted upon, i.e. controlled drinking, didn't work out after trying it for some time and so I myself eventually decided on the detox/abstinence route, which I achieved with a lot of help and support from the above centre. It was my decision and that is a large part of why, incredibly difficult though it was, it worked.

Account provided by a member of the RCPsych Service User Recovery Forum

It should, however, be borne in mind that some people with mental health problems can be very reluctant to accept a psychiatric referral and may fear psychiatrists. A view from primary care is that a referral should work as a personal introduction from the GP, who is trusted by the service user, to a particular specialist, and that the 'choose and book' approach could work against this. If the GP can describe the person the patient will see, it can undoubtedly help to reassure them and make it more likely that the patient will attend. This can be an important aspect of providing continuity of care.

NICE quality standards state that people using mental health services should be actively involved in shared decision-making and supported in self-management.<sup>90</sup> In shared decision-making, the patient's knowledge and preferences are taken into account, alongside the clinician's expertise, and the decisions they reach in agreement with each other are informed by research evidence on effective treatment, care or support strategies.<sup>91</sup>

People with mental health problems are experts in their own symptoms and support needs, and involvement in making decisions can be an important part of the recovery process in itself. Choice can also lead to better value for money: when people are involved in decisions about their care, treatment is more likely to be effective and to lead to speedier recovery. In a recent Mind survey, people who had a choice of therapies were three times more likely to be happy with their treatment than those who wanted a choice but did not get it, and five times more likely to report that therapy had helped them get back to work.<sup>85</sup>

However, we know that shared decisions are far from the reality for many people, for reasons such as lack of consultation time between patient and clinician, stigma and discrimination within the healthcare system, and compulsion under the Mental Health Act. Furthermore, block contracts in mental health frequently lead to a lack of choice in mental health services, with services commissioned with one provider which does not adapt to cater for the changing local demographic.

It is important to note that true shared decision-making lies not merely in provider choice, but in enabling patients and clinicians to work together to select treatments, devise joint care plans and identify desired outcomes which are specific to each individual. A recent Mind survey of more than 500 people with mental health problems found that being able to choose types of treatment and taking part in planning their care were the most important aspects of shared decision-making, while choice of provider was considered less important.<sup>92</sup>

It is also important to remember that people with mental health problems should be able to choose not to choose, that is, to refer a decision to a clinical expert or other person who they feel can best represent their interests. Some people will feel most in control if they are able to explain what factors are important to them and have expert advice to help guide them to the most appropriate choices, based on those factors. To elicit information on what factors matter most to an individual, GPs or other primary care professionals must have the means and expertise to help people with mental health problems articulate their requirements.

There thus needs to be a greater focus on real choice. However, this must also recognise that service users and carers are concerned to balance choice with continuity of care.

Carers need to be recognised as important partners in service users' mental healthcare, just as they are in caring for people with physical health problems. The 'triangle of care' model describes the importance of staff being willing 'champions' for better partnership working, and the importance of challenging practice that excludes carers. A more inclusive attitude for carers and families is needed, where carers are appropriately listened to, heard and consulted.<sup>93</sup>

## Recommendations

### Access to care

To help drive change, the government and the NHS Commissioning Board should work together to:

- Make it clear, including as part of the NHS Constitution, that parity is expected between mental and physical health, in all relevant aspects of the work of the NHS.
- Give people equivalent levels of access to treatment for mental health problems as for physical health problems, agreed standards for waiting times for this treatment, and agreed standards for emergency/crisis mental healthcare.
- Continue to improve access to psychological therapies so that they are provided as a timely and appropriate response to assessed need for such interventions.
- Include a right in the NHS Constitution for service users, when it is judged clinically appropriate, to receive treatments that have been recommended by NICE in clinical guidelines as well as in technology appraisals.

At present, the NHS Constitution confers this right (if clinically appropriate) only to drugs and treatments recommended by NICE technology appraisals and not to those recommended by NICE clinical guidelines. This is a parity issue, as, in practice, a greater proportion of mental health treatments than physical health treatments have undergone a clinical guideline assessment process rather than a technology appraisal process. This means that they are, in practice, less available to service users, as there is not the same legal imperative for mental health service providers to make them available. NICE clinical guidelines are the gold standard for evidence-based care. To use the example of mild depression, guidelines recommend talking therapies as a first-stage treatment and explicitly discourage the use of antidepressants. It is not equitable that a recommended treatment such as group cognitive-behavioural therapy does not have to be provided within the same reasonable time frame as the majority of treatments for physical complaints because it has been through a clinical guideline assessment rather than a technology appraisal. We recognise that, as a first stage, this may initially need to be a pledge rather than a right.

- Include a pledge in the NHS Constitution that service users with mental health problems, including people treated under the Mental Health Act, will be given information and support in making as many collaborative decisions about their treatment as possible.

We welcome the requirement in the NHS Mandate for the NHS Commissioning Board to work with CCGs to quantify waiting times for mental health services, including for when people are in crisis, and to address unacceptable delays in access to such services. The subsequent development of access standards should result in the introduction of waiting time standards for secondary care mental health assessment, diagnosis and treatment.

It is important that clinicians should be able to talk without constraint about treatment options. They should advise the service user of the treatment options from which they could benefit in line with national guidance, whether or not those treatments are available locally within a reasonable timescale. There should be a mechanism for service users to complain if they cannot receive their choice in a timely fashion, which does not involve the clinician. The clinician has a duty to enable the service user to reach informed choices and should not be constrained from doing so, which includes the fear of a complaint made directly to them for what is a problem of service provision. We therefore propose a fair access-to-care complaint approach that involves both the providers and commissioners. The clinician's role in this would simply be to confirm that the service user would benefit from the treatment.

### Emergency and crisis care

People who are in crisis because of a mental health problem should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems.

People with mental health problems presenting at accident and emergency departments should have the same level of access to physical healthcare and the same quality of response as those without a mental health problem.

Accident and emergency departments should have access to liaison psychiatrists and CCGs should ensure that emergency care provision is stipulated in the appropriate service contracts.

CCGs should ensure that they commission a sufficient mix of crisis services on the scale required by the needs and composition of the local population. These services should be staffed in accordance with extant national guidelines. Local communities should be meaningfully involved in the planning and review of such services.<sup>8,93</sup>

## Improving Access to Psychological Therapies (IAPT) programme

Given the significant commitment the government has made to IAPT, clarity is needed on where the national IAPT programme will now sit and how it will be taken forward.

## Choice

The Department of Health should consider how people with mental health problems can be offered greater choice in their care, and how this might operate in a variety of settings, including when people have been detained. People should be offered high-quality local services, within which there should be choice not only about which clinician they see, but also the type of treatment they are given and access to beds if appropriate. Choice should be offered in the context of shared decision-making and continuity of care.

## Personalisation

The forthcoming roll-out of personal health budgets should not replicate the current disparity in access to direct payments experienced by people with mental health problems. Support, brokerage and advocacy should be in place to enable people to take up the offer in both health and social care should they wish to do so.

## Severe mental illness and primary care

The working group welcomes Professor Helen Lester's call at the 2012 RCGP annual conference for GPs to make service users with conditions such as bipolar disorder and schizophrenia their 'core business' and her recommendations that they offer them longer consultations (in order to consider the various biopsychosocial factors that may be involved) and provide separate waiting areas away from what may be noisy and distressing waiting rooms.<sup>94</sup>

## Commitments

The RCPsych College Centre for Quality Improvement (CCQI) will conduct a literature review of evidence regarding staff expectations of the physical health of service users with severe mental illness, the results of which may lead to a small research study.

As it routinely reviews the methods and processes for assessing and interpreting evidence in its guidance programmes, NICE will take the opportunity to ensure that it takes account of the particular features of the evidence for psychological therapies.

The MRCPsych (Member of the Royal College of Psychiatrists) examination will reaffirm the importance of preventing, identifying, assessing and managing physical illness.

The RCPsych and the NHS Confederation Mental Health Network will explore the reasons underlying the lower aspirations of health professionals for those with mental health problems and how these might best be addressed.

# NHS Outcomes Framework

## Domain 4: Ensuring that people have a positive experience of care

### Attitudes, culture, stigma and blame, resulting in discrimination

*The words that we use to address the problem are important because the activities that result are very much dependent on the lens through which we view it.*<sup>95</sup>

*I still have mental health problems; it doesn't mean that I can't do things... mental illness doesn't restrict people nearly as much as attitudes towards it.*<sup>96</sup>

A key issue affecting people with mental health problems, which influences their quality of life, their care and treatment and their ability to recover, is stigmatisation of mental illness and the discrimination to which this can lead. This also affects those who care for them. Factors influencing this include the often high level of ignorance among the general public and the media about mental illness. This may be connected to a fear of the unknown and also to unbalanced and sensationalist media representation and reporting of mental health problems, risk and dangerousness.

Discrimination against people with mental health problems and, to a lesser extent, their families, is a constant and a common problem. A recent study of people with depression found that more than three-quarters had experienced discrimination in at least one area of their lives. These experiences of discrimination were associated with subsequent non-disclosure of their condition (which can act as a barrier to accessing treatment) and, of the total study cohort, more than a third had stopped themselves from forming a close personal relationship and a quarter had not applied for employment because of their illness.<sup>97</sup> The discrimination that some people experience can extend into all areas of their lives, and just coping with this adds an extra layer of distress. Difficulties, once a person has admitted to a mental illness, can include the attitudes of health professionals. These experiences can seriously slow recovery.

Stigma thus has a significant bearing on the behaviour of people in seeking treatment for mental health problems,<sup>98</sup> or even talking about their problem to friends and family. Previous negative experiences of services can lead to a feeling of disempowerment and affect a person's ability to have an active say in their healthcare.

When an individual has presented for treatment, discrimination can continue to be a significant source of unequal treatment. Some professionals' attitudes towards mental ill health can be a cause of poor attention to individuals' physical healthcare needs and low aspirations for their recovery. In accident and emergency departments, for example, it is the presenting behaviours, such as self-harm or problems with alcohol, and the reasons for these which need to be properly addressed, without assigning blame to the person.

Some groups – such as young offenders, children in care, asylum-seekers and lesbian, gay, bisexual and transgender people – have higher levels of mental health problems due to their experiences and lack of access to services. These can be compounded by additional stigma linked to their particular circumstances, which can further affect both their mental health and their access to mental health services.

Children and young people with intellectual difficulties or developmental disorders, such as autism, also face discrimination, particularly in school. They often have insufficient support and their increased incidence of mental health problems, particularly anxiety and depression, is not always understood.

People from some Black and minority ethnic groups with mental illness are even further disadvantaged. For these groups, engagement with mental health services is poorer than for other population groups, and they are significantly more likely to be treated coercively than White British members of the public.<sup>99</sup>

The condition of some (though not all) of the mental health estate – its buildings and wards – would never be accepted in settings for physical healthcare and arguably reflects the lower esteem in which mental health is held, and potentially stigma towards mental health within the Health Service (relevant also to Domain 5).

## Professional attitudes to physical and mental health

The attitudes of mental health professionals also need to be considered more broadly, as, in general, service users report more discrimination from people with whom they have the most frequent contact. Findings from the Time to Change initiative, for example, indicate that mental health professionals are showing the least improvement in their attitudes to service users.<sup>100</sup>

There was also a widespread view in the working group that there is an undercurrent of low aspirations within some services for mental health patients in relation to their physical health, such as their smoking status and weight gain, and future employment prospects.

## Recommendations

### Improving health professionals' attitudes towards and aspirations for service users

No part of the NHS should tolerate professional attitudes, behaviour or policies that stigmatise mental illness and thus contribute to the discrimination experienced by people with mental health problems. Unless such attitudes are challenged and changed, mental health will not gain parity with physical health. An element of this is showing the same respect to mental health professionals as to professionals working in other areas of health, as the stigma associated with mental health can also affect the esteem in which they are held.

We recommend that organisations providing NHS-funded care review their diversity and equality policies to ensure they include clear statements about non-discrimination in relation to mental health, and that a 'zero tolerance' approach is adopted in all health settings in relation to stigmatising and discriminating attitudes and behaviour towards people with mental health problems and their carers.

In every trust and hospital, non-discrimination policies should be supported first by an encouragement to report episodes of discrimination and secondly by provision of reparative training.



## Case example: Managing chronic pain and the attitude of dualism in acute hospital trusts

I have many years' experience of treating patients whose psychological/psychiatric problems have resulted in stigmatisation and inferior care within physical medicine.

Many of the patients referred to the chronic pain clinic have mental health problems; few have had any specific input from mental health services. The appointment of a liaison psychiatrist to work with the chronic pain team led to improved plans of management for patients with more severe mental health problems.

However, many chronic pain patients are referred from either primary care, or more commonly from secondary care, having been investigated for multiple physical diseases, and no abnormalities have been found. The patients convey a clear message from their clinician that she or he does not believe them that there is anything wrong (because the tests are normal) and that therefore they, the patients, are lying, malingering, making it up, or plain mad.

My most difficult and important job was to get the patients to trust me; to listen to them and convince them that I believed them. Once this was achieved it became possible to introduce psychological therapies and make progress with managing pain. There are several important points arising from my work with patients with chronic pain:

- Patients do not view physical and mental illness with equal esteem. They see physical illness and physical diagnoses as 'real' and something that gains sympathy from friends and employers. Mental illness is 'not real' and any sort of psychological diagnosis is something to be ashamed of and kept secret.
- Doctors and nurses are even more dualistic. Weighted phrases such as 'she claims to get severe pain' convey disbelief of the patient and a paradigm in which physical illness is real, whereas mental illness is not.
- Surgical and drug treatments are prioritised over talking therapies. This happens at all levels. Talking therapies are poorly researched due to lack of funding, and primary and secondary care commissioning groups are likely to fund physical treatments over psychological ones.
- Patients with chronic pain who apply for benefits are pushed towards physical explanations for their pain and a need to exaggerate physical symptoms if they want to be believed and get their benefits. 'Chronic pain syndrome' is not an acceptable diagnosis to the benefit assessors.

Personal communication from a consultant with 17 years' experience of working in a chronic pain clinic and 5 years' experience as a pain psychotherapist.

## Case example: Personal testimony from the carer of a patient with cocaine and alcohol addiction

My brother, a professional and respected TV presenter and reporter, was admitted to the A&E department. That afternoon a junior house doctor came by, glanced briefly at John's chart, and said 'Your brother is doing very well. He can be discharged very shortly.'

'Oh no, please,' I replied, 'if you send him back to that flat again.... You don't understand, it will all start all over again....'

'What will?' The doctor spoke patronisingly, as if to some difficult child.

'Don't you understand why he is here?' I protested. 'He's drinking and doing drugs all the time ... he's destroying himself. I hoped you would help....'

'Help? I don't think your brother needs any help. He certainly hasn't asked for any. In fact, he strikes me as a very competent man. He's been telling me about his work as a journalist. I am sure a man who could look after himself in a war zone can manage to make himself the odd plate of baked beans on toast.'

'Would you at least arrange for him to see a drugs counsellor before you discharge him?' I asked angrily.

'I can't do that, I am afraid. Not unless he asks for a visit himself. Anyway, they only come round once a fortnight.'

'When is their next visit?'

'You've missed it.... It was last week. So it looks like your brother will be discharged before the next one.'

'Don't you understand what I'm telling you? ... He will die if he goes back to that flat.'

The doctor cut across me: 'Your brother's body is mended now. I've done my job. What goes on in his mind is none of my business.'

I found my brother dead in his flat within a few weeks of this incident.

This testimony is provided by a member of the RCPsych Carers' Forum.

We recommend that, for the next 2 years, the Department of Health should consider how the work of the Time to Change initiative can improve the attitudes of mental health and other health professionals towards people with mental health problems and their carers.

The BMA and medical Royal Colleges should consider how doctors can adopt a more aspirational approach to the care of people with mental health problems, such as is found within physical healthcare, in relation, for example, to recovery. This would also have significant benefits for the employment prospects of people with mental health problems, given the established link between employment and mental health.

## Equality Act 2010

The Equality Act 2010 established that mental impairment (where the impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities) is a protected characteristic. Since April 2011, public authorities have had a duty, *inter alia*, to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act and to remove or minimise disadvantages suffered by people due to their protected characteristics.<sup>101</sup> As such, there is a legal requirement for the different elements of the Health Service to develop mechanisms to address both implicit and explicit discrimination.

Academic studies which have demonstrated implicit discrimination against people with mental health problems within healthcare systems<sup>60,61</sup> have been dependent on comprehensive data collection. The Department of Health should consider the methodology these studies have utilised when devising its own strategy for tackling discrimination. The Department should also conduct a literature review to identify examples of implicit discrimination experienced by people with mental health problems within the wider healthcare system and use this to inform its approach and areas of initial focus.

## Values-based approach to mental healthcare

The Department of Health, the NHS Commissioning Board, CCGs and mental health providers should consider developing a human rights-based values approach to healthcare commissioning and provision to improve standards of care. A useful way of conceptualising these values is the FREDA framework (Fairness, Respect, Equality, Dignity and Autonomy), whereby all five aspects are jointly considered, and the framework informs rather than determines decisions.<sup>102</sup> There is an encouraging (if nascent) evidence base that a bottom-up approach based on FREDA principles can improve service user outcomes.<sup>103</sup>

## Medical and nursing education

The GMC and NMC should consider how medical and nursing study and training could give greater emphasis to mental health. This would help to improve the care and treatment provided by non-specialists to people who present with mental health problems, and to those with physical health problems who develop mental health problems. Mental and physical health should be integrated within undergraduate medical education, with an emphasis on joint placements and on engaging with service users who have comorbid physical and mental health problems.

Medical and nursing examination curricula and training routes should incorporate the key skills required to ensure a holistic approach to the diagnosis, care and treatment of ill health. For example, examinations for psychiatrists should cover aspects of the diagnosis and treatment of common physical health problems experienced by people with mental health problems, and those for physicians should cover depression, health anxiety and severe mental illness. Joint training sessions at postgraduate level would also be beneficial.

Psychiatrists should learn from physicians about attitudes towards risk and how it is collaboratively handled with patients, as part of medical education and continuing professional development. Similarly, an appreciation of the underlying psychological reasons why someone is, for example, obese or alcohol-dependent would be highly beneficial for physicians.

## Mental health awareness training

The GMC and the NMC should review the place and role of evidence-based mental health awareness training for all doctors and nurses.

## Commitments

The BMA Psychiatry Sub-Committee is fully supportive of achieving parity of esteem between mental and physical health, and will be pursuing appropriate avenues with a view to having these principles adopted as BMA policy.

The Royal College of Anaesthetists (RCoA) will offer support and engage with the AoMRC positioning on parity by pushing the message on its own website(s); there is also the possibility of a *Bulletin* article.

