

Parity in progress?

The All Party Parliamentary Group on Mental Health's
inquiry into parity of esteem for mental health

March 2015



All Party Parliamentary Group on Mental Health

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Foreword

James Morris MP

Chairman of the All Party Parliamentary Group on Mental Health

Mental health, for so long the Cinderella service of the NHS, is finally being taken seriously by policymakers and medical professionals alike. For those of us on the APPG for Mental Health and others who have long championed the importance of good mental health provision, this has been a welcome development but none of us believe that the work is done.

We believe that in order for improvements to be made in the overall health and wellbeing of the nation, mental health must be given the same level of priority as physical health. The evidence backing this up is very straightforward: mental illnesses cause more disability than any other health condition, lead to unnecessary suffering for both patients and families, and cause long-term economic damage when not properly addressed.

It is good to see all Westminster political parties talking about prioritising mental health ahead of the General Election in May and I am proud of the achievements of both the APPG and ministers across departments since 2010 on mental health. This report is a timely one, coming a year after we began our inquiry and at a time when parity of esteem is finally being taken seriously.

I would like to thank all those who contributed evidence, appeared as witnesses, attended inquiry sessions and contributed their expertise. In particular I would like to thank Lynn Burling, Sue Goddard and Shalini Bhalla who all spoke very movingly about their own experiences, as well as Megan Cleaver, Katie Howe, Paula Reid and Lizzie Blow who worked very hard to ensure the inquiry and this report were a success.

Mike Thornton MP

Vice-Chair of the All Party Parliamentary Group on Mental Health

Mental health is everyone's business. It can affect anyone, anywhere, at any point in our lives. Indeed, it is estimated that as many as one in four will at some point experience a mental health problem. Many more of us will be indirectly affected as family or friends – yet in our society, mental health does not receive the same attention as physical health.

The Coalition Government has made good progress on the issue of mental health. Last October, came the promise by the Deputy Prime Minister Nick Clegg of a £120 million investment in mental health and the landmark announcement of the first ever waiting time standards for mental health in the NHS.

This truly is a watershed moment in the campaign for improved mental healthcare and, as I pen this page, I have a real sense of optimism that things are finally moving in the right direction.

But we must not stop here. At the heart of this report is a clear message: we need to do more to ensure the commitment to parity is translated into concrete improvements in care on the ground. We have set ambitious, but realistic, targets and now we need to ensure these important changes translate into tangible improvements for everyone trying to access the help they need.

There is still so much more to do. Services and agencies must work together to better respond to people who are in mental health crisis, and the Mental Health Crisis Care Concordat is a welcome step in the right direction.

Gloria De Piero MP

Vice-Chair of the All Party Parliamentary Group on Mental Health

We should all care about mental health. Anyone can develop mental health problems no matter what their age or background. Every year one in four people will experience a mental health problem.

That is why ensuring people are able to access the appropriate services at the right time is fundamental to achieving 'parity of esteem' between mental and physical health. The Labour Party is absolutely committed to providing fairer access to mental health services.

Ministers must do more to honour the government's promise to treat patients with mental illnesses with the same importance and attention as they do patients with physical ill health. It is also vital that all professional NHS staff receive mental health training.

We have seen public attitudes towards mental health start to improve and people are speaking out about mental health more than ever before, but the road to breaking down the stigma and discrimination people with mental health problems still face is a long one. This report is a stark reminder that 'parity of esteem' is far from being achieved in mental health services.

Most of all, we need a society where mental health problems are not hidden in shame and secrecy. Stepping out mental health stigma is imperative and we should support awareness campaigns like Time to Change.

As the Coalition Government is coming to an end, the challenge and the opportunity for the next Government is clear. Achieving parity for mental health is a monumental task and, although much progress has been made during this Government, it is evident the task is far from finished. We need to use this momentum to bring a lasting change and once and for all end the 'Cinderella' mental health service.

It is shocking that people with severe mental health problems die on average twenty years earlier than the general population because their physical health needs are not addressed and that people who are experiencing a mental health crisis in different areas of Britain have such different experiences in the response, support and treatment they receive. We have heard evidence from people who've been told to wait 'until the morning' to get the help they need, or are taken to a police cell as a first port of call.

The group also took evidence on public mental health. It makes economic sense to help prevent people from developing mental health problems in the first place, and the recommendations for early interventions in mental health would enable this. If we are to see genuine 'parity of esteem', then mental health has to be made a priority. This report makes recommendations that would bring real improvements for us all.