The RCPsych, in its efforts to achieve parity, will continue to meaningfully engage with service users and carers to learn about their lived experience of mental health problems and services.

The RCPsych will recognise excellence in delivering parity through an open category at the RCPsych Awards (from 2014 onwards).

# NHS Outcomes Framework

## Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

There are a number of areas where action needs to be taken to protect people with mental health problems from avoidable harm, and where there is evidence that their care is not on a par with that of people with physical health problems:

- Safe care for people with mental health problems who are giving up smoking, as doses of some medications for mental health problems need to be reduced by up to half within 4 weeks of cessation; otherwise, toxicity develops. This is addressed in the section on Domain 1, which contains recommendations for improving care in this area.
- Good prescribing practice is central to protecting people with mental health problems from avoidable harm, and this is addressed below.
- In-patient mental health wards, also addressed below.

### Safe prescribing

The RCPsych Prescribing Observatory for Mental Health has observed a wide variation in the prescribing practices of healthcare organisations in terms of their compliance with evidence-based clinical practice standards.<sup>104</sup> The Royal Pharmaceutical Society (RPS) recently undertook a consultation about 'Getting the Medicines Right – When the Patient Transfers Between Care Providers', which identified that 30–70% of patients have an error or unintentional change to their medicines when they transfer between acute providers.<sup>105</sup>

Within mental health this problem will likely be exacerbated by the number of transfers that occur within the various teams of NHS mental health providers and a number of other factors that affect the ability of pharmacy to intervene. Multiple interfaces between clinical teams, variable access to support services such as pathology, variable quality of electronic patient record systems and the relatively poor development of electronic prescribing systems in comparison to primary care and acute medicine suggest there are likely to be more challenges in prescribing within mental health than there are within physical health (D. Branford, Chief Pharmacist, Derbyshire Healthcare NHS Foundation Trust, personal Communication, 12 July 2012).

Common characteristics of the service user group in terms of their vulnerability, limited access to advice and comorbid physical health problems may compound this. Other issues that relate to the prescribing of medicines in mental health include the widespread prescribing of medicines, both at doses outside those recommended in the *British National Formulary* (BNF) and for indications outside that for which there is a licence, as well as the widespread use of

combinations of psychotropic medicines (which may individually appear reasonable but when taken together increase the risks of untoward events). Training about medicines for mental health nurses is very weak, when compared with that for nurses in a general setting. In addition, the availability of mandatory study time for nurses to undertake further training to remedy these deficiencies is minimal (D. Branford, Chief Pharmacist, personal communication, 12 July 2012).

Training for paediatricians in psychopharmacology prescribing is also weak and can lead to inappropriate prescribing.

The New Medicine Service (NMS) is a recent initiative to encourage community pharmacists to provide additional inputs within the first few weeks to people receiving a number of specific treatments. Four conditions/therapy areas were selected to be included in the initial roll-out of the NMS. Depression – an area renowned for poor adherence and problems in the first few weeks of treatment – was not included.

## Recommendations

Mental health services should ensure that medicines reconciliation occurs as a routine part of every admission to care within mental health services. This should include admission to crisis resolution home treatment (CRHT) teams, and other community teams. When GP medicine records are incomplete due to lack of provision of information from the mental health trust, it should be the responsibility of the CMHT to inform GPs to amend their records.

Mental health service providers should ensure that all care coordinators receive training and support to enable them to ensure that the medicines aspects of a service user's care are attended to.

Psychiatrists, pharmacists and GPs should work more closely together to coordinate prescribing for comorbid conditions.

Mental health medicines should be included in the pharmacy New Medicine Service.

## Commitments

The NHS Confederation Mental Health Network will work with the College of Mental Health Pharmacy (CMHP) to promote the value of community-based specialist mental health pharmacists for helping to ensure that plans for service users' medicines are followed through, and will disseminate examples of good practice in this area.

The RCoA will work with the RCPsych and the RCP to consider how anaesthetists could work with psychiatrists and physicians to better evaluate the risk of anaesthetics for someone who already has mental health issues, particularly dementia, and be clearer on possible outcomes.

The RCPCH review of its training for paediatricians will include a review of its psychopharmacology training.

The RCPsych will continue to host and support national audits such as the Prescribing Observatory for Mental Health (POMH-UK) and the National Audit of Schizophrenia, which aim to improve prescribing practices and the quality of healthcare that people with mental health problems receive.

The RCPsych, CMHP and RPS will explore with the NMC and the NHS Confederation Mental Health Network the potential for a more significant component of teaching about mental health medicines in the undergraduate training of all nurses, in particular mental health nurses, and in the training of nurses by mental health provider organisations.

The RCPsych, RCGP, CMHP and RPS are committed to working together to review shared care of the prescribing of psychotropic medicines and any professional training needs in this area.

## In-patient mental health wards

There is a consensus within the working group that the condition of much, if by no means all, of the mental healthcare estate is of a significantly lower standard than that of the physical healthcare estate. It is noteworthy that the NHS Premises Assurance Model (PAM), which gauges the quality of healthcare premises, did not originally include mental health provision; the recent amendment of the metrics to include mental health is, however, very welcome.<sup>106</sup>

Providing a relaxed, comfortable, safe and predictable environment is essential to recovery and can be fostered through physical surroundings. A ward's physical environment should be considered as part of patient treatment and should be factored into the early designs of wards.<sup>107</sup>

A 2008 Healthcare Commission survey of service users on in-patient mental health wards discovered that less than half (45%) reported that they 'always' felt safe on the ward.<sup>108</sup> In contrast, a 2011 CQC survey found that only 3% of people on physical health in-patient wards reported feeling threatened by either other service users or visitors.<sup>109</sup> This disparity is not only morally unacceptable but also has clinical implications, as mental health service users who have previously experienced a frightening, unsafe ward may delay voluntarily re-engaging with services, to the point where their condition significantly worsens and coercive treatment sadly becomes necessary.<sup>110</sup>

The CQC's 2010/11 examination of mental health in-patient conditions found that 88% of wards were successfully complying with the Mental Health Act Code of Practice's direction that single-sex sleeping areas, toilets, bathrooms and lounges be provided. Whereas the remaining 12% do potentially represent a safety risk to female service users, it is also important to consider how ward culture might affect the reporting of an intrusion of a service user of a different sex onto a neighbouring ward.<sup>111</sup>

## Recommendations

The Department of Health should ensure that data on safety in mental health in-patient services continue to be collected, in a manner directly comparable to physical health in-patient services (if not as part of the same survey, which would be preferable) so that progress towards parity can be measured.

There should be an expectation at every level of provision and accountability from the NHS Commissioning Board down to individual members of staff that in-patient mental health units should consistently be safe, calm and therapeutic environments.

The NHS Commissioning Board should as an early priority extend the NHS staff 'family and friends' test to mental health in-patient wards. This test asks staff whether they would recommend a health setting as a place for their family to be treated.

The CQC should reinstate its annual survey of mental health acute in-patient services, or identify a different mechanism for considering the experiences of mental health in-patients, given that mental health patients are excluded from the general in-patient survey.

Mental health providers should review the physical environment within which they provide care, and consider whether it is fit for the purpose of providing a therapeutic environment.

# A life-course approach: early intervention, children and young people and older people

Much of the evidence and many of the recommendations in this report relate either to working-age adults or across the spectrum of services. However, specific action is also needed for achieving parity for children and young people and older people.

## Early influences on mental and physical health

*The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during those early years, starting in the womb, has lifelong effects on many aspects of health and well-being, from obesity, heart disease and mental health, to educational achievement and economic status.<sup>39</sup>*

There is now substantial evidence from a broad range of interdisciplinary fields, including developmental neuroscience, molecular biology, epigenetics and developmental psychology, of how brain architecture is shaped by the interactive effects of both genetic predisposition and environmental influence, and how this affects health, learning and behaviour throughout the life course.<sup>112</sup>

The longitudinal Adverse Childhood Experiences (ACE) study found that childhood experience of adversity associated with such experiences as child abuse, neglect, domestic violence, parental separation/divorce, and living in a household with substance misuse has been linked to a range of compromised physical and health outcomes. For example, children with a single ACE of emotional neglect, physical neglect or living with substance/alcohol misuse in the family at the age of 0–3 years were three times more likely to develop heart disease. If a child had experienced four or more adverse childhood experiences, they were three times more likely to develop depression, 11 times more likely to engage in intravenous drug use, twice as likely to develop liver disease and three times more likely to develop chronic obstructive pulmonary disease.<sup>113,114</sup>

A review of research shows that half of all lifetime cases of diagnosable mental illness, other than dementia, have begun by the age of 14,<sup>115</sup> and there is evidence that improved availability of early intervention services for children and young people could prevent up to 50% of adult mental illness.<sup>116</sup>

However, as stated above, the level of treatment of childhood mental illness is, at only 25%,<sup>6</sup> very low, nearly identical to the adult level.

An early-intervention and life-course approach is vital for tackling parity issues and can save money in the longer term, not least in the prison estate and forensic mental health services, as the impact of mental health needs of all kinds over time are exacerbated by lack of early support and understanding, both early in life and early in the onset of mental health problems. Early, appropriate and effective support is required in primary care and in other generalist support services, as well as in secondary and tertiary care services for more severe or disabling conditions. Graham Allen MP, in commending his report on early intervention to the Prime

Minister in 2011, described the need for a commitment to 'provide a social and emotional bedrock for ... current and future generations of babies, children and young people by helping them and their parents (or other main caregivers) before problems arise'.<sup>117,118</sup>

There must also be widespread recognition of the social and cultural factors affecting mental health, such as exclusion, trauma, abuse, domestic and other violence, and other social and inter-personal stress. Social policy on poverty, employment, violence, parenting and body image issues, to name but a few, are just as important for achieving parity as efforts to reform healthcare.

## Infants and very young children

The United Kingdom is a signatory to the United Nations Convention on the Rights of the Child, Article 24 of which affirms the right of children to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.<sup>119</sup>

The Marmot Review examined and presented extensive evidence for how health inequalities result from social inequalities and the need for action to reduce health inequalities across the social determinants of health. The Review identified 'giving every child the best start in life' as 'crucial to reducing health inequalities across the life course', and emphasised as a key priority objective the need to 'build the resilience and well-being of young children across the social gradient'.<sup>39</sup> Such an approach has the potential to prevent the development of longer-term mental health problems and can save money.

Efforts to achieve parity thus need to begin with preconception care and to continue throughout the life course. This means considering the mental health needs of infants equally with their physical health needs, and adopting health and social care approaches which optimise their development at this stage of life, with a particular focus on the quality of the relationship between parents and their infants.

The significance of adverse childhood experiences on mid-life mental and physical health outcomes cannot be overestimated,<sup>120</sup> both for quality of life and their cost to society, and there is significant scope for child mental health services to mediate this link.

There is a need to create family and social environments that nurture and understand children and young people from infancy onwards and are capable of responding appropriately at an early stage when problems arise.

### Case example: Early intervention for under-3s

The Mental Health Foundation and London Borough of Sutton have established an early-intervention and prevention project designed to support the emotional well-being of young children. The project will deliver an early-intervention and prevention programme to under-3s and their families in Sutton. It will:

- offer a universal service to all during pregnancy
- focus on preparation for parenting and attachment
- focus on parent–infant relationships, development of emotional well-being, resilience, self-esteem and autonomy
- promote secure parent–infant relationships and set a template for effective parenting
- have reflective parenting as a central theme
- include a key focus on fathers (research shows significantly better outcomes for infant well-being with fathers' engagement)
- target complex ('troubled') families who are struggling with attachment and have risk factors
- offer a 'buddy' (through voluntary sector input)
- include the views of parents in shaping activities.



## Recommendations: pre-birth and earliest years

The priority objectives and policy recommendations of the Marmot Review Policy Objective A, to give every child the best start in life, should be fully implemented. These include supporting families to achieve progressive improvements in early child development.<sup>39</sup>

Commissioners should ensure that antenatal and postnatal education for parents includes a focus on the emotional well-being of both the infant and the parents. They should also invest in perinatal and parent–infant mental health services to work with particularly vulnerable parents and babies and with families where there are parenting difficulties. The provision and function of such specialist services are currently variable and inequitable, and it is considered there is significant unmet need in this area.<sup>11</sup>

Consideration should be given to adopting the use of a simple assessment tool, which can be used at a universal level by health visitors and family-intervention projects, to aid early identification of families where further support would be helpful for nurturing an appropriately responsive and attuned relationship between mother and child. It is important that such a tool should be used universally only if additional support is also available to families when this is needed. The Solihull approach adopted by many health visiting and family nurse partnership services across the UK is a well-evaluated tool.<sup>121</sup>

Another tool that can be used is the Ages and Stages Questionnaire – Social and Emotional (ASQE-SE).<sup>122</sup> This is a parent-completed child monitoring system for social-emotional behaviours designed to identify those children who may need help with, or further assessment of, social and emotional development. This was designed to encourage screening of large numbers of children in an economic and efficient way. The questionnaires are designed to be completed at different stages of development up to 65 months and can be used either to monitor change or as a single measure. Each questionnaire comprises 30 developmental items, divided into five areas (communication, gross motor, fine motor, problem-solving and personal-social) written in simple language accompanied by illustrations. A parent can choose to respond 'yes', 'not yet' or 'sometimes'. The person scoring converts each answer to a point value and then generates a total score, which can be compared with established screening cut-offs.

Widely used in the USA, the ASQE-SE is gradually becoming a widely used tool in the UK. For example, in Gloucestershire all health visitors and pre-school workers use this tool to identify children in need of further assistance from secondary services. In addition, they are able to use a tool developed by Robin Balbernie, a consultant child psychotherapist, from a review of the literature of risk in infant mental health. This tool, the Stress on the Care Giving Relationship, has not been developed as a tool for scoring and early identification but to help professionals working with infants who may not be fully au fait with the extensive literature on infancy mental health risk to think through their cases and identify those babies and families who are likely to need secondary intervention and support.

## Commitments

The Royal College of Obstetricians and Gynaecologists (RCOG) will develop an advanced training study module on psychiatric illness in pregnancy, to educate young obstetricians in the processes of supporting a person with a psychiatric illness through pregnancy and the puerperium. It also aspires to develop a similar programme for disadvantaged and refugee people.

## Children and young people

### Pre-school programmes

The net benefits of pre-school educational programmes for 3- and 4-year-olds with low IQ and low income are the equivalent of £17 for each £1 invested.<sup>123</sup> Savings arise from better school performance, higher income, reduced crime, fewer drug problems and reduced use of antidepressants.

Interventions for 3- and 4-year-olds are much more cost-effective than interventions for those aged 5 or over, or prenatal interventions,<sup>124</sup> although such programmes are also needed. Those at highest risk benefit the most from early childhood programmes.<sup>125</sup>

## Schools

Schools should take children and young people's mental health as seriously as their physical health; their role in promoting children's mental health and well-being should be recognised as a key element of early-intervention work to build children's resilience, enhance their well-being and identify and respond early to mental health problems.

Research shows that school-based mental health promotion significantly improves well-being, which in turn has a significant impact on academic performance, social and emotional skills, and classroom behaviour.<sup>126,127</sup>

In primary schools, an integrated approach, using universal and targeted interventions, is cost-effective and can prevent negative behaviours which otherwise have costly consequences for health services, social services and the criminal justice system.<sup>12</sup>

Secondary-school curriculum approaches to promote pro-social behaviours and skills can also prevent the development of anxiety and depression.<sup>128</sup> A meta-analysis of more than 270 000 students from a US social and emotional programme found a 10% decrease in classroom misbehaviour, anxiety and depression, as well as an 11% improvement in achievement tests and a 25% improvement in social and emotional skills.<sup>128</sup>

Further:

- Prevention of conduct disorder through school-based social and emotional learning programmes results in total returns of £83.73 for every £1 invested. Cost savings over 2 years are more than twice the initial investment, with cumulative gross savings per child of £6369 after 5 years and £10 032 after 10 years.<sup>47</sup>
- School-based interventions to reduce bullying result in total returns of £14.35 for every £1 invested.<sup>47</sup>
- School-based violence-prevention programmes are cost-saving by year 3, with net savings of £829 per child at year 6 and £6446 at year 10.<sup>129</sup>

The extension of the IAPT programme to children and young people (<http://www.iapt.nhs.uk/cyp-iapt>) is a welcome step in broadening access to mental health for children who may fall below the threshold of secondary care mental health services. Its embedding into CAMHS is a good example of ensuring an integrated pathway of care, and this needs to continue. However, clarity is needed, as stated above, on where the national IAPT programme will sit in the future.

## Recommendations

### Schools

The Department for Education should encourage the widespread adoption in pre-school and school settings of well-evidenced programmes shown to have positive effects on children's mental health.

Schools, with the encouragement of the Department for Education, should implement the NICE public health guidance on mental health promotion in schools.<sup>12,13</sup> This aims to develop psychological, emotional and social skills to support resilience and coping mechanisms and will help to develop better mental health 'literacy' in children and young people. In the longer term this has the potential also to contribute to less stigmatising attitudes to mental ill health in the wider population, as well as to earlier identification of and response to mental health problems throughout life, through educational and therapeutic means.

## Recommendations

### Professional understanding of child development

All professionals working with children and families should be able to identify mental health problems, and factors that adversely affect mental well-being, at an early stage, including signs of abuse and neglect, and to respond to them effectively. They should be trained in child development, the importance of emotional resilience, the relationship between a child's physical and mental development, and the determinants and risk factors for poor emotional and mental health. This is a vital underpinning for an early-intervention approach both to children's mental health problems and to population mental health as a whole.

The Children and Young People's Health Outcomes Forum has also highlighted such training as a priority for action.<sup>10</sup>

The working group strongly supports the proposed extra year for GP training, which presents an important opportunity to teach more about child development and mental health, and the relationship between physical and mental health.

The Health and Care Professions Council should consider including a child development and a mental health module as part of mandatory core training for social workers, not just as specialisms. This could be complemented by a greater focus in the children and families specialism on the relationship between physical and mental development.

Health Education England (for healthcare staff) and the Teaching Agency (for early-years and teaching staff) should map the quality and quantity of training that currently exists in this area, including initial training and continuing professional development, and review the common core of skills and knowledge in workforce training. Relevant training should be developed and put in place where this is lacking.

Local authorities and NHS services should ensure that child development and child mental health are included in child safeguarding training to ensure a full understanding of the role of violence and abuse in the development of mental health problems.

## Commitments

The RCPCH is launching a major review of child health research in the UK, which will include a focus on mental health.

The RCPCH is scoping the options for developing an alliance/coalition of children's healthcare professionals and organisations to promote best possible service models, research and education in children's health services. One aim will be to ensure that CAMHS are given the priority that they urgently need within the children's service framework.

The RCPCH will review its training for paediatricians, including the curriculum, competencies and assessments to ensure there is sufficient focus on mental health.

The RCPCH would be supportive of a review of the undergraduate medical curriculum to ensure there is emphasis on both physical and mental health.

The RCPCH is working with the RCPsych and others to develop an e-portal (funded by the Department of Health) on children and young people's mental health issues. This aims to ensure that everyone involved with children and young people has appropriate understanding and knowledge about mental health issues.

The RCPsych and the RCPCH will explore how, within the new structures, they might assist schools to support children and young people who have mental health problems and thus help them to thrive in school.

Young Minds will work with schools to prioritise parity of esteem via the BOND (Better Outcomes, New Delivery) Project, Young Minds in Schools and the Children and Young People's Mental Health Coalition.

## Transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS)

Transition from child and young person services to adult equivalents is not perfect within physical healthcare. A 2002 study found that attendance of young people at four diabetes services averaged 94% before transfer to an adult clinic but fell to 57% 2 years after transfer. There was large inter-district variation in clinic attendance 2 years post-transfer (29–71%).<sup>130</sup> The Department of Health examined this issue in its 2006 report *Transition: Getting It Right For Young People*, although this report did not cover mental health services. This is regrettable, as the quality of transitions between mental health services is an area that could be significantly improved.

The TRACK study, which evaluated the process, outcomes and user and carer experience of transition from CAMHS to AMHS, found in 2010 that 'optimal transition, defined as adequate transition planning, good information transfer across teams, joint working between teams and continuity of care following transition, was experienced by less than 5% of those who made a transition'.<sup>131</sup>

It is very important that children and young people have a positive experience of mental healthcare and are supported in making a successful transition to adult mental healthcare.

### Recommendations

There is evidence that a large number of transitions are not good enough; for example, only 5% of CAMHS to AMHS transitions are 'optimal', yet the NHS has pledged through the NHS Constitution to ensure that service users have as smooth a transition as possible when referred between services, and be fully included in all relevant discussions. This is an area that requires substantial improvement. We recommend that consideration is given to how transitions can be made as smooth as possible, for example through payment incentives, or a pooled budget.

Commissioners of CAMHS and AMHS should develop services to allow greater flexibility to enable a smoother and more supportive transition from children's to adult mental health services. This should focus on young people moving when they are developmentally ready, not just when they reach a particular age. A joint assessment team comprising staff from both AMHS and CAMHS to create a joint transition plan would assist in more effective transition.

CAMHS staff and managers and participation workers should ensure that young people are at the centre of this planning process, to enable shared decision-making that results in the most effective and supportive transition plan.

Providers of mental health services should develop an assessment framework to support collaborative decision-making with the young person, and increase the likelihood of services being more flexible. We recommend a model that also includes 'transition' meetings between CAMHS and AMHS, with the young person present, that can be used either as a decision-making forum or to help the young person transition more smoothly into AMHS.

## Older people

Depression is highly prevalent in older people (around 12% of the over-65 population), although both access to treatment and the nature of treatment are poor. Only 6% of older adults with depression are referred to mental health services (compared with 50% of working-age adults with depression) and only one in six older adults receives any treatment at all for their depression.<sup>132</sup>

There is a need to support health professionals in both primary and secondary care to improve the diagnosis and treatment of dementia. In primary care, surveys have indicated that around 40–50% (rising in some areas to 80%) of GPs do not feel that there is any benefit in early diagnosis of dementia.<sup>133</sup> Furthermore, the positive predictive rate for a GP diagnosis of dementia (when it is made) is 16%,<sup>134</sup> meaning that for every six people whom a GP thinks has dementia, only one in fact has it.

This reflects the fact that the onset of memory problems presents a particularly complex diagnostic challenge for clinicians and that it is difficult to make an accurate 'early' diagnosis of dementia using clinical tests. While factors might include a lack of GP confidence in this area and access to memory clinics, persistent widespread diagnostic stigma and the need to treat comorbid conditions and to avoid 'false positives' by excluding treatable (and reversible) causes of memory disturbance such as depression or megaloblastic anaemia are also important.

There is a range of evidence-based early interventions available, for example for people with Alzheimer's disease, with growing evidence that they are effective in treating symptoms, including improving cognitive function, treating depression, improving the carer's mood and delaying institutionalisation<sup>135</sup> and its consequent expense. However, despite progress being made, the ultimate progression of the underlying disease is not yet affected by these interventions.

Health professionals should be supported to make a timely diagnosis and ensure that individuals, their families and carers are able to access support.

Alongside this there is a need to raise awareness of dementia among patients and tackle stigma associated with the condition. There is also a need to dedicate resources to improving access to both assessment and treatment services once a person has been diagnosed with dementia; for example, in some areas there are considerable problems with access to memory clinics.

A further challenge is that one-fifth of all those receiving treatment within a typical acute hospital will have dementia.<sup>136</sup> Of those admitted as emergencies, only half will have been previously diagnosed with dementia<sup>137</sup> and they will be part of only a third of all people with dementia who will receive a diagnosis at all.<sup>138</sup> Many people with possible dementia do not receive a psychogeriatric assessment on admission.<sup>139</sup>

A common misunderstanding about the needs of older people is that dementia is the most prevalent, and even inevitable, mental health condition. In fact, dementia accounts for only a quarter of the psychiatric morbidity among the over-65s and is by no means an inevitability; although the incidence does increase with age, more than two-thirds of people over 90 years of age will not suffer from it.<sup>140</sup>

Older people tend to have multiple physical comorbidities (such as stroke, Parkinson's disease or heart disease) or frailty, which often complicate their mental health treatment. Many older people also have specific cognitive problems, social issues or end-of-life concerns which may precipitate or sustain their illness.<sup>141</sup> For these reasons, older people require specialist older-adult services for all aspects of mental healthcare, and not just for dementia.<sup>141</sup>

The compulsory cut-off point of the age of 65 for many AMHS (when people 'graduate' to mental health services for older people whether they want to or not, and may experience care of a lower quality than they did before) has been described by the Centre for Policy on Ageing as 'one of the few remaining examples within the NHS of explicit institutional "direct" age discrimination'.<sup>142</sup> The Equality Act 2010, which came into force on 1 October 2012, now makes such discrimination illegal. However, to integrate older adults' mental health services into 'ageless' services makes no sense; older people have very different physical, social and psychological issues, which require specialist old age psychiatrists working in specialist services for older adults.

The Department of Health has acknowledged the underrepresentation of over-65s in the IAPT initiative (4% as opposed to an anticipated 12%) and, in line with the provisions of the Equality Act 2010, has made a commitment to undertake various corrective actions to address this.<sup>143</sup>

## Recommendations

CCGs should ensure that older people have access to comprehensive, specific older people's mental health services that can diagnose and manage all mental illnesses and not just dementia.

CCGs should strongly consider making flexibility of access a cornerstone of service contracts, so that someone being treated within AMHS, for example for depression, does not become automatically ineligible to continue to be treated by that service once they pass 65 years of age, and someone under the age of 65 with, for example, early-onset dementia can access the expertise of comprehensive older adult mental health services. This is important for fulfilling public sector duties under the Equality Act 2010. CCGs should ensure they provide specialist age-appropriate services that have porosity with adult services to ensure the mental health of this disadvantaged population is appropriately addressed.

### Case example: Non-discriminatory service criteria for older adults' psychiatry services

A large mental health trust in north-west London underwent an extensive programme of consultation and evaluation to develop meaningful, non-discriminatory service criteria for older adults' psychiatry services. These have been adopted locally and work well. The criteria are:

- People of any age with a primary dementia. (This excludes traumatic brain injury and Korsakoff syndrome).
- People with mental disorder and significant physical illness or frailty which complicates the management of their mental disorder. Exceptionally this may include people under 60.
- People with psychological or social difficulties related to the ageing process, or end-of-life issues, or who feel their needs may be best met by an older adults and healthy ageing service.

These criteria meet the exigencies of the Equality Act 2010 while providing logical criteria for older adults' psychiatry services.

Physicians should be able to do basic capacity assessments and to distinguish between delirium and dementia.

More funds need to be made available for research into older people's mental health. A 2010 study found that dementia was costing the UK 200% as much as cancer but receiving 3.8% of the research funding.<sup>144</sup> The recent announcement that research funding for dementia will double to more than £66 million by 2015 is extremely welcome, and should be highlighted as an important step towards parity.<sup>145</sup>

# Measurement and monitoring of parity: data, research, audit and inspection

## Observational data collection

There are many sources of data available to monitor prevalence rates of mental health problems, mental health service use and quality of services. These include the mental health minimum data-set (MHMDS), national psychiatric morbidity surveys, hospital episode statistics (HES), Care Quality Commission (CQC) surveys and reports, Improving Access to Psychological Therapy (IAPT) reports, Audit Commission reports, NHS Quality Observatory and Public Health Observatory data, community care statistics, surveys of attitudes to mental illness, patient surveys (where service user researchers may play a central role) and reports from the National Confidential Inquiry into Suicides and Homicides by People with a Mental Illness.

There is a similar range of data collected on physical health problems.

Commissioners and health and well-being boards should use data from the national Public Health Observatories and NHS Quality Observatories to highlight differences in expenditure and uptake of physical healthcare for people with mental health problems, and whether resources spent are appropriate to the assessed needs of the population.

However, only a few of these data sources record anything other than factors to do with the primary diagnosis, so there is in fact very little data available for analysis and action (such as making commissioning decisions or reconfiguring services) in respect of people with co-morbidity or multiple morbidity. This is the basis for major inequalities in mental health, with people with a primary diagnosis of a mental health problem having significantly poorer physical health (possibly as a side-effect of medication), and in many cases dying earlier of treatable diseases, than the general population. In addition, people with physical health problems with mental health comorbidities also have poorer outcomes and cost more to care for.

National surveys, such as the psychiatric morbidity surveys, have a key role in highlighting poor physical healthcare for people with mental health problems. Analyses of these surveys have provided much of the evidence of disparity in treatment that informs this report. However, it is not clear whether the adult national psychiatric morbidity survey is to be published again. Occurring every 7 years, it provides the most comprehensive national data-set on mental health problems, which highlighted that in 2007 only a minority of those with mental health problems received any treatment.<sup>42</sup>

Comprehensive data on children and young people's mental health used to be provided by the child and adolescent national psychiatric morbidity survey. This population survey of 8000 children and adolescents also occurred every 7 years and was the single largest data-set providing information about levels of mental health problems among children and adolescents across the country. The last survey was published in 2005.<sup>6</sup>



## Recommendations

### National psychiatric morbidity surveys

The Department of Health should continue the adult psychiatric morbidity survey to underpin its commitment to achieving parity. Without it, we lose the most comprehensive, and therefore important, information we have about the prevalence of mental health problems and our efforts to treat them. This information will be vital for measuring the impact of actions to achieve parity for mental health.

The Department of Health should also consider reinstating the child and adolescent national psychiatric morbidity survey and should repeat its survey of psychiatric morbidity among prisoners in England and Wales. Since the survey published in 1998,<sup>146</sup> the number of prisoners in England and Wales has increased by c.18 000,<sup>147</sup> and there is a need for up-to-date data on the mental health of this very vulnerable population.

### Quality and outcomes

There is a strong argument for strengthening data-sets by including not only data on primary diagnoses, but also on co- and multi-morbid diagnoses. CQUIN might also be used to reward improvements in recording and treating physical and mental comorbidity.

Planners and commissioners should benchmark mental health provision and outcomes against physical health provisions. This should be undertaken locally by planners, commissioners and service providers so that parity of esteem for mental health is a reality – something they need to ensure under direction from the NHS Commissioning Board and within the Implementation Framework for the mental health strategy. The Commissioning Outcomes Framework (COF) can also be used to support commissioners to include parity issues in their service specifications.

The determination of outcomes should be strongly informed by users and carers. This would ensure that outcomes reflect a recovery approach, as opposed to a purely clinical one, which is important for mental health in particular. We recommend that further development of mental health-related patient reported outcomes measures (PROMS) should be included within the NHS Outcomes Framework and Commissioning Outcomes Framework. Benchmarking activity could include the following:

- comparisons of measures of patient and carer involvement, such as the opportunity people were given to ask questions about their condition and care, for example who to contact when they need help with their care, and whether they have a number for a person to contact in an emergency
- comparisons between delayed discharges (including those waiting in prison for transfer to hospital for care)
- comparison between levels of satisfaction with care/treatment/care environment (especially in-patient)
- comparison of staff attitudes towards patients
- comparison of information given about potential side-effects of medication
- comparison of information given about general healthy-living improvements (e.g. diet, exercise, smoking cessation)
- comparison of range of choices offered to patients
- comparison of identification and treatment of comorbid problems
- comparison between waiting times for assessment and treatment (and specifically treatment in A&E units and treatment in an emergency/crisis situation)
- comparisons between how patients, although unwell, rate their time 'spent well'.



Primary care is increasingly important for the support of mental health, including for people previously receiving mental health services. Results and experiences in primary care should be the same for both physical and mental health issues, yet there is considerable variation in awareness and understanding of mental health within primary care. This can create barriers for people with mental health problems in accessing physical and mental healthcare within primary care, which in turn leads to poor outcomes. We would like to see incentives addressing parity of care within the QOF.

## Parity of measurement of service use and outcomes

The Department of Health and NHS Commissioning Board should encourage parity of measurement of service use and outcomes for mental health service users who require physical healthcare through examining how existing and future data registers, such as those for cancer and diabetes, can be utilised to learn more about comorbidity of physical and mental health problems. Our understanding is that there is a significant amount of unanalysed data on mental health in some cancer data-sets (Professor Sir Mike Richards, National Clinical Director for Cancer, personal communication, July 2012). There thus already exists unrealised potential to learn more about comorbidity of physical and mental health problems in this area of care; the same may be true in other areas.

## Proposed new ratings system for health and social care

The proposed new ratings system for improving standards of health and social care should give equal attention to providing information about mental healthcare.<sup>148</sup>

## Research

Parity should inform decision-making about all areas of health and social care research and development. This is partly a question of funding, to make sure that mental health research receives its share of the research budget proportionate to the health, social and economic burden that poor mental health imposes on the country. As stated above, mental illness has the largest proportion of disease burden in the UK, at 22.8%. In England alone, mental illness costs over £105.2 billion a year,<sup>28</sup> through the costs of medical or social care, loss of production and a monetary valuation of the human cost of disability and distress.

Health researchers and research funders need to recognise the scale of mental health problems and commit to funding research programmes that will produce the evidence to reduce this burden, both for the sake of individuals who experience mental health problems and for society more generally. This includes looking at patient experience and patient-defined quality-of-life measures, and involving service users in designing and collaborating in the research.

## Recommendations

### Co- and multi-morbidity

To inform their efforts to achieve parity, each NHS Commissioning Board domain lead should collect, analyse and report data (including currently unanalysed existing data) on people with and without mental health problems.

The Department of Health should consider a refocusing of research onto areas of co- or multi-morbidity, involving mental health and physical health problems, rather than single diseases/disorders. This would help to demonstrate the interconnectivity of mental and physical health, and to underpin the developments of evidence-based treatments that address all an individual's health needs, not just their primary diagnosis.

## Attitudes and culture affecting the treatment of people with mental health problems

To help understand why mental health does not enjoy parity of esteem at present, there should also be a greater research focus on health and social care staff culture, attitudes and behaviour towards patients with mental health problems; and further research on the factors behind why people with more severe mental health problems are at higher risk of dying earlier from treatable diseases.

## Recovery

To improve the evidence relating to models of support for individuals' recovery, it would be beneficial to promote more social care research in mental health, to include not only clinical resolution, but also social recovery and self-management when problems persist. Social recovery often enables people to maintain themselves in communities, thus reducing demand on formal services (acute services in particular).

# Audit and inspection

Greater transparency of new and existing sources of data on the treatment that people receive would help service users and carers demand improvements to current care.

National audits such as the National Audit of Schizophrenia provide a valuable means of assessing the prevention and treatment of physical health problems among people with mental disorders. Similarly, data collected through established national audits of stroke, cancer and other conditions should be used to ensure that the mental health needs of people with acute and chronic physical health problems are being met. Future audits of people with intellectual disability and cognitive impairment provide a valuable opportunity to assess parity by examining the quality of care that people receive.

Use of the Department of Health 'You're Welcome' criteria<sup>149</sup> to audit NHS organisations providing care for young people would support the development of high-quality young-people-friendly health services.

## Recommendation

The CQC has an important role in monitoring compliance with legislation, guidance and standards affecting parity. It should, working with existing third-sector quality networks (for example those operated by the RCPsych College Centre for Quality Improvement), assess the provision and quality of physical healthcare for people with mental health problems and vice versa, in order to assess other organisations' efforts to deliver parity of esteem.

# Commitments

The RCPsych College Centre for Quality Improvement (CCQI) will embed the principles of parity of esteem within all of its quality networks.

The CQC will consider whether the physical healthcare needs of mental health service users, and the mental healthcare needs of people using services for long-term conditions, are suitable topics for its programmes of themed inspections and thematic reviews of data.

The CQC will explore whether there are indicators that it can use to identify when routine compliance inspections should focus on the physical healthcare needs of mental health service

users, and the mental healthcare needs of people using services for long-term conditions. Indicators might, for example, come from tracking patient contacts through the different data-sets for mental health, primary care and hospital and community healthcare, or from other sources, such as accreditation and survey data.

# A cross-government approach to parity

Parity is an issue not only for health and adult social care services – those for which the Department of Health takes government responsibility. Population mental health is also affected by many policies for which other government departments are responsible, and can be improved by actions they can take, for example providing adequate housing. It is thus vital that there should be a cross-government approach to achieving parity.

The terms of reference for this work and the time available to complete it have not allowed for a full analysis of all aspects of government policy affecting the relatively poor outcomes experienced by people with mental health problems. However, the working group wishes to highlight four particular areas of disparity which require action by other government departments: employment, welfare reform, criminal justice and schools/education.

## Employment

The benefits of work for both mental and physical health are well documented,<sup>150</sup> yet mental illness is now the largest category of occupational ill health.<sup>151</sup>

Employment is an integral part of recovery from mental ill health; there are very large (and growing) numbers of people with a mental illness who are unemployed, yet most want to work. Currently, 43% of people using mental health services who would like support with employment do not get the assistance they require.<sup>152</sup>

There is considerable research regarding the most effective interventions to place people with established mental health problems in paid work and support them in such work, with success rates of up to 60%.<sup>153</sup>

There is less evidence for people with common mental health problems, but enabling people to remain in work when they become unwell can be crucial, just as it is for people with physical health problems. Line managers and supervisors can make all the difference by intervening early and effectively to support colleagues to stay at work or to return after time off sick. GPs can also offer support to people in these early stages and timely access to psychological therapy is vital for many.