Executive summary

It is estimated that 1 in 4 people in the UK are affected by mental health problems. Despite this, the quality of mental health services, and the resources available to them, continues to lag behind physical health. Mental health problems account for 23% of the total impact of ill health in the UK. However, only 13% of the NHS budget is allocated to mental health.¹

This lack of parity has a significant effect on the support available for people affected by mental health problems. For example, only 24% of people with anxiety and depression currently access treatment, compared with the 51% treatment rate for arthritis and 72% treatment rate for chronic pain.²

There are three key areas where we believe the disparity between mental health and physical health is most evident:

- **The unacceptably large ‘premature mortality gap’:** People with serious mental illness die on average 15–20 years earlier than those without. They are also at an increased risk of developing physical health conditions such as heart disease and diabetes.³
- **An acute shortage of high quality mental health crisis care:** People experiencing a mental health crisis often do not receive timely and appropriate support from mental health services. In 2013/14 6,000 people were detained in police cells because of this lack of health-based alternatives.⁴ The range and quality of care people receive also varies enormously depending on where they live.

- **The failure to prioritise mental health promotion and prevention in public health strategies:** Despite the high numbers of people affected by mental illness, local authority public health strategies currently concentrate overwhelmingly on physical health, with only 1.4% of public health spending allocated to mental health.⁵

While our inquiry found that the Government is indeed taking welcome steps in addressing the lack of parity in these areas (with areas of good practice existing around the country), given the progress that still needs to be made, we strongly urge that their efforts be accelerated. The APPG would therefore like to see the following recommendations implemented to reduce premature mortality for people with mental health problems, improve the quality of mental health emergency care, and ensure mental health is a public health priority.

Furthermore, we have outlined further courses of action for the Government to take which would ensure the disparity between mental and physical health is tackled at its core.

Recommendations

Reducing premature mortality for people with mental health problems

- The Government should introduce an objective setting out a quantified national reduction in premature mortality among people with mental health problems so progress against this commitment can be measured. This should be supported by long-term alignment of key policy levers, such as CQUINs and the Outcomes Frameworks, under this objective.
- All mental health professionals should receive basic physical health training as part of their mandatory training. Likewise, mandatory continuous professional development in mental health should be introduced for all doctors and nurses, (similar to, for example, the annual mandatory resuscitation training for psychiatrists).
- People with mental health problems should be offered tailored support to quit smoking, and staff in mental health services should be provided with training to support them. Targets such as the current 18.5% target for smoking reduction by the end of 2015 should apply equally to people with mental health problems.
- To support people to make informed choices about their treatment, they should be offered clear and accessible information about the side effects of antipsychotic medication. Their physical health should be monitored closely so that any identified health needs are quickly acted upon.
- Commissioners and service providers must ensure that systems are in place locally so that primary and secondary care services are clear about their respective responsibilities for monitoring and managing the physical health of people with mental health problems.

Improving the quality of mental health emergency care

Everyone experiencing a mental health crisis should be able to access safe and speedy access to quality crisis care 24 hours a day, 7 days a week, regardless of where they turn to first.

This should be achieved by:

- Delivering training in mental health to all professionals that may come into contact with people in crisis, with a focus on interagency training to ensure police, ambulance and health staff understand their respective roles and responsibilities. The delivery of this training should also involve people using mental health services and carers to emphasise the importance of compassion and understanding in assisting an individual's recovery.
- Increasing the use of joint crisis plans. These are developed by patients and staff together and contain an individual's preferred treatment in the case of a mental health emergency, thereby embedding the principles of choice and control in crisis care provision.
- Clinical Commissioning Groups (CCGs) should commission a wider range of community-based support services for people in crisis, for example crisis care houses, ensuring they have appropriate staffing levels. They should also ensure sufficient mental health inpatient beds are commissioned to avoid people being turned away or forced to travel out of their local area to receive support.
- A commitment from the next Government to ensure the implementation of the Crisis Care Concordat beyond 2015, including the roll out of effective liaison psychiatry services in those remaining hospitals currently without such services.

- A commitment to continued funding for a national network of liaison and diversion mental health services, to ensure close working between mental health nurses and other mental health professionals and the police and courts.