Early diagnosis and treatment of depression at work results in total returns of £5.03 for every £1 invested, with net savings starting by year 1. For a company with 500 employees, screening and treatment of depression and anxiety result in net savings in the first year of £19 700 (£20 676 cost of intervention, £17 508 in reduced absenteeism and £22 868 in reduced presenteeism) and £63 578 in the second year (£10 522 in reduced health costs, £23 006 in reduced absenteeism and £30 050 in reduced presenteeism).<sup>47</sup>

## Recommendations

The Department of Health and the NHS should take a lead role in modelling good employment practice to support staff well-being.

We welcome the recognition in the NHS Mandate that the NHS should promote the mental and physical well-being of the NHS workforce. We hope that this work will include implementation of the recommendations of the Boorman report.<sup>154</sup>

NHS trusts and foundation trusts should review their management of staff health and well-being. This should include the management of sickness absence and sickness presence relating to mental ill health and the ability of managers and supervisors to deal confidently and successfully with depression and anxiety.

Employment and health services need to work more effectively together to achieve better outcomes for people with mental health conditions. The Joint Pledge on Employment and Mental Health,<sup>155</sup> signed by all Work Programme prime contractors, should be used as a starting point for efforts to help more people to gain and sustain paid work.

The Access to Work scheme<sup>156</sup> can also be used to achieve greater parity: recent figures suggest that just 1% of Access to Work funding is supporting people with mental health problems in work, yet it has great potential to help many more people to get or keep work, with inexpensive but important adjustments and supports.

## Welfare reform

People with mental health problems who are out of work must be appropriately supported by the welfare system. Recent changes to the system – such as the creation of the Work Programme, the use of the Work Capability Assessment to reassess incapacity benefit claimants and proposals to replace Disability Living Allowance – have major implications for people with mental health problems. These should be closely monitored and the data should be published and made widely available.

There is increasing evidence that the current Work Capability Assessment is disadvantaging and causing distress and hardship to people with mental health problems, as it does not adequately assess their health status.<sup>157</sup> The value of providing good-quality and accurate additional medical evidence to the benefits claims and assessment process is well documented.<sup>158–160</sup> The provision of this additional information can result in fewer unnecessary face-to-face assessments and aids assessors in complex cases, and can reduce the likelihood of needing to appeal a decision.<sup>159</sup>

### The replacement of Disability Living Allowance (DLA) with Personal Independence Payment (PIP)

The government proposes to replace working-age Disability Living Allowance (DLA) with the Personal Independence Payment (PIP) from April 2013. In replacing DLA with PIP the government has an objective of making a 20% saving in the DLA budget. This has the potential to lead to claimants with mental health problems missing out on an essential benefit. The purpose of DLA and PIP is to provide a payment for the additional costs that a person faces from a disability. The eligibility for PIP should be based on a person's needs, not on the need to cut welfare budgets. The integrity of an objective assessment is compromised if decisions are thought to be influenced by a savings target rather than a transparent and consistent system based on the support needed for independent living.

## Recommendations

The Department for Work and Pensions should review and appropriately revise the Work Capability Assessment to take full account of the complexities of mental health problems that people experience. All aspects of the Work Capability Assessment pathway should have a robust integrated system of information transfer that includes all necessary information about a claimant's mental health.

The PIP implementation process, which involves extension of qualifying periods, face-to-face assessments, the skills of the assessors and the presence of advocates, should be fully informed by the nature of the condition of people with mental, intellectual or cognitive impairments in order to assess their capabilities.

In relation to the specific PIP assessment, two main components must be considered, namely the quality of the interview that is undertaken and the nature and scope of the descriptors. It is also important that any review of the DLA assessment does not include repeating the problems in the Work Capability Assessment.

PIP should take into account the full range of social, practical and environmental barriers faced by all people with disabilities.

## Criminal justice

The Bradley report highlighted the very large numbers of people in the prison population with mental health problems and the fact that prison is not always an appropriate environment for people with severe mental illness, as custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide. The report also highlighted research showing that more work needed to be done before mental health services for prisoners achieved equivalence with mental health services in the community.<sup>161</sup> These are issues that still require action.

## Recommendations

The NHS Commissioning Board should work with the Ministry of Justice to ensure that prison mental healthcare is developed to provide an equivalent service to that which would be available in the community, including primary care and psychological therapies as well as the provision of in-reach services.

The NHS Commissioning Board should ensure that transfers from prison to secure care are completed in a timely manner, dealing with emergencies as a matter of urgency (on a par with an emergency hospital admission for a physical illness) and aiming in all cases to make transfers within 14 days.

The NHS Commissioning Board should commission secure mental health services with a view to improving patient outcomes, patient experience and efficiency. This should include action to prevent delayed discharges and develop robust outcome measures for secure services.

As stated above, the Department of Health should repeat its survey of psychiatric morbidity among prisoners in England and Wales.<sup>148</sup>

## Schools/education

One in ten children and young people has an emotional or behavioural difficulty,<sup>6</sup> and one in four young people of secondary-school age will have been severely neglected, physically attacked or even sexually abused at some point in their lives.<sup>162</sup> These difficulties and experiences can significantly affect a child's ability to learn and to attain in school.<sup>163</sup> Schools have a very important role in recognising and responding to children's mental health problems, working with others as necessary, and in creating environments that promote mental health. This can help to build children's resilience and ability to cope with the challenges they face and also help them to achieve in school and reach their potential.

The Department for Education has an important role to play in encouraging schools to recognise and respond to the needs of children and young people with mental health problems in the ways recommended above in the section on children and young people (see pp. 58–59).

## National leadership for parity across government

The Department of Health is ideally positioned to take a lead role in government in advocating parity for mental health and people with mental health problems, to help ensure that they are properly considered in relevant policies developed by other government departments.

### Recommendation

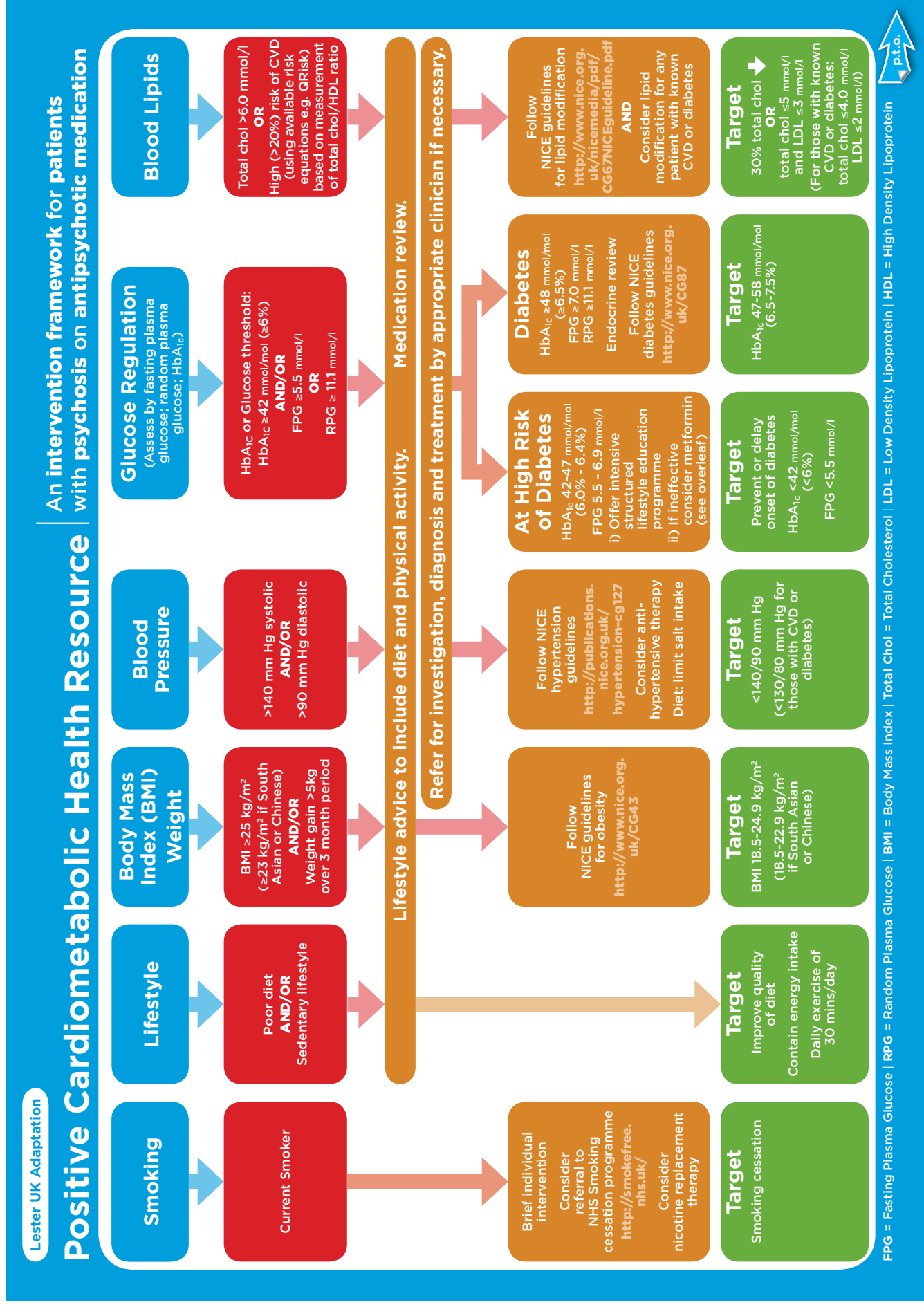
Focused work on achieving parity should continue, as long-term, sustained commitment is required to achieve it.

We recommend that mechanisms are identified for driving a parity approach to relevant policy areas across government. Options might include a cross-government committee under ministerial leadership, or the development of some kind of assessment process to ensure that parity can inform all policy developments – across all areas of government – that have implications for mental health.

## Conclusion

If these recommendations and others in the report are adopted, if action in these areas is sustained at national and local level, and a parity test is consistently applied to policy, commissioning and practice, then, over time, parity between mental and physical health should be realised.

Until then, much work remains to be done by leaders, policy-makers and professionals at all levels, working in partnership to common purpose across all communities.





Although this clinical resource tool targets antipsychotic medication, many of the principles apply to other psychotropic medicines given to people with long term mental disorders.

The general practitioner and psychiatrist will work together to ensure appropriate monitoring and interventions are provided and communicated. The general practitioner will usually lead on supervising the provision of physical health interventions. The psychiatrist will usually lead on decisions to significantly change antipsychotic medicines.

Primary care's **Quality and Outcomes Framework (QOF)** includes four physical health indicators in the mental health domain: BMI (MH12); blood pressure (MH13); total to HDL cholesterol ratio (MH14); Blood glucose (MH15). Currently MH14 and MH15 are only for those aged over 40yrs.

## History and examination following initiation or change of antipsychotic medication

**Frequency:** as a minimum review those prescribed a new antipsychotic at baseline and at least once after 3 months.

Ideally weight should be assessed 1-2 weekly in the first 8 weeks of taking a new antipsychotic as rapid early weight gain may predict severe weight gain in the longer term.

Subsequent review should take place annually unless an abnormality of physical health emerges, which should then prompt appropriate action and/or continuing review at least every 3 months.

### At review

**History:** Seek history of substantial weight gain (e.g. 5kg) and particularly where this has been rapid (e.g. within 3 months). Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD in first degree relatives <60 yrs) and gestational diabetes. Note ethnicity.

**Examination:** Weight, BMI, BP.

**Investigations:** Fasting estimates of plasma glucose (FPG), HbA<sub>1c</sub> and lipids (total cholesterol, LDL, HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for LDL or triglycerides.

**ECG:** Include if history of CVD, family history of CVD, or if patient taking certain antipsychotics (see Summary of Product Characteristics) or other drugs known to cause ECG abnormalities (eg erythromycin, tricyclic anti-depressants, anti-arrhythmics – see British National Formulary for further information).

# Don't just SCREEN - INTERVENE

for all patients in the "red zone"

## Interventions

**Nutritional counselling:** reduce take away and "junk" food, reduce energy intake to prevent weight gain, stop soft drinks and juices, increase fibre intake.

**Physical activity:** structured education-lifestyle intervention. Advise physical activity: e.g. Advise a minimum of 150 minutes of 'moderate-intensity' physical activity per week (<http://bit.ly/Oe7DeS>).

If unsuccessful after 3 months in reaching targets, then consider specific pharmacological interventions (see below).

## Specific Pharmacological Interventions

**Anti-hypertensive therapy:** Normally GP supervised. Follow NICE recommendations <http://publications.nice.org.uk/hypertension-cg127>.

**Lipid lowering therapy:** Normally GP supervised. Follow NICE recommendations <http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf>.

**Treatment of Diabetes:** Normally GP supervised. Follow NICE recommendations <http://www.nice.org.uk/CG87>.

**Treatment of those at high risk of diabetes:** FPG 5.5-6.9 mmol/l; HbA<sub>1c</sub> 42-47 mmol/mol (6.0-6.4%). Follow NICE guideline PH 38 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk (recommendation 19) – <http://guidance.nice.org.uk/PH38>.

- Where intensive lifestyle intervention has failed **consider metformin trial** (this would normally be GP supervised).
- Please be advised that **off-label** use requires documented informed consent as described in the GMC guidelines, [http://www.gmc-uk.org/static/documents/content/Good\\_Practice\\_in\\_Prescribing\\_Medicines\\_0911.pdf](http://www.gmc-uk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf). These GMC guidelines are recommended by the MPS and MDU, and the use of metformin in this context has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate). Start with a low dose e.g 500 mg once daily and build up, as tolerated, to 1500-2000 mg daily.

**Review of antipsychotic medication:** Normally psychiatrist supervised. Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effect:

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic requires careful clinical judgment to weigh benefits against risk of relapse of the psychosis.
- Benefit from changing antipsychotic for those on the drug for a long time (>1 year) is likely to be minimal.
- If clinical judgment and patient preference support continuing with the same treatment then ensure appropriate further monitoring and clinical considerations.



# Annexe A2. Programme for implementing the Lester UK Adaptation

Objective	Outcome	Specific action	By whom	When
Reduce the high rates of type 2 diabetes and cardiovascular disease in people with severe mental illness through a primary prevention approach. <sup>165,166</sup> Two key phases with different opportunities:		Change clinical practice based on the CMH Resource <sup>164</sup> so that all practitioners irrespective of role or clinical setting work towards agreed and shared treatment goals.  Collaborative care underpinned by local commissioning 1. Primary care and specialist care agree where the roles and responsibilities lie for physical health monitoring and above all how results are communicated between sectors and to patients  For those in the early phase of psychosis 2a. Weight increase from baseline is less than 5% at 2 years after initiating antipsychotic treatment  2b. There will be no deterioration in blood glucose, lipid profile or blood pressure at 2 years after initiating antipsychotic treatment  2c. Rates of tobacco smoking less than 30% at 2 years after initiating antipsychotic treatment <sup>167</sup>  2d. 90% of people are discharged to their GP with a letter that details the result of a recent full physical health review  For those with an established mental illness 3a. Cardiovascular disease risk is regularly assessed and treated according to the CMH Resource and NICE CG82 schizophrenia guidance <sup>168</sup>  3b. Those found to be at highest risk for cardiovascular disease are considered for pharmacological interventions (e. g. statins)  3c. Those at high risk of diabetes are detected and treated according to the CMH Resource and NICE PH38 diabetes prevention guidance <sup>169</sup>	Collaboration of the RCPsych, RCGP, RCN, RCP, Rethink Mental Illness and Diabetes UK to embed the CMH Resource into clinical practice  CCGs commission physical health outcomes  Potential to link with International collaboration to create a consensus statement led by iphYs group (International Early Psychosis SIG). UK royal college buy-in?	2013  2013  July 2013 RCPsych Edinburgh International Congress
For those in the early phase of psychosis, prevent weight gain and cardiometabolic risk becoming established	I can be confident that my health team (whether they are professionals from my psychiatry team or my GP surgery) work together to help me avoid preventable risks for cardiovascular disease and type 2 diabetes			
For those with established disorder, improve recognition and treatment of cardiometabolic risks				
All people with severe mental illness are offered primary prevention for cardiovascular disease and type 2 diabetes, tailored to need and as a fundamental part of their healthcare	From the onset of my treatment my health team will help me reduce my risks of premature cardiovascular disease and type 2 diabetes	This population is a public health priority for access to evidence-based programmes for smoking cessation, diet and exercise	National through Public Health England Local through directors of public health via the JSNA and health and well-being board plans	April 2013

# Annexe B. Summary of recommendations for parity

Note: The key recommendations appear at the beginning of the report on pp. 9–14.

## The funding gap

Parity is about equal value being placed on mental health and mental healthcare, and responses being proportionate to need. Funding for mental health must be commensurate with its impact on children and young people, working-age adults, older adults and society as a whole.

The NHS Commissioning Board and CCGs should allocate funding in a way that supports and promotes parity.

This should include ensuring that any person with mental health problems (including comorbid mental and physical health problems) can expect the same access to services and the same quality of care and treatment as people who have only physical health problems.

Consideration should be given to the percentage improvement in overall health outcomes that could be achieved if investment were to be reallocated to mental health, community and dementia services from the acute physical healthcare sector.

## NHS Outcomes Framework Domain 1: Preventing people from dying prematurely

### Reducing excess mortality in those with common mental health problems

The Department of Health should clarify the roles of the NHS Commissioning Board, Care Quality Commission (CQC) and the NHS Information Centre in relation to collating data on the physical health morbidity of people with mental health diagnoses.

The NHS Outcomes Framework should complement the indicator of 'excess under-75 mortality in people with severe mental illness' with an additional indicator that measures excess mortality in people with mild or moderate mental illness. Without this, the picture of premature mortality is incomplete. There should be an expectation that the mortality differential will reduce year on year.

### Smoking

Efforts to reduce premature mortality must include a major focus on reducing smoking among people with mental health problems.

All secondary and primary care services should make minor, inexpensive changes to primary/secondary care electronic records so that both smoking status and any smoking cessation intervention offered to people with different mental disorders are recorded. An alert about the need for certain medication dosages and potential toxicity would then automatically come up (relevant also to Domain 5).

The Quality Outcomes Framework indicator for smoking status in people with severe mental illness should be modified so that it records not only an individual's smoking status but also what action is taken to address smoking behaviour, such as provision of or referral for smoking cessation intervention(s).

Commissioners should require smoking cessation services to include a focus on smokers with mental health problems. They should also ensure that younger smokers receive early intervention, since most smoking has started by adulthood; smokers with emotional or conduct disorder in particular require targeted intervention.

### NHS services

All NHS staff working with people with mental health problems should be required not to smoke in their presence.

### Venous thromboembolism

Action should be taken to detect, monitor and reduce the incidence of VTE on in-patient mental health wards.

The national focus on VTE in medical and surgical in-patients should be expanded to include psychiatric in-patients, who should be subject to the same national guidelines as other in-patients. Specifically:

- The NHS Commissioning Board and CCGs should consider an annual mortality review being included as part of the contract for mental health trusts.

- More research should be undertaken on hospital-acquired VTE in psychiatric in-patients so that its actual incidence is better understood.
- NICE should consider making specific reference to mental health patients when the VTE guideline is reviewed.
- Improved guidance should be given to mental health trusts on which NICE guidelines are relevant to them, and mental health trusts should be included in the national programme for VTE prevention.
- The NHS Litigation Authority (NHS LA) should review its standards to include VTE prevention for mental health in-patients.

At a local level, mental health trusts should include a reduction in incidence of VTE and implementation of the policy as part of their clinical strategy. In addition, they should:

- Develop and implement a VTE prevention policy for subsequent auditing, with the involvement of clinicians throughout.
- Ensure that existing local incident reporting procedures incorporate VTE as a significant incident, to enable effective monitoring of incidence.
- Develop and implement an educational programme to raise awareness among all staff of VTE as an issue for mental health.

### Primary prevention: reducing rates of type 2 diabetes and cardiovascular disease in those with severe mental illness

The NHS Commissioning Board and CCGs should promote widespread adoption of the Lester UK Adaptation Positive Cardiometabolic Health Resource. This newly developed clinical algorithm for reducing the high rates of type 2 diabetes and cardiovascular disease in psychiatric patients treated with antipsychotic medication is a key primary prevention approach to reducing the increased mortality and morbidity experienced by those with severe mental illness. (See Annexe A1 for the Lester UK Adaptation and Annexe A2 for a proposed programme for its implementation.)

The Department of Health and NHS Commissioning Board should explore the potential of the Quality and Outcomes Framework (QOF) to provide improved incentives for GPs to give their at-risk psychiatric patients an annual healthcare check.

### Pathology tests

The Department of Health should fund a programme of research that will lead to better physical care and treatment of people with mental health problems.

## NHS Outcomes Framework Domain 2: Enhancing quality of life for people with long-term conditions

The integration agenda needs to be widely promoted for different audiences, subdivided into structural, educational and individual clinical practice considerations. The NHS Commissioning Board and local health and well-being boards should ensure representation from people and groups who can champion the integration of mental and physical health and social care in primary and secondary care.

### Commissioning

Commissioners need to regard liaison services as an absolute necessity rather than as an optional luxury.<sup>9</sup> NHS and social care commissioners should commission liaison psychiatry and liaison physician services to drive a whole-person, integrated approach to healthcare in acute, secure, primary care and community settings, for all ages, including multidisciplinary paediatric liaison services for children both in and out of hospital. This will not only improve patient outcomes but also save money.

There is strong support from the Royal College of Physicians (RCP) for all acute trusts to have a liaison psychiatrist.

Commissioners should ensure that service specifications include the treatment of comorbid health issues as well as addressing primary diagnoses, and might call for year-on-year improvements in recording comorbidity.

CCGs should ensure integrated commissioning of physical and mental health services for long-term conditions in children. All contracts for paediatric services should include measurable outcomes for mental health.

CCGs should ensure that providers of mental health services have a physical and procedural infrastructure in place to enable monitoring of people's physical health in accordance with NICE guidelines. This should be audited regularly as part of the commissioning process.

CCG commissioners should require that assessments at all stages of the pathway to care and recovery should include questions on both physical and mental health.

### Quality and Outcomes Framework

Routine screening for depression, anxiety and other common mental illness in people with long-term physical conditions such as diabetes, cardiovascular disease and chronic pain should be extended under the QOF.

### NICE quality standards and guidance

NICE quality standards and guidance could play a central role in establishing parity, by considering integrated physical and mental healthcare in respect of the particular disease or disorder that is being considered. This is not to downplay the importance of setting out the evidence of best treatment for a particular disorder, nor

auditing, monitoring or researching treatment of specific disorders. However, the standards and guidance should address prevalence and treatment of comorbidity and guide clinicians towards a holistic approach to care. This should apply as much to the physical health needs of someone with, for example, depression, as to the mental health needs of someone with, for example, chronic obstructive pulmonary disease (COPD).

All NICE guideline development groups for physical conditions should consider including representation from co-opted mental health experts to ensure that the mental health aspects of conditions are comprehensively considered. This will ensure that NICE quality standards have a sufficient focus on mental health.

## Public health

A parity approach should be adopted for addressing major health and social care priorities such as dementia, obesity and dignity-in-care issues. The report on obesity from the Academy of Medical Royal Colleges<sup>82</sup> models this approach.

Public Health England and local authorities should take a parity approach to their work and support the development of local public health strategies and interventions that recognise and fully consider the mental health dimension of issues commonly conceptualised as physical health concerns, such as smoking, obesity and substance misuse. Public health programmes should also involve appropriately integrated work across health and social care in order to consider and address the wider determinants of mental health and mental illness, such as social isolation, parenting, violence and abuse.

This 'whole person' approach should apply across the life course.

Health Education England should as a priority support the development of core skills and competencies in public mental health for health and public health professionals.

## NHS trusts

To help ensure that mental and physical health work together:

- all providers of specialist mental health services should have someone at board level who leads for physical health
- all providers of physical healthcare should have a board member who leads for mental health
- all providers of specialist mental health services should have a liaison physician who focuses on physical health
- all providers of physical healthcare should have a liaison psychiatrist who focuses on mental health.

## Local authorities

All local authorities should have a lead councillor for mental health as recognition of the need for all Local Authority activities and commissioning to take full account of mental and physical health and their social determinants.

The Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services should work with local authorities to ensure that mental health is given parity with physical health in the areas for which they are responsible, including in their new responsibilities for public health and the commissioning of addictions services.

All local authority activities and commissioning should recognise the social determinants of mental and physical health, and the importance of housing, education, social care eligibility, green spaces, access to leisure activities and employment for mental health resilience and recovery in the following ways:

- Local authorities should consider the mental health and well-being impact of all their policy decisions, including decisions about cuts and services. The Mental Well-being Impact Assessment (MWIA) toolkit developed by the National MWIA Collaborative (England) can assist this process, and its use should be widely adopted (available at: <http://www.apho.org.uk/resource/item.aspx?RID=95836>)
- People with mental health problems should receive social care on the same basis as people with physical health problems – according to the impact on the quality of their day-to-day life, the risk of further deterioration in health and the need for further health or social care.
- Mental health social work should be jointly commissioned by CCGs and local authorities to promote an integrated approach to health and social care.
- Local authorities should demonstrate their active commitment to parity through health and well-being and commissioning strategies.
- Health and well-being boards should benchmark their activities against the Mental Health Strategy Implementation Framework.
- Health and well-being boards should ensure that more common mental health problems are included in the Joint Strategic Needs Assessment (JSNA), not only severe mental illness.
- Health and well-being boards should also take an asset-based approach to needs assessment to determine the resources available locally for promoting good mental health and well-being.

## NHS Outcomes Framework Domain 3: Helping people to recover from episodes of ill health or following injury

### Access to care

To help drive change, the government and the NHS Commissioning Board should work together to:

- Make it clear, including as part of the NHS Constitution, that parity is expected between mental and physical health, in all relevant aspects of the work of the NHS.

- Give people equivalent levels of access to treatment for mental health problems as for physical health problems, agreed standards for waiting times for this treatment, and agreed standards for emergency/crisis mental healthcare.
- Continue to improve access to psychological therapies so that they are provided as a timely and appropriate response to assessed need for such interventions.
- Include a right in the NHS Constitution for service users, when it is judged clinically appropriate, to receive treatments that have been recommended by NICE in clinical guidelines as well as in technology appraisals. At present, the NHS Constitution confers this right (if clinically appropriate) only to drugs and treatments recommended by NICE technology appraisals and not to those recommended by NICE clinical guidelines. This is a parity issue, as, in practice, a greater proportion of mental health treatments than physical health treatments have undergone a clinical guideline assessment process rather than a technology appraisal process. This means that they are, in practice, less available to service users, as there is not the same legal imperative for mental health service providers to make them available. NICE clinical guidelines are the gold standard for evidence-based care. To use the example of mild depression, guidelines recommend talking therapies as a first-stage treatment and explicitly discourage the use of antidepressants. It is not equitable that a recommended treatment such as group cognitive-behavioural therapy does not have to be provided within the same reasonable time frame as the majority of treatments for physical complaints because it has been through a clinical guideline assessment rather than a technology appraisal. We recognise that, as a first stage, this may initially need to be a pledge rather than a right.
- Include a pledge in the NHS Constitution that service users with mental health problems, including people treated under the Mental Health Act, will be given information and support in making as many collaborative decisions about their treatment as possible.

We welcome the requirement in the NHS Mandate for the NHS Commissioning Board to work with CCGs to quantify waiting times for mental health services, including for when people are in crisis, and to address unacceptable delays in access to such services. The subsequent development of access standards should result in the introduction of waiting time standards for secondary care mental health assessment, diagnosis and treatment.

It is important that clinicians should be able to talk without constraint about treatment options. They should advise the service user of the treatment options from which they could benefit in line with national guidance, whether or not those treatments are available locally within a reasonable timescale. There should be a mechanism for service users to complain if they cannot receive their choice in a timely fashion, which does not involve the clinician. The clinician has a duty to enable the service user to reach informed choices and should not be constrained from doing so, which includes the fear of a complaint made directly to them for what is a problem of service provision. We therefore propose a fair access-to-care complaint approach that involves both the providers and commissioners. The clinician's role in this would simply be to confirm that the service user would benefit from the treatment.

## Emergency and crisis care

People who are in crisis because of a mental health problem should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems.

People with mental health problems presenting at accident and emergency departments should have the same level of access to physical healthcare and the same quality of response as those without a mental health problem.

Accident and emergency departments should have access to liaison psychiatrists and CCGs should ensure that emergency care provision is stipulated in the appropriate service contracts.

CCGs should ensure that they commission a sufficient mix of crisis services at the scale required by the needs and composition of the local population. These services should be staffed in accordance with extant national guidelines. Local communities should be meaningfully involved in the planning and review of such services.<sup>8,93</sup>

## Improving Access to Psychological Therapies (IAPT) programme

Given the significant commitment the government has made to IAPT, clarity is needed on where the national IAPT programme will now sit and how it will be taken forward.

### Choice

The Department of Health should consider how people with mental health problems can be offered greater choice in their care, and how this might operate in a variety of settings, including when people have been detained. People should be offered high-quality local services, within which there should be choice not only about which clinician they see, but also the type of treatment they are given and access to beds if appropriate. Choice should be offered in the context of shared decision-making and continuity of care.

### Personalisation

The forthcoming roll-out of personal health budgets should not replicate the current disparity in access to direct payments experienced by people with mental health problems. Support, brokerage and advocacy should be in place to enable people to take up the offer in both health and social care should they wish to do so.

### Severe mental illness and primary care

The working group welcomes Professor Helen Lester's call at the 2012 RCGP annual conference for GPs to make service users with conditions such as bipolar disorder and schizophrenia their 'core business' and her recommendations that they offer them longer consultations (in order to consider the various biopsychosocial factors that may be involved) and provide separate waiting areas away from what may be noisy and distressing waiting rooms.<sup>94</sup>



## NHS Outcomes Framework Domain 4: Ensuring that people have a positive experience of care

### Improving health professionals' attitudes towards and aspirations for service users

No part of the NHS should tolerate professional attitudes, behaviour or policies that stigmatise mental illness and thus contribute to the discrimination experienced by people with mental health problems. Unless such attitudes are challenged and changed, mental health will not gain parity with physical health. An element of this is showing the same respect to mental health professionals as to professionals working in other areas of health, as the stigma associated with mental health can also affect the esteem in which they are held.

We recommend that organisations providing NHS-funded care review their diversity and equality policies to ensure they include clear statements about non-discrimination in relation to mental health, and that a 'zero tolerance' approach is adopted in all health settings in relation to stigmatising and discriminating attitudes and behaviour towards people with mental health problems and their carers.

In every trust and hospital, non-discrimination policies should be supported first by an encouragement to report episodes of discrimination and secondly by provision of reparative training.

We recommend that, for the next 2 years, the Department of Health should consider how the work of the Time to Change initiative can improve the attitudes of mental health and other health professionals towards people with mental health problems and their carers.

The BMA and medical Royal Colleges should consider how doctors can adopt a more aspirational approach to the care of people with mental health problems, such as is found within physical healthcare, in relation, for example, to recovery. This would also have significant benefits for the employment prospects of people with mental health problems, given the established link between employment and mental health.

### Equality Act 2010

The Equality Act 2010 established that mental impairment (where the impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities) is a protected characteristic. Since April 2011, public authorities have had a duty, *inter alia*, to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act and to remove or minimise disadvantages suffered by people due to their protected characteristics.<sup>101</sup> As such, there is a legal requirement for the different elements of the Health Service to develop mechanisms to address both implicit and explicit discrimination.

Academic studies which have demonstrated implicit discrimination against people with mental health problems within healthcare systems<sup>60,61</sup> have been dependent on comprehensive data collection. The Department of Health should consider the methodology these studies have utilised when devising its own strategy for tackling discrimination. The Department should also conduct a literature review to identify examples of implicit discrimination experienced by people with mental health problems within the wider healthcare system and use this to inform its approach and areas of initial focus.

### Values-based approach to mental healthcare

The Department of Health, the NHS Commissioning Board, CCGs and mental health providers should consider developing a human rights-based values approach to healthcare commissioning and provision to improve standards of care. A useful way of conceptualising these values is the FREDa framework (Fairness, Respect, Equality, Dignity and Autonomy), whereby all five aspects are jointly considered, and the framework informs rather than determines decisions.<sup>102</sup> There is an encouraging (if nascent) evidence base that a bottom-up approach based on FREDa principles can improve service user outcomes.<sup>103</sup>

### Medical and nursing education

The GMC and NMC should consider how medical and nursing study and training could give greater emphasis to mental health. This would help to improve the care and treatment provided by non-specialists to people who present with mental health problems, and to those with physical health problems who develop mental health problems. Mental and physical health should be integrated within undergraduate medical education, with an emphasis on joint placements and on engaging with service users who have comorbid physical and mental health problems.

Medical and nursing examination curricula and training routes should incorporate the key skills required to ensure a holistic approach to the diagnosis, care and treatment of ill health. For example, examinations for psychiatrists should cover aspects of the diagnosis and treatment of common physical health problems experienced by people with mental health problems, and those for physicians should cover depression, health anxiety and severe mental illness. Joint training sessions at postgraduate level would also be beneficial.

Psychiatrists should learn from physicians about attitudes towards risk and how it is collaboratively handled with patients, as part of medical education and continuing professional development. Similarly, an appreciation of the underlying psychological reasons why someone is, for example, obese or alcohol-dependent would be highly beneficial for physicians.

### Mental health awareness training

The GMC and the NMC should review the place and role of evidence-based mental health awareness training for all doctors and nurses.

## NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

### Safe prescribing

Mental health services should ensure that medicines reconciliation occurs as a routine part of every admission to care within mental health services. This should include admission to crisis resolution home treatment (CRHT) teams, and other community teams. When GP medicine records are incomplete due to lack of provision of information from the mental health trust it should be the responsibility of the CMHT to inform GPs to amend their records.

Mental health service providers should ensure that all care coordinators receive training and support to enable them to ensure that the medicines aspects of a service user's care are attended to.

Psychiatrists, pharmacists and GPs should work more closely together to coordinate prescribing for comorbid conditions.

Mental health medicines should be included in the pharmacy New Medicine Service.

### In-patient mental health wards

The Department of Health should ensure that data on safety in mental health in-patient services continue to be collected, in a manner directly comparable to physical health in-patient services (if not as part of the same survey, which would be preferable) so that progress towards parity can be measured.

There should be an expectation at every level of provision and accountability from the NHS Commissioning Board down to individual members of staff that in-patient mental health units should consistently be safe, calm and therapeutic environments.

The NHS Commissioning Board should as an early priority extend the NHS staff 'family and friends' test to mental health in-patient wards. This test asks staff whether they would recommend a health setting as a place for their family to be treated.

The CQC should reinstate its annual survey of mental health acute in-patient services, or identify a different mechanism for considering the experiences of mental health in-patients, given that mental health patients are excluded from the general in-patient survey.

Mental health providers should review the physical environment within which they provide care, and consider whether it is fit for the purpose of providing a therapeutic environment.

## A life-course approach

### Pre-birth and first year of life

The priority objectives and policy recommendations of the Marmot Review Policy Objective A, to give every child the best start in life, should be fully implemented. These include supporting families to achieve progressive improvements in early child development.<sup>39</sup>

Commissioners should ensure that antenatal and postnatal education for parents includes a focus on the emotional well-being of both the infant and the parents. They should also invest in perinatal and parent-infant mental health services to work with particularly vulnerable parents and babies and with families where there are parenting difficulties. The provision and function of such specialist services are currently variable and inequitable, and it is considered there is significant unmet need in this area.<sup>11</sup>

Consideration should be given to adopting the use of a simple assessment tool, which can be used at a universal level by health visitors and family-intervention projects, to aid early identification of families where further support would be helpful for nurturing an appropriately responsive and attuned relationship between mother and child. It is important that such a tool should be used universally only if additional support is also available to families when this is needed. The Solihull approach adopted by many health visiting and family nurse partnership services across the UK is a well-evaluated tool.<sup>121</sup>

### Schools

The Department for Education should encourage the widespread adoption in pre-school and school settings of well-evidenced programmes shown to have positive effects on children's mental health.

Schools, with the encouragement of the Department for Education, should implement the NICE public health guidance on mental health promotion in schools.<sup>12,13</sup> This aims to develop psychological, emotional and social skills to support resilience and coping mechanisms and will help to develop better mental health 'literacy' in children and young people. In the longer term this has the potential also to contribute to less stigmatising attitudes to mental ill health in the wider population, as well as to earlier identification of and response to mental health problems throughout life, through educational and therapeutic means.

### Professional understanding of child development

All professionals working with children and families should be able to identify mental health problems, and factors that adversely affect mental well-being, at an early stage, including signs of abuse and neglect, and to respond to them effectively. They should be trained in child development, the importance of emotional resilience, the relationship between a child's physical and mental development, and the determinants and risk factors for poor



emotional and mental health. This is a vital underpinning for an early-intervention approach both to children's mental health problems and to population mental health as a whole.

The Children and Young People's Health Outcomes Forum has also highlighted such training as a priority for action.<sup>10</sup>

The working group strongly supports the proposed extra year for GP training, which presents an important opportunity to teach more about child development and mental health, and the relationship between physical and mental health.

The Health and Care Professions Council should consider including a child development and a mental health module as part of mandatory core training for social workers, not just as specialisms. This could be complemented by a greater focus in the children and families specialism on the relationship between physical and mental development.

Health Education England (for healthcare staff) and the Teaching Agency (for early-years and teaching staff) should map the quality and quantity of training that currently exists in this area, including initial training and continuing professional development, and review the common core of skills and knowledge in workforce training. Relevant training should be developed and put in place where this is lacking.

Local authorities and NHS services should ensure that child development and child mental health are included in child safeguarding training to ensure a full understanding of the role of violence and abuse in the development of mental health problems.

### Transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS)

There is evidence that a large number of transitions are not good enough; for example, only 5% of CAMHS to AMHS transitions are 'optimal', yet the NHS has pledged through the NHS Constitution to ensure that service users have as smooth a transition as possible when referred between services, and be fully included in all relevant discussions. This is an area that requires substantial improvement. We recommend that consideration is given to how transitions can be made as smooth as possible, for example through payment incentives, or a pooled budget.

Commissioners of CAMHS and AMHS should develop services to allow greater flexibility to enable a smoother and more supportive transition from children's to adult mental health services. This should focus on young people moving when they are developmentally ready, not just when they reach a particular age. A joint assessment team comprising staff from both AMHS and CAMHS to create a joint transition plan would assist in more effective transition.

CAMHS staff and managers and participation workers should ensure that young people are at the centre of this planning process, to enable shared decision-making that results in the most effective and supportive transition plan.

Providers of mental health services should develop an assessment framework to support collaborative decision-making with the young person, and increase the likelihood of services being more flexible. We recommend a model that also includes 'transition' meetings between CAMHS and AMHS, with the young person present, that can be used either as a decision-making forum or to help the young person transition more smoothly into AMHS.

### Older people

CCGs should ensure that older people have access to comprehensive, specific older people's mental health services that can diagnose and manage all mental illnesses and not just dementia.

CCGs should strongly consider making flexibility of access a cornerstone of service contracts, so that someone being treated within AMHS, for example for depression, does not become automatically ineligible to continue to be treated by that service once they pass 65 years of age, and someone under the age of 65 with, for example, early-onset dementia can access the expertise of comprehensive older adult mental health services. This is important for fulfilling public sector duties under the Equality Act 2010. CCGs should ensure they provide specialist age-appropriate services that have porosity with adult services to ensure the mental health of this disadvantaged population is appropriately addressed.

Physicians should be able to do basic capacity assessments and to distinguish between delirium and dementia.

More funds need to be made available for research into older people's mental health. A 2010 study found that dementia was costing the UK 200% as much as cancer but receiving 3.8% of the research funding.<sup>144</sup> The recent announcement that research funding for dementia will double to more than £66 million by 2015 is extremely welcome, and should be highlighted as an important step towards parity.<sup>145</sup>

## Measurement and monitoring of parity: data, research, audit and inspection

### National psychiatric morbidity surveys

The Department of Health should continue the adult psychiatric morbidity survey to underpin its commitment to achieving parity. Without it, we lose the most comprehensive, and therefore important, information we have about the prevalence of mental health problems and our efforts to treat them. This information will be vital for measuring the impact of actions to achieve parity for mental health.

The Department of Health should also consider reinstating the child and adolescent national psychiatric morbidity survey and should repeat its survey of psychiatric morbidity among prisoners in England and Wales. Since the survey published in 1998,<sup>146</sup> the number of prisoners in England and Wales has increased by c.18 000,<sup>147</sup> and there is a need for up-to-date data on the mental health of this very vulnerable population.

## Quality and outcomes

There is a strong argument for strengthening data-sets by including not only data on primary diagnoses, but also on co- and multi-morbid diagnoses. CQUIN might also be used to reward improvements in recording and treating physical and mental comorbidity.

Planners and commissioners should benchmark mental health provision and outcomes against physical health provisions. This should be undertaken locally by planners, commissioners and service providers so that parity of esteem for mental health is a reality – something they need to ensure under direction from the NHS Commissioning Board and within the Implementation Framework for the mental health strategy. The Commissioning Outcomes Framework (COF) can also be used to support commissioners to include parity issues in their service specifications.

The determination of outcomes should be strongly informed by users and carers. This would ensure that outcomes reflect a recovery approach, as opposed to a purely clinical one, which is important for mental health in particular. We recommend that further development of mental health-related patient reported outcomes measures (PROMS) should be included within the NHS Outcomes Framework and Commissioning Outcomes Framework. Benchmarking activity could include the following:

- comparisons of measures of patient and carer involvement, such as the opportunity people were given to ask questions about their condition and care, for example who to contact when they need help with their care, and whether they have a number for a person to contact in an emergency
- comparisons between delayed discharges (including those waiting in prison for transfer to hospital for care)
- comparison between levels of satisfaction with care/treatment/care environment (especially in-patient)
- comparison of staff attitudes towards patients
- comparison of information given about potential side-effects of medication
- comparison of information given about general healthy-living improvements (e.g. diet, exercise, smoking cessation)
- comparison of range of choices offered to patients
- comparison of identification and treatment of comorbid problems
- comparison between waiting times for assessment and treatment (and specifically treatment in A&E units and treatment in an emergency/crisis situation)
- comparisons between how patients, although unwell, rate their time 'spent well'.

Primary care is increasingly important for the support of mental health, including for people previously receiving mental health services. Results and experiences in primary care should be the same for both physical and mental health issues, yet there is considerable variation in awareness and understanding of mental health within primary care. This can create barriers for people with mental health problems in accessing physical and mental healthcare within primary care, which in turn leads to poor outcomes. We would like to see incentives addressing parity of care within the QOF.

## Parity of measurement of service use and outcomes

The Department of Health and NHS Commissioning Board should encourage parity of measurement of service use and outcomes for mental health service users who require physical healthcare through examining how existing and future data registers, such as those for cancer and diabetes, can be utilised to learn more about comorbidity of physical and mental health problems. Our understanding is that there is a significant amount of unanalysed data on mental health in some cancer data-sets (Professor Sir Mike Richards, National Clinical Director for Cancer, personal communication, July 2012). There thus already exists unrealised potential to learn more about comorbidity of physical and mental health problems in this area of care; the same may be true in other areas.

## Proposed new ratings system for health and social care

The proposed new ratings system for improving standards of health and social care should give equal attention to providing information about mental healthcare.<sup>148</sup>

## Research into co- and multi-morbidity

To inform their efforts to achieve parity, each NHS Commissioning Board domain lead should collect, analyse and report data (including currently unanalysed existing data) on people with and without mental health problems.

The Department of Health should consider a refocusing of research onto areas of co- or multi-morbidity, involving mental health and physical health problems, rather than single diseases/disorders. This would help to demonstrate the interconnectivity of mental and physical health, and to underpin the developments of evidence-based treatments that address all an individual's health needs, not just their primary diagnosis.

## Research into attitudes and culture affecting the treatment of people with mental health problems

To help understand why mental health does not enjoy parity of esteem at present, there should also be a greater research focus on health and social care staff culture, attitudes and behaviour towards patients with mental health problems; and further research on the factors behind why people with more severe mental health problems are at higher risk of dying earlier from treatable diseases.

## Research into recovery

To improve the evidence relating to models of support for individuals' recovery, it would be beneficial to promote more social care research in mental health, to include not only clinical resolution, but also social recovery and self-management when problems persist. Social recovery often enables people to maintain themselves in communities, thus reducing demand on formal services (acute services in particular).

## Audit and inspection

The CQC has an important role in monitoring compliance with legislation, guidance and standards affecting parity. It should, working with existing third-sector quality networks (for example those operated by the RCPsych College Centre for Quality Improvement), assess the provision and quality of physical healthcare for people with mental health problems and vice versa, in order to assess other organisations' efforts to deliver parity of esteem.

## A cross-government approach to parity

### Employment

The Department of Health and the NHS should take a lead role in modelling good employment practice to support staff well-being.

We welcome the recognition in the NHS Mandate that the NHS should promote the mental and physical well-being of the NHS workforce. We hope that this work will include implementation of the recommendations of the Boorman report.<sup>154</sup>

NHS trusts and foundation trusts should review their management of staff health and well-being. This should include the management of sickness absence and sickness presence relating to mental ill health and the ability of managers and supervisors to deal confidently and successfully with depression and anxiety.

Employment and health services need to work more effectively together to achieve better outcomes for people with mental health conditions. The Joint Pledge on Employment and Mental Health,<sup>155</sup> signed by all Work Programme prime contractors, should be used as a starting point for efforts to help more people to gain and sustain paid work.

The Access to Work scheme<sup>156</sup> can also be used to achieve greater parity: recent figures suggest that just 1% of Access to Work funding is supporting people with mental health problems in work, yet it has great potential to help many more people to get or keep work, with inexpensive but important adjustments and supports.

### Welfare reform

The Department for Work and Pensions should review and appropriately revise the Work Capability Assessment to take full account of the complexities of mental health problems that people experience. All aspects of the Work Capability Assessment pathway should have a robust integrated system of information transfer that includes all necessary information about a claimant's mental health.

The PIP implementation process, which involves extension of qualifying periods, face-to-face assessments, the skills of the assessors and the presence of advocates, should be fully informed by the nature of the condition of people with mental, intellectual or cognitive impairments in order to assess their capabilities.

In relation to the specific PIP assessment, two main components must be considered, namely the quality of the interview that is undertaken and the nature and scope of the descriptors. It is also important that any review of the DLA assessment does not include repeating the problems in the Work Capability Assessment.

PIP should take into account the full range of social, practical and environmental barriers faced by all people with disabilities.

### Criminal justice

The NHS Commissioning Board should work with the Ministry of Justice to ensure that prison mental healthcare is developed to provide an equivalent service to that which would be available in the community, including primary care and psychological therapies as well as the provision of in-reach services.

The NHS Commissioning Board should ensure that transfers from prison to secure care are completed in a timely manner, dealing with emergencies as a matter of urgency (on a par with an emergency hospital admission for a physical illness) and aiming in all cases to make transfers within 14 days.

The NHS Commissioning Board should commission secure mental health services with a view to improving patient outcomes, patient experience and efficiency. This should include action to prevent delayed discharges and develop robust outcome measures for secure services.

As stated above, the Department of Health should repeat its survey of psychiatric morbidity among prisoners in England and Wales.<sup>148</sup>

### National leadership for parity across government

Focused work on achieving parity should continue, as long-term, sustained commitment is required to achieve it.

We recommend that mechanisms are identified for driving a parity approach to relevant policy areas across government. Options might include a cross-government committee under ministerial leadership, or the development of some kind of assessment process to ensure that parity can inform all policy developments – across all areas of government – that have implications for mental health.

# Annexe C. Parity commitments from working group member organisations, Royal Colleges and others

Organisation(s)	Commitment
<b>Definition and vision for parity of esteem</b>	
Academy of Medical Royal Colleges (AoMRC)	The AoMRC will ensure that work programmes are designed appropriately to achieve the aim of parity of esteem.
The European Psychiatric Association (EPA) Council of national psychiatric associations	At its meeting on 22 November 2012 the Council agreed to set up a working group on parity of esteem. This will be led by Professor Sue Bailey, President of the Royal College of Psychiatrists. Its first product will be an article in a journal of international psychiatry which includes a questionnaire seeking information from other countries.
<b>The funding gap</b>	
RCPsych	The RCPsych will continue to advise the Department of Health on the development of payment by results for mental health, with a view to refining the cluster system so that payments can be more clearly linked to treatments that are recommended by NICE guidelines.
<b>Domain 1 of the NHS Outcomes Framework: Preventing people from dying prematurely</b>	
FPH	The FPH is developing interactive tools to disseminate both the evidence base for public mental health and examples of good practice to its membership.
FPH	The FPH will take an active stance in promoting the public health importance of mental health and well-being in continuous professional development for members and in the current review of the public health training curriculum.
NHS Confederation MHN and RCPsych	The NHS Confederation Mental Health Network and the RCPsych will work towards the ambition that NHS non-smoking should be the norm for both staff and service users in mental health trusts, on the basis that all smokers (staff and service users alike) should receive smoking cessation intervention, including assistance with temporary abstinence (including for staff smokers at work).
RCGP	The RCGP is working with Time to Change to provide a master class in reflective practice specifically for GPs – to raise awareness of mental health problems and management of patients with chronic mental illness within primary care.
RCN and RCGP	The RCN will work with the RCGP to explore the role of practice nurses in primary care in providing health assessments for people with severe mental illness. This will take the form of a series of workshops to be held in 2013.
RCP and RCPsych	The RCP and RCPsych will jointly publish a report about public health and drug, alcohol and tobacco use aimed at government, medical Royal Colleges, CCGs and health and well-being boards.
RCPsych, RCPsych and RCP	The RCPsych, RCPsych and RCP will explore how variations in the use of and access to appropriate pathology tests for people with mental health problems could be investigated and create both educational material and clinical guidelines to address any agreed problems.
RCPsych	The RCPsych will draft and propose improvements to the current smoking-related QOFs.

RCPsych	The RCPsych will engage with NHS stop smoking services with the aim of improving the information available to people with mental health problems (including the Quit Kit), ensuring that mental health status (including current medication) is routinely recorded and that access to smoking cessation interventions for people with mental disorder is greater than for the general population.
RCPsych	The RCPsych will update and disseminate its current medical education materials on smoking and mental health.
RCPsych, RCGP and RCN	The RCPsych, RCGP and RCN will continue to make efforts to embed the Lester UK Adaptation: Positive Cardiometabolic Health Resource into clinical practice.

### **Domain 2 of the NHS Outcomes Framework: Enhancing quality of life for people with long-term conditions**

CEM	The CEM has identified a lead for mental health, with responsibility for liaising with the RCPsych and other relevant bodies. They will continue to report as a standing agenda item to every meeting of the College Clinical Effectiveness Committee.
CEM	The CEM is creating a management 'toolkit' to promote mental health services in the emergency department. This includes a range of resources, including current standards and guidelines, sample business cases for service development, staff and patient resources, and a range of materials that will assist in working towards parity between mental and physical health in the emergency department.
CEM and RCPsych	The CEM and RCPsych are developing a set of mental health standards for emergency departments. They will then proceed to complete a national audit against these standards during 2013/14.
NHS Confederation MHN	The NHS Confederation Mental Health Network actively supports the principles of recovery and social inclusion for mental health service users. It will work with the RCPsych to collate and disseminate examples of best practice (at trust or service level) in improving the physical health of people with mental health problems.
RCP	The RCP Future Hospitals Commission includes a representative from the RCPsych and is considering both physical and mental health issues. The Commission is expected to report in summer 2013.
RCPCH and RCPsych	The RCPCH and RCPsych will explore the development of paediatric liaison services, with production of a joint document for commissioners.
RCPE	The RCPE will continue to include mental health as a cross-cutting issue within other work streams.
RCPE	The RCPE will, on occasion, hold full events with a sole mental health focus. Extracts from such meetings will be recorded and uploaded to the RCPE website.
RCPsych	The RCPsych will develop draft CQUINs and QOFs which might also be used to reward improvements in recording and treating physical and mental comorbidity.
RCPsych and Centre for Mental Health	The RCPsych and Centre for Mental Health are exploring the development of a network of local authority 'mental health champions'. It is anticipated that other mental health charities will also be involved in this project.

### **Domain 3 of the NHS Outcomes Framework: Helping people to recover from episodes of ill health or following injury**

CCQI	The CCQI will conduct a literature review of evidence regarding staff expectations of the physical health of service users with severe mental illness, the results of which may lead to a small research study.
NICE	As it routinely reviews the methods and processes for assessing and interpreting evidence in its guidance programmes, NICE will take the opportunity to ensure that it takes account of the particular features of the evidence for psychological therapies.
RCPsych	The MRCPsych (Member of the Royal College of Psychiatrists) examination will reaffirm the importance of preventing, identifying, assessing and managing physical illness.
RCPsych and NHS Confederation MHN	The RCPsych and the NHS Confederation Mental Health Network will explore the reasons underlying the lower aspirations of health professionals for those with mental health problems and how these might best be addressed.

### **Domain 4 of the NHS Outcomes Framework: Ensuring that people have a positive experience of care**

BMA Psychiatry Sub-Committee	The BMA Psychiatry Sub-Committee is fully supportive of achieving parity of esteem between mental and physical health, and will be pursuing appropriate avenues with a view to having these principles adopted as BMA policy.
RCOA	The RCoA will offer support and engage with the AoMRC positioning on parity by pushing the message on its own website(s); there is also the possibility of a <i>Bulletin</i> article.

RCPsych	The RCPsych, in its efforts to achieve parity, will continue to meaningfully engage with service users and carers to learn about their lived experience of mental health problems and services.
RCPsych	The RCPsych will recognise excellence in delivering parity through an open category at the RCPsych Awards (from 2014 onwards).
<b>Domain 5 of the NHS Outcomes Framework: Treating and caring for people in a safe environment and protecting them from avoidable harm</b>	
NHS Confederation MHN and CMHP	The NHS Confederation Mental Health Network will work with the CMHP to promote the value of community-based specialist mental health pharmacists for helping to ensure that plans for service users' medicines are followed through, and will disseminate examples of good practice in this area.
RCoA, RCPsych and RCP	The RCoA will work with the RCPsych and the RCP to consider how anaesthetists could work with psychiatrists and physicians to better evaluate the risk of anaesthetics for someone who already has mental health issues, particularly dementia, and be clearer on possible outcomes.
RCPCH	The RCPCH review of its training for paediatricians will include a review of their psychopharmacology training.
RCPsych	The RCPsych will continue to host and support national audits such as the Prescribing Observatory for Mental Health (POMH-UK) and the National Audit of Schizophrenia, which aim to improve prescribing practices and the quality of healthcare that people with mental health problems receive.
RCPsych, CMHP, RPS and NHS Confederation MHN	The RCPsych, CMHP and RPS will explore with the NMC and the NHS Confederation Mental Health Network the potential for a more significant component of teaching about mental health medicines in the undergraduate training of all nurses, in particular mental health nurses, and in the training of nurses by mental health provider organisations.
RCPsych, RCGP, CMHP and RPS	The RCPsych, RCGP, CMHP and RPS are committed to working together to review shared care of the prescribing of psychotropic medicines and any professional training needs in this area.
<b>A life-course approach: early intervention, children and young people and older people</b>	
RCOG	The RCOG will develop an advanced training study module in psychiatric illness in pregnancy, to educate young obstetricians in the processes of supporting a person with a psychiatric illness through pregnancy and the puerperium. It also aspires to develop a similar programme for disadvantaged and refugee people.
RCPCH	The RCPCH is launching a major review of child health research in the UK, which will include a focus on mental health.
RCPCH	The RCPCH is scoping the options for developing an alliance/coalition of children's healthcare professionals and organisations to promote best possible service models, research and education in children's health services. One aim will be to ensure that CAMHS are given the priority that they urgently need within the children's service framework.
RCPCH	The RCPCH will review its training for paediatricians, including the curriculum, competencies and assessments to ensure there is sufficient focus on mental health.
RCPCH	The RCPCH would be supportive of a review of the undergraduate medical curriculum to ensure there is emphasis on both physical and mental health.
RCPCH and RCPsych	The RCPCH is working with the RCPsych and others to develop an e-portal (funded by the Department of Health) on children and young people's mental health issues. This aims to ensure that everyone involved with children and young people has appropriate understanding and knowledge about mental health issues.
RCPsych and RCPCH	The RCPsych and the RCPCH will explore how, within the new structures, they might assist schools to support children and young people who have mental health problems and thus help them to thrive in school.
Young Minds	Young Minds will work with schools to prioritise parity of esteem via the BOND (Better Outcomes, New Delivery) Project, Young Minds in Schools and the Children and Young People's Mental Health Coalition.

**Measurement and monitoring of parity: data, research, audit and inspection**

CCQI	The CCQI will embed the principle of parity of esteem within all of its quality networks.
CQC	The CQC will consider whether the physical healthcare needs of mental health service users, and the mental healthcare needs of people using services for long-term conditions, are suitable topics for its programmes of themed inspections and thematic reviews of data.
CQC	The CQC will explore whether there are indicators that it can use to identify when routine compliance inspections should focus on the physical healthcare needs of mental health service users, and the mental healthcare needs of people using services for long-term conditions. Indicators might, for example, come from tracking patient contacts through the different data-sets for mental health, primary care and hospital and community healthcare, or from other sources, such as accreditation and survey data.

## Key to abbreviations

AoMRC	Academy of Medical Royal Colleges
BMA	British Medical Association (Psychiatry Sub-Committee)
CCQI	RCPsych College Centre for Quality Improvement
CEM	College of Emergency Medicine
CMHP	College of Mental Health Pharmacy
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
FPH	Faculty of Public Health
MHN	(NHS Confederation) Mental Health Network
NICE	National Institute for Health and Clinical Excellence
QOF	Quality and Outcomes Framework
RCoA	Royal College of Anaesthetists
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCOG	Royal College of Obstetrics and Gynaecology
RCP	Royal College of Physicians
RCPATH	Royal College of Pathologists
RCPCH	Royal College of Paediatrics and Child Health
RCPE	Royal College of Physicians of Edinburgh
RCPsych	Royal College of Psychiatrists
RPS	Royal Pharmaceutical Society



# References

All URLs in the list below were accurate as of February 2013.

- 1 Sterne L. *The Life and Opinions of Tristram Shandy, Gentleman* (1761), vol. 3, ch. 4 (eds M New, J New). University of Florida Press, 1978.
- 2 Crossley DR. Holistic psychiatry without the whole self. *The Psychiatrist* 2012; **36**: 97–100.
- 3 Sixty-Fifth World Health Assembly, Ninth plenary meeting, 25 May 2012, WHA65.4, Agenda item 13.2. Available at [http://www.who.int/mental\\_health/WHA65.4\\_resolution.pdf](http://www.who.int/mental_health/WHA65.4_resolution.pdf)
- 4 HM Government. *The Coalition: Together in the National Interest – Mid-Term Review*. Cabinet Office, 2013. Available at [http://assets.cabinetoffice.gov.uk.s3-external-3.amazonaws.com/midtermreview/HMG\\_MidTermReview.pdf](http://assets.cabinetoffice.gov.uk.s3-external-3.amazonaws.com/midtermreview/HMG_MidTermReview.pdf)
- 5 HM Government. *No Health Without Mental Health: Implementation Framework*. Department of Health, July 2012. Available at <http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf>
- 6 Green H, McGinnity A, Meltzer H, Ford T, Goodman R. *Mental Health of Children and Young People in Great Britain 2004*. Office for National Statistics, 2005.
- 7 Mind. *Mental Health Crisis Care: Commissioning Excellence*. Mind, 2012, p. 5. Available at [http://www.mind.org.uk/assets/0002/2011/CommissioningExcellence\\_WEB\\_VERSION\\_2.pdf](http://www.mind.org.uk/assets/0002/2011/CommissioningExcellence_WEB_VERSION_2.pdf)
- 8 Department of Health. *Mental Health Policy Implementation Guide*. Department of Health, 2001. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4058960.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058960.pdf)
- 9 Parsonage M, Fossey M, Tutty C. *Liaison Psychiatry in the Modern NHS*. Centre for Mental Health, 2012, p. 6.
- 10 Children and Young People's Health Outcomes Forum. *Report*. Children and Young People's Health Outcomes Forum, July 2012. Available at <http://www.dh.gov.uk/health/files/2012/07/CYP-report.pdf>
- 11 Joint Commissioning Panel for Mental Health. *Guidance for Commissioners of Perinatal Mental Health Services*. Royal College of Psychiatrists, 2012. Available at <http://www.rcpsych.ac.uk/policy/projects/live/commissioning.aspx>
- 12 National Institute for Health and Clinical Excellence. *Promoting Children's Social and Emotional Wellbeing in Primary Education* (Public Health Guidance 12). NICE, March 2008. Available at <http://www.nice.org.uk/nicemedia/pdf/PH012Guidance.pdf>
- 13 National Institute for Health and Clinical Excellence. *Promoting Young People's Social and Emotional Wellbeing in Secondary School* (Public Health Guidance 20). NICE, September 2009. Available at <http://www.nice.org.uk/nicemedia/live/11991/45484/45484.pdf>
- 14 Health and Social Care Act 2012. Available at <http://www.legislation.gov.uk/ukpga/2012/7/section/1/enacted>
- 15 *Hansard* (House of Lords), 8 February 2012, vol. 735, cols 26–274.
- 16 HM Government. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Department of Health, 2011, p. 88. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124058.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf)
- 17 United Nations. Principles for the protection of persons with mental illness and the improvement of mental health care. Adopted by General Assembly resolution 46/119 of 17 December 1991. Available at [http://www.equalrightstrust.org/ertdocumentbank/UN\\_Resolution\\_on\\_protection\\_of\\_persons\\_with\\_mental\\_illness.pdf](http://www.equalrightstrust.org/ertdocumentbank/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf)
- 18 United Nations Committee on Economic, Social and Cultural Rights. *Concluding Observations: United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories*. United Nations, 2009, p. 9.



- 19 US Government. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). US Department of Labor Employee Benefits Security Administration.
- 20 Barry C, Huskamp H, Goldman H. A political history of federal mental health and addiction insurance parity. *Milbank Q* 2010; **88**: 404–33
- 21 US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
- 22 HM Government. *The NHS Outcomes Framework 2012/13*. Department of Health, p. 12. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131723.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf)
- 23 Department of Health. *Department of Health Improving Outcomes and Supporting Transparency: Part 1: A Public Health Outcomes Framework for England, 2013–16*. Department of Health, 2012. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132559.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf)
- 24 Department of Health. *Transparency in Outcomes: A Framework for Quality in Adult Social Care*. Department of Health, 2011. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_125686.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125686.pdf)
- 25 Fritz GK, Kennedy PJ. The long road ahead to mental health parity. *J Am Acad Child Adolesc Psychiatry* 2012; **51**: 458–60.
- 26 Goldberg D. Improved investment in mental health services: value for money? *Br J Psychiatry* 2008; **192**: 89.
- 27 World Health Organization. *Global Burden of Disease Report*. WHO, 2008. Available at [http://www.who.int/healthinfo/global\\_burden\\_disease/estimates\\_country/en/index.html](http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html)
- 28 Centre for Mental Health. *The Economic and Social Costs of Mental Health Problems in 2009/10*. Centre for Mental Health, 2010. Available at [http://www.centreformentalhealth.org.uk/pdfs/Economic\\_and\\_social\\_costs\\_2010.pdf](http://www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf)
- 29 Government Office for Science. *Foresight Report. Tackling Obesities: Future Choices – Modelling Future Trends in Obesity and the Impact on Health*. Government Office for Science, 2007, p. 40. Available at <http://www.bis.gov.uk/assets/foresight/docs/obesity/17.pdf>
- 30 British Heart Foundation Health Promotion Research Group. *Coronary Heart Disease Statistics 2010*. British Heart Foundation, 2010.
- 31 Department of Health. National expenditure data 2003–04 to 2010–11. Available at [http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH\\_075743#\\_3](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_3)
- 32 Beecham J, Knapp M, Fernández J-L, Huxley P, Mangalore R, McCrone P, et al. *Age Discrimination in Mental Health Services* (PSSRU Discussion Paper 2536). Personal Social Services Research Unit, 2008. Available at <http://www.pssru.ac.uk/pdf/dp2536.pdf>
- 33 Kennedy I. *Getting It Right for Children and Young People*. Department of Health, 2010.
- 34 Medical Research Council. *Review of Mental Health Research*. MRC, 2010.
- 35 UK Clinical Research Collaboration. *UK Health Research Analysis*. UKCRC, 2006.
- 36 Royal College of Psychiatrists. *Mental Health and the Economic Downturn: National Priorities and NHS Solutions* (OP70). RCPsych, 2009, p. 9. Available at <http://www.rcpsych.ac.uk/files/pdfversion/OP70.pdf>
- 37 Centre for Mental Health, Mental Health Foundation, Mind, Rethink Mental Illness. *The Mental Health Strategy, System Reforms and Spending Pressures: What Do We Know So Far?* Mental Health Foundation, 2011. Available at [http://www.mentalhealth.org.uk/content/assets/PDF/publications/mental\\_health\\_strategy\\_what\\_do\\_we\\_know\\_so\\_far.pdf?view=Standard](http://www.mentalhealth.org.uk/content/assets/PDF/publications/mental_health_strategy_what_do_we_know_so_far.pdf?view=Standard)
- 38 Bambra C. Yesterday once more? Unemployment and health in the 21st century. *J Epidemiol Community Health* 2010; **64**: 213–15.
- 39 Marmot Review. *Fair Society, Healthy Lives. The Strategic Review of Health Inequalities in England Post-2010*. Marmot Review, February 2010.
- 40 Health equity – an election manifesto? *Lancet* 2010; **375**: 525. Available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60210-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60210-3/fulltext)
- 41 Department of Health. *Services for People with Learning Disabilities, Challenging Behaviour or Mental Health Needs*. Project Group Report. Department of Health, 1993.

- 42 McManus S, Meltzer H, Brugha T, *et al.* *Adult Psychiatric Morbidity in England, 2007. Results of a Household Survey.* NHS Information Centre for Health and Social Care, 2009. Available at <https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-apx.pdf>
- 43 Ormel J, Petukhova M, Chatterji S, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, *et al.* Disability and treatment of specific mental and physical disorders across the world. *Br J Psychiatry* 2008; **192**: 368–75.
- 44 Russell G. Identification of children with the same level of impairment as children on the autistic spectrum, and analysis of their service use. *J Child Psychol Psychiatry* 2010; **51**: 643–51.
- 45 Wahlbeck K, Westman J, Nordentoft M, Gissler M, Laursen TM. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *Br J Psychiatry* 2011; **199**: 453–8.
- 46 Osborn DPJ. Physical activity, dietary habits and coronary heart disease risk factor knowledge amongst people with severe mental illness: a cross-sectional comparative study in primary care. *Soc Psychiatry Psychiatr Epidemiol* 2007; **42**: 787–93.
- 47 Knapp M, McDaid D, Parsonage M, eds. *Mental Health Promotion and Mental Illness Prevention: The Economic Case.* Personal Social Services Research Unit, 2011. Available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_126085](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126085)
- 48 HM Government. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. Supporting Document – The Economic Case for Improving Efficiency and Quality in Mental Health.* Department of Health, 2011, p. 6. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_123993.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123993.pdf)
- 49 Saha S, Chant D, McGrath JA. Systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time? *Arch Gen Psychiatry* 2007; **64**: 1123–31.
- 50 Brown S, Kim M, Mitchell C, *et al.* Twenty-five year mortality of a community cohort with schizophrenia. *Br J Psychiatry* 2010; **196**: 116–21.
- 51 Russ TC, Stamatakis E, Hamer M, Starr JM, Kivimäki M, Batty GD. Association between psychological distress and mortality: individual participant pooled analysis of 10 prospective cohort studies. *BMJ* 2012; **345**: e4933.
- 52 Mykletun A, Bjerkeset O, Overland S, *et al.* Levels of anxiety and depression as predictors of mortality: the HUNT study. *Br J Psychiatry* 2009; **195**: 118–25.
- 53 Chang C-K, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, Lee WE, *et al.* Life expectancy at birth for people with severe mental illness and other major disorders from a secondary mental health care case register in London. *PLoS ONE* 2011; **6**: e19590.
- 54 Thornicroft G, Brohan E, Kassam A, Lewis-Holmes E. Reducing stigma and discrimination: candidate interventions. *Int J Ment Health Syst* 2008; **2**: 3.
- 55 Mitchell AJ, Lord O, Malone D. Differences in the prescribing of medication for physical disorders in individuals with v. without mental illness: meta-analysis. *Br J Psychiatry* 2012; **201**: 435–43.
- 56 McManus S, Meltzer H, Campion J. *Cigarette Smoking and Mental Health in England. Data from the Adult Psychiatric Morbidity Survey 2007.* National Centre for Social Research, 2010. Available at [http://www.natcen.ac.uk/media/660073/smoking\\_and\\_mental\\_health\\_-\\_final\\_report\\_revised%20and%20final.pdf](http://www.natcen.ac.uk/media/660073/smoking_and_mental_health_-_final_report_revised%20and%20final.pdf)
- 57 Phelan M, Stradins L, Morrison S. Physical health of people with severe mental illness. *BMJ* 2001; **322**, 443–4.
- 58 Siru R, Hulse GK, Tait RJ. Assessing motivation to quit smoking in people with mental illness: a review. *Addiction* 2009; **104**: 719–33.
- 59 Department of Health. *Local Stop Smoking Services. Service Delivery and Monitoring Guidance 2011/12.* Department of Health, 2011, p. 77. Available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_125389](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389)
- 60 Lawrence DM, Holman CD, Jablensky AV, Hobbs MS. Death rate from ischaemic heart disease in Western Australian psychiatric patients 1980–1998. *Br J Psychiatry* 2003; **182**: 31–6.
- 61 Sullivan G. Disparities in hospitalisation for diabetes among persons with and without co-occurring mental health disorders. *Psychiatr Serv* 2006; **57**: 1126–31.
- 62 National Institute for Health and Clinical Excellence. *Venous Thromboembolism: Reducing the Risk.* NICE, 2010.
- 63 Zhang R, Dong L, Shao F, Tan X, Ying K. Antipsychotics and venous thromboembolism risk: a meta-analysis. *Pharmacopsychiatry* 2011; **44**: 183–8.

- 64 Jenkinson J. A critical analysis of VTE prophylaxis in psychiatric inpatients. Poster presentation, Royal College of Psychiatrists' International Congress, July 2012.
- 65 Independent Advisory Panel on Deaths in Custody. *Deaths of Patients Detained Under the Mental Health Act*. Independent Advisory Panel, 2011. Available at <http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/deaths-of-patients-detained-under-the-mental-health-act-mha>
- 66 Hippisley-Cox J, Coupland C. Development and validation of risk prediction algorithm (QThrombosis) to estimate future risk of venous thromboembolism: prospective cohort study. *BMJ* 2011; **343**: d4656.
- 67 Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. *Br J Psychiatry* 2011; **199**: 441–2.
- 68 Reilly S, Planner C, Hann M, Reeves D, Nazareth I, Lester H. The role of primary care in service provision for people with severe mental illness in the United Kingdom. *PLoS One* 2012; **7**: e36468.
- 69 National Institute for Health and Clinical Excellence. *Depression in Adults with a Chronic Physical Health Problem: Treatment and Management*. NICE, 2010, p. 23. Available at <http://www.nice.org.uk/nicemedia/live/12327/45913/45913.pdf>
- 70 Unützer J, Schoenbaum M, Katon WJ, Fa MY, Pincus H, Hogan D, et al. Healthcare costs associated with depression in medically ill fee-for-service Medicare participants. *J Am Geriatr Soc* 2009; **57**: 506–10.
- 71 Naylor C, Galea A, Parsonage M, McDaid D, Knapp M, Fossey M. *Long-Term Conditions and Mental Health: The Cost of Co-morbidities*. King's Fund and Centre for Mental Health, 2012.
- 72 Hemingway H, Marmot M. Evidence-based cardiology: psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. *BMJ* 1999; **318**: 1460–7.
- 73 Nicholson A, Kuper H, Hemingway H. Depression as an aetiological and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146,538 participants in 54 observational studies. *Eur Heart J* 2006; **318**: 1460–7.
- 74 Fenton W, Stover E. Mood disorders: cardiovascular and diabetes co-morbidity. *Curr Opin Psychiatry* 2006; **19**: 421–7.
- 75 Ryan J, Carriere I, Ritchie K, Stewart R, Toulemonde G, Dartigues JF, et al. Late-life depression and mortality: influence of gender and antidepressant use. *Br J Psychiatry* 2008; **192**: 12–18.
- 76 Burgess C. Depression and anxiety in women with early breast cancer: five year observational cohort study. *BMJ* 2005; **330**: 702.
- 77 Office for National Statistics (2008), cited in Children and Young People's Mental Health (joint briefing paper). Royal College of Paediatrics and Child Health, 2010.
- 78 Academy of Medical Royal Colleges. *No Health Without Mental Health: The ALERT Summary Report*. Academy of Medical Royal Colleges, 2009, p. 11.
- 79 Royal College of Psychiatrists. *Liaison Psychiatry and the Management of Long-Term Conditions and Medically Unexplained Symptoms* (Faculty of Liaison Psychiatry Faculty Report FR/LP/1). RCPsych, February 2012. Available at <http://www.rcpsych.ac.uk/pdf/Liaison-psychiatry-faculty-report.pdf>
- 80 Parsonage M, Fossey M. *Economic Evaluation of a Mental Health Service*. Centre for Mental Health, 2011. Available at [http://www.centreformentalhealth.org.uk/pdfs/economic\\_evaluation.pdf](http://www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf)
- 81 Hindley P, Mahomed F. An international survey of paediatric liaison services. Paper presented at the CAFE residential conference, September 2012.
- 82 Academy of Medical Royal Colleges. *Measuring Up: The Medical Profession's Prescription for the Nation's Obesity Crisis*. AoMRC, 2013. Available at [http://www.aomrc.org.uk/publications/reports-a-guidance/doc\\_details/9673-measuring-up.html](http://www.aomrc.org.uk/publications/reports-a-guidance/doc_details/9673-measuring-up.html).
- 83 College of Emergency Medicine. *Mental Health in Emergency Departments: A Toolkit for Improving Care*. CEM, 2013 (forthcoming).
- 84 Centre for Economic Performance Mental Health Policy Group. *How Mental Health Loses Out in the NHS*. London School of Economics, 2012.
- 85 We Need To Talk Coalition. *We Need To Talk – Getting the Right Therapy at the Right Time*. We Need To Talk Coalition, 2010. Available at [http://www.mind.org.uk/assets/0001/0090/Mind\\_We\\_need\\_to\\_talk\\_Report\\_\\_REVISED\\_20\\_10\\_10\\_.pdf](http://www.mind.org.uk/assets/0001/0090/Mind_We_need_to_talk_Report__REVISED_20_10_10_.pdf)
- 86 Mind. *Listening to Experience: An Independent Inquiry into Acute and Crisis Mental Healthcare*. Mind, 2011. Available at [http://www.mind.org.uk/assets/0001/5921/Listening\\_to\\_experience\\_web.pdf](http://www.mind.org.uk/assets/0001/5921/Listening_to_experience_web.pdf)

- 87 Mind. *Personalisation in Mental Health: A Review of the Evidence*. Mind, 2009. Available at [http://www.mind.org.uk/assets/0000/2164/putting\\_us\\_first\\_personalisation.pdf](http://www.mind.org.uk/assets/0000/2164/putting_us_first_personalisation.pdf)
- 88 Mental health patients to be given new rights. *Guardian*, 13 December 2012. Available at <http://www.guardian.co.uk/society/2012/dec/13/mental-health-patients-new-rights>
- 89 Department of Health. Steps set out for greater patient involvement and more choice (Press release). Department of Health, 2012. Available at <http://www.dh.gov.uk/health/2012/12/choice-response>
- 90 National Institute for Health and Clinical Excellence. *QS14: Quality Standard for Service User Experience in Adult Mental Health. Quality Statement 3: Shared Decision-Making and Self-Management*. NICE, 2011. Available at <http://publications.nice.org.uk/quality-standard-for-service-user-experience-in-adult-mental-healthqs14/quality-statement-3-shared-decision-making-and-self-management>
- 91 King's Fund. *Making Shared Decision-Making a Reality*. King's Fund, 2011, p. 3. Available at <http://www.kingsfund.org.uk/publications/making-shared-decision-making-reality>
- 92 Mind. Online personal health budget survey. Survey sample size of 502 respondents, available from 20 June 2012–13 August 2012. Mind, 2012.
- 93 Worthington A, Rooney P. *The Triangle of Care – Carers Included: A Guide to Best Practice in Acute Mental Health Care*. National Mental Health Development Unit and Princess Royal Trust for Carers, 2010. Available at <http://static.carers.org/files/caretriangle-web-5250.pdf>
- 94 Lester H. Speech to the RCGP annual conference 2012, as reported by GP Online at <http://www.gponline.com/News/article/1161375/offer-longer-consultations-mental-health-urges-senior-gp>
- 95 Judi Chamberlin, cited in the introduction to Thornicroft G. *Shunned: Discrimination Against People With Mental Illness*. Oxford University Press, 2006.
- 96 Mental health service user quoted in Coleman C, Dunmur J. *Surveying Mental Health Advocacy Needs in Sheffield*. Commissioned by Sheffield Community Mental Health Trust, published by Sheffield Community Health Council, 2001 (ISBN 0-9541553-0-0).
- 97 Lasalvia A, Zoppei S, Van Bortel T, Bonetto C, Cristofalo D, Wahlbeck K, *et al.* Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *Lancet* 2013; **381**:55–62.
- 98 Thornicroft G. Stigma and discrimination limit access to mental health care. *Epidemiol Psychiatr Soc.* 2008; **17**: 14–19.
- 99 Bhugra D, Cochrane R. *Psychiatry in Multicultural Britain*. Gaskell, 2001.
- 100 Henderson C, Corker E, Lewis-Holmes E, Hamilton S, Flach C, Rose D, *et al.* England's Time to Change antistigma campaign: one-year outcomes of service user-rated experiences of discrimination. *Psychiatr Serv* 2012; **63**: 451–7.
- 101 Equality and Human Rights Commission. *The Essential Guide to the Public Sector Equality Duty: England (and Non-Devolved Public Authorities in Scotland and Wales)*. EHRC, 2012, pp. 2–4. Available at [http://www.equalityhumanrights.com/uploaded\\_files/EqualityAct/PSSED/essential\\_guide\\_update.pdf](http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSSED/essential_guide_update.pdf)
- 102 Curtice M, Exworthy T. FREDA: a human rights-based approach to healthcare. *The Psychiatrist* 2010; **34**: 150–6, at pp. 153, 151.
- 103 Department of Health/Ipsos Mori. *Human Rights in Healthcare Evaluation*. Department of Health, 2008, p. 1. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_088980.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088980.pdf)
- 104 Barnes T, Paton C. Improving prescribing practice in psychiatry: the experience of the Prescribing Observatory for Mental Health (POMH-UK). *Int Rev Psychiatry* 2011; **23**: 328–35.
- 105 Royal Pharmaceutical Society. *Getting the Medicines Right – When the Patient Transfers Between Care Providers*. RPS, 2012. Available at <http://www.rpharms.com/current-campaigns-pdfs/rps-transfer-of-care-final-report.pdf>
- 106 Department of Health. *NHS Premises Assurance Model*. Department of Health, 2011. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_128760.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128760.pdf)
- 107 Royal College of Psychiatrists. *Do the Right Thing: How to Judge a Good Ward (OP79)*. RCPsych, 2011. Available at <http://www.rcpsych.ac.uk/files/pdfversion/OP79.pdf>
- 108 Healthcare Commission. *The Pathway to Recovery: A Review of NHS Acute Inpatient Mental Health Services*. Healthcare Commission, 2008.

- 109 Care Quality Commission. *Inpatient Survey 2011: National Summary*. CQC, 2011. Available at [http://www.cqc.org.uk/sites/default/files/media/documents/ip11\\_national\\_summary\\_final.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/ip11_national_summary_final.pdf)
- 110 Schizophrenia Commission. *The Abandoned Illness*. Rethink, 2012. Available at <http://www.schizophreniacommission.org.uk/the-report>
- 111 Care Quality Commission. *Monitoring the Mental Health Act in 2010/11*. CQC, 2011. Available at [http://www.cqc.org.uk/sites/default/files/media/documents/cqc\\_mha\\_report\\_2011\\_main\\_final.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mha_report_2011_main_final.pdf)
- 112 Shonkoff JP, Garner AS. The Lifetime Effects of Early Childhood Adversity and Toxic Stress (Technical Report). *Pediatrics* 2012; **129**: e232.
- 113 Centers for Disease Control and Prevention, Kaiser Permanente's Health Appraisal Clinic in San Diego. *Adverse Childhood Experiences Study*. Detailed information available at <http://www.cdc.gov/ace>; complete bibliography of ACE Study publications listed by topic area at <http://www.cdc.gov/nccdphp/ace>
- 114 Anda RF, Felitti VJ, Bremner JD, Walker JD, Whitfield C, Perry BD, *et al*. The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci* 2006; **256**: 174–86.
- 115 Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustün TB. Age of onset of mental disorders: A review of recent literature. *Curr Opin Psychiatry* 2007; **20**: 359–64.
- 116 Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Prior juvenile diagnosis in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. *Arch Gen Psychiatry* 2003; **60**: 709–17.
- 117 Allen G. *Early Intervention: The Next Steps: An Independent Report to Her Majesty's Government*. Cabinet Office, 2011. Available at <http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf>
- 118 Allen G. *Early Intervention: Smart Investment, Massive Savings*. Cabinet Office, 2011. Available at <http://www.cabinetoffice.gov.uk/sites/default/files/resources/earlyintervention-smartinvestment.pdf>
- 119 United Nations Convention on the Rights of the Child at <http://www2.ohchr.org/english/law/pdf/crc.pdf>
- 120 Edwards VJ, Anda RF, Dube SR, Dong M, Chapman DF, Felitti VJ. The wide-ranging health consequences of adverse childhood experiences. In *Victimization of Children and Youth: Patterns of Abuse, Response Strategies* (ed K Kendall-Tackett, S Giacomoni). Civic Research Institute, 2005.
- 121 Douglas H. Supporting emotional health and wellbeing: the Solihull Approach. *Community Practitioner* 2010; **83**: 22–5.
- 122 Squires J, Bricker D, Heo K, Twombly E. Identification of social-emotional problems in young children using a parent-completed screening measure. *Early Childhood Research Quarterly* 2001; **16**: 405–19.
- 123 Karoly LA, Kilburn RA, Cannon JS. *Early Childhood Interventions: Proven Results, Future Promises*. RAND Corporation, 2005, p. xxv. Available at <http://www.rand.org/pubs/monographs/MG341>
- 124 Reynolds AJ, Temple JA. Cost-effective early childhood development programs from preschool to third grade. *Annu Rev Clin Psychol* 2008; **4**: 109–39.
- 125 Reynolds AJ, Temple JA, Zigler E. Economic benefits of investments in preschool education. In *A Vision for Universal Prekindergarten* (ed W Gilliam, S Jones). Cambridge University Press, 2006.
- 126 Weare K, Nind M. Promoting mental health of children and adolescents through schools and school-based interventions: report of workpackage three of the DataPrev Project. DataPrev, 2011. Available at [http://www.dataprevproject.net/files/final\\_reports/WP3%20-%20Final%20Report%20-%20Promoting%20Mental%20Health%20of%20Children%20and%20Adolescents.pdf](http://www.dataprevproject.net/files/final_reports/WP3%20-%20Final%20Report%20-%20Promoting%20Mental%20Health%20of%20Children%20and%20Adolescents.pdf)
- 127 National Institute for Health and Clinical Excellence. *Promoting Young People's Social and Emotional Well-Being in Secondary Education*. NICE, 2009. Available at <http://www.nice.org.uk/nicemedia/live/11991/45484/45484.pdf>
- 128 Durlak JA, Weissberg RP, Dymnicki AB, *et al*. The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions. *Child Dev* 2011; **82**: 474–501.
- 129 Beecham J, Baingana F, Bonin E, *et al*. School-based universal violence prevention programmes. Personal Social Services Research Unit. Unpublished paper prepared for the Department of Health, 2010.
- 130 Kipps S, Bahu T, Ong K, Ackland FM, Brown RS, Fox CT, *et al*. Current methods of transfer of young people with Type 1 diabetes to adult services. *Diabet Med* 2002; **19**: 649–54.
- 131 Singh S. Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. *Br J Psychiatry* 2010; **197**: 305–12.



- 132 Age Concern. *Improving Services and Support for Older People with Mental Health Problems*. The Second Report from the UK Inquiry into Mental Health and Well-Being in Later Life. Age Concern, 2007.
- 133 Audit Commission. *Forget Me Not: Mental Health Services For Older People*. Audit Commission, 2000, p. 22. Available at <http://www.audit-commission.gov.uk/subwebs/publications/studies/studyPDF/1368.pdf>
- 134 Mitchell AJ, Meader N, Pentzek M. Clinical recognition of dementia and cognitive impairment in primary care: a meta-analysis of physician accuracy. *Acta Psychiatr Scand* 2011; **124**: 165–83.
- 135 Prince M, Bryce R, Ferri C. *World Alzheimer Report 2011: The Benefits of Early Diagnosis and Intervention*. Alzheimer's Disease International, 2011, p. 66. Available at <http://www.alz.co.uk/research/WorldAlzheimerReport2011.pdf>
- 136 Royal College of Psychiatrists. *Who Cares Wins*. RCPsych, 2005. Available at <http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf>
- 137 Sampson EL, Blanchard MR, Jones L, Tookman A, King M. Dementia in the acute hospital: prospective cohort study of prevalence and mortality. *Br J Psychiatry* 2009; **195**: 61–6.
- 138 Banerjee S, Chan J. Organization of old age psychiatric services. *Psychiatry* 2008; **7**: 49–54.
- 139 Gordon A. Dementia screening in acute medical and geriatric hospital admissions. *The Psychiatrist* 2009; **33**: 52–4.
- 140 Alzheimer's Society. *Dementia UK: A Report into the Prevalence and Cost of Dementia*. Personal Social Services Research Unit, 2007.
- 141 Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H, et al. *The Need to Tackle Age Discrimination in Mental Health: A Compendium of Evidence*. Royal College of Psychiatrists, 2010.
- 142 Centre for Policy on Ageing. *Ageing and Age Discrimination in Mental Health Care in the United Kingdom*. CPA, 2009. Available at [http://www.cpa.org.uk/information/reviews/CPA-ageism\\_and\\_age\\_discrimination\\_in\\_mental\\_health\\_care-report.pdf](http://www.cpa.org.uk/information/reviews/CPA-ageism_and_age_discrimination_in_mental_health_care-report.pdf)
- 143 Department of Health. *Talking Therapies: A Four-Year Plan of Action. A Supporting Document to No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Department of Health, 2011. Available at <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf>
- 144 Alzheimer's Research Trust, University of Oxford. *Dementia 2010: The Prevalence, Economic Cost and Research Funding of Dementia Compared to Other Major Disorders*. Alzheimer's Research Trust, 2010. Available at <http://www.dementia2010.org/reports/Dementia2010ExecSummary.pdf>
- 145 Department of Health. *The Prime Minister's Challenge on Dementia: Delivering Major Improvements in Care and Research by 2015*. Department of Health, 2012. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_133176.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133176.pdf)
- 146 Department of Health. *Psychiatric Morbidity Among Prisoners in England and Wales*. Department of Health, 1998. Available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH\\_4007132](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4007132)
- 147 Ministry of Justice. *Story of the Prison Population: 1993–2012 England and Wales*. Ministry of Justice, 2013. Available at <http://www.justice.gov.uk/downloads/statistics/mojstats/story-prison-population.pdf>
- 148 Department of Health. Health Secretary orders review into new rating system for NHS and social care. Department of Health, 28 November 2012. Available at <http://www.dh.gov.uk/health/2012/11/new-ratings>
- 149 Department of Health. *Quality Criteria for Young People Friendly Health Services*. Department of Health, 2011. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_127632.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127632.pdf)
- 150 Waddell G, Burton AK. *Is Work Good for Your Health and Well-being? The Stationery Office*, 2006.
- 151 British Occupational Health Research Foundation. *Workplace Interventions for People with Common Mental Health Problems: Evidence Review and Recommendations*. BOHRF, 2005. Available at [http://www.bohrf.org.uk/downloads/cmh\\_rev.pdf](http://www.bohrf.org.uk/downloads/cmh_rev.pdf)
- 152 Centre for Mental Health. CQC survey shows that people are not getting the support that they need to find a job (Press release). CMH, 2012. Available at [http://www.centreformentalhealth.org.uk/news/2012\\_cqc\\_results.aspx](http://www.centreformentalhealth.org.uk/news/2012_cqc_results.aspx)

- 153 Centre for Mental Health. Commissioning what works can save millions to the NHS, says Sainsbury Centre report (Press release). CMH, 2009. Available at [http://www.centreformentalhealth.org.uk/news/2009\\_commissioning\\_what\\_works.aspx](http://www.centreformentalhealth.org.uk/news/2009_commissioning_what_works.aspx)
- 154 Department of Health. *NHS Health and Well-Being*. Department of Health, 2009. Available at <http://www.nhshealthandwellbeing.org/pdfs/NHS%20Staff%20H&WB%20Review%20Final%20Report%20VFinal%2020-11-09.pdf>
- 155 Joint pledge on work and mental wellbeing. New Savoy Partnership, *et al*, 2011. Available at [http://www.newsavoypartnership.org/2011presentations/joint\\_pledge\\_on\\_work\\_and\\_mental\\_well-being.pdf](http://www.newsavoypartnership.org/2011presentations/joint_pledge_on_work_and_mental_well-being.pdf)
- 156 HM Government. Access to Work pages on [http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG\\_4000347](http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_4000347)
- 157 Royal College of Psychiatrists. *The Work Capability Assessment and People with Mental Health Problems: The Case for Better Use of Medical Evidence*. RCPsych, 2012. Available at <http://www.rcpsych.ac.uk/pdf/WCA%20Medical%20Evidence%20joint%20briefing%20April%202012%20V%20FINAL.pdf>
- 158 Work and Pensions Select Committee. Inquiry into IB migration, 18 May 2011
- 159 Barnes H, Aston J, Williams C. *Employment and Support Allowance: Customer and Staff Experience of the Face-to-Face Work Capability Assessment and Work-Focused Health-Related Assessment (DWP report 719)*. Department for Work and Pensions, 2010.
- 160 Work and Pensions Select Committee. The role of incapacity benefit reassessment in the helping claimants into employment. July 2011
- 161 Bradley Review. *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. Department of Health, 2009. Available at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_098698.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf)
- 162 NSPCC. *Child Cruelty in the UK 2011: The Facts*. NSPCC, 2011.
- 163 Children and Young People's Mental Health Coalition. *Resilience and Results: How to Improve the Emotional and Mental Wellbeing of Children and Young People in Your School*. Children and Young People's Mental Health Coalition, 2012. Available at [http://www.cypmhc.org.uk/media/common/uploads/Final\\_pdf.pdf](http://www.cypmhc.org.uk/media/common/uploads/Final_pdf.pdf)
- 164 Lester H, Shiers DE, Rafi I, Cooper SJ, Holt RIG (2012) Positive cardiometabolic health resource: an intervention framework for patients with psychosis on antipsychotic medication. Royal College of Psychiatrists, 2012. Available at <http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx>. See Annexe A1.
- 165 Manu P, Correll C, van Winkel R, Wampers M, De Hert M. Prediabetes in patients treated with antipsychotic drugs. *J Clin Psychiatry* 2011; **73**: 460–6.
- 166 Mitchell A, Vancampfort D, De Herdt A, Yu W, De Hert M. Is the prevalence of metabolic syndrome and metabolic abnormalities increased in early schizophrenia? A comparative meta-analysis of first episode, untreated and treated patients. *Schizophr Bull* 2013 [Epub ahead of print, doi 10.1093/schbul/sbs082].
- 167 Myles N, Newall HD, Curtis J, Nielssen O, Shiers D, Large M. Tobacco use before, at and after first-episode psychosis – a systematic meta-analysis. *J Clin Psychiatry* 2012; **73**: 468–75.
- 168 National Institute for Health and Clinical Excellence. *Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care* (Update CG 82). NICE, 2009.
- 169 National Institute for Health and Clinical Excellence. *Preventing Type 2 Diabetes: Risk Identification and Interventions for Individuals at High Risk* (Public Health Guidance PH38). NICE, 2012.