Ensuring mental health is a public health priority

- The Department of Health should require all Joint Strategic Needs Assessments (JSNAs) to include information about the size, impact and cost of local mental health needs to ensure the commissioning of sufficient public mental health interventions.
- Every Health and Wellbeing Board should have a designated Mental Health Champion to ensure public mental health is a priority in Joint Health and Wellbeing Strategies (JHWBS).
- Mental health education should form a core part of the Personal, Social and Health Education (PSHE) curriculum, to promote wellbeing and resilience in children and young people and prevent mental health problems developing. This should also include training for teachers to recognise early signs of mental health problems and ensure they can signpost students to appropriate services.
- The Government should commit to national investment in evidence-based parenting programmes to improve the life chances of children and the wellbeing of families.

Addressing the institutional bias against mental health

- An independent review to be undertaken into i) how the Government holds NHS England to account in meeting its commitment to parity of esteem as set out in the NHS Mandate; and ii) how NHS England holds Clinical Commissioning Groups (CCGs) to account in meeting their commitment to parity of esteem as set out in the NHS Mandate. This review would set out what action(s) should be taken if any breach of the Mandate is found.
- The Government should undertake a review into how NHS funding for mental health is allocated to ensure that it is commensurate with its impact on children and young people, working-age adults, older adults and society as a whole.
- By the end of the next Parliament, the Department of Health should commit to increasing research on mental health to ensure it is proportionate to the prevalence of mental health problems and their impact. The Government should also seek to increase research into areas of co-/multi-morbidity, to accelerate the development of evidence-based treatments that demonstrate the interconnectivity of mental and physical health and comprehensively address an individual's health needs.

Introduction

In the last few years, no debate about mental health has taken place without reference to the concept of ‘parity of esteem’ – where mental health is given equal value to physical health. Indeed, a cross-party consensus has emerged that much more must be done to improve mental health care in England.

This has spanned the 2011 *No Health Without Mental Health* Government strategy,⁶ the 2014 Crisis Care Concordat, the most recent Department of Health strategy *Achieving Better Access to Mental Health Services by 2020*⁷ and iterations of the NHS Mandate. In October 2014, NHS England published the *NHS Five Year Forward View*, a vision for the future of health services.⁸ It clearly commits to breaking down the barriers between how care is provided for physical and mental health. These initiatives have made numerous high level commitments to achieving parity, with mental health never before having had such a high profile.

But in spite of these very welcome commitments, there is still a long way to go before what Care Minister Rt. Hon. Norman Lamb MP describes as an ‘institutional bias’ against mental health in the NHS is eliminated, and genuine parity is achieved. Indeed, a recent example of this bias was seen in early 2014 when NHS England and Monitor mandated a 20% bigger cut to mental health and community services’ budgets than their acute counterparts – something the Minister described as ‘totally unacceptable’.

In its most simple form, parity of esteem is defined as mental health having ‘equal value’ to physical health. What this would mean in practice is that taking a holistic view of an individual’s health (seeing the interdependencies between both their physical and mental health needs) would be the norm. And ‘parity’ would be entrenched in

every aspect of health policy, be it the planning, commissioning or delivery of all mental and physical health services and public health activity.

Widespread cultural change in the NHS is key to achieving such parity. Through improving both attitudes and knowledge of mental health, parity should be seen as a core element of the priorities, training and practice of all health professionals. In essence, such an approach would ensure that anyone experiencing a mental health problem should expect the same quality and access to treatment – and indeed the level of respect – as someone with a physical health problem.

The APPG acknowledges that achieving genuine parity of esteem is a considerable task – requiring a sustained long term commitment from future governments, policy-makers, commissioners, providers, professionals and indeed the public. Given the scale of this task, the APPG has held a yearlong inquiry into parity of esteem, concentrating on three areas:

- Reducing premature mortality for people with mental health problems.
- Improving the quality of mental health emergency care.
- Ensuring mental health is a public health priority.

The APPG had an overwhelming response to our inquiry, receiving more than 1500 responses from a wide range of organisations and individuals, including Government Ministers, health bodies, mental health professionals, people with lived experience of mental health problems, local government and third sector organisations.

The evidence received shows that there are indeed areas of good practice around the country and these should be celebrated and spread. However, too often the quality and provision of care in the three areas we looked at are simply not good enough and amount to a situation which would not be tolerated for those with physical health problems.

This report sets out what the current failings are in implementing parity of esteem and highlights what commitments the Government and others have made. We then set out a roadmap for action – outlining a series of recommendations for the Government and other relevant bodies to implement in order to accelerate the pace at which parity is being achieved.

We have also outlined some additional recommendations on how the Government and others can tackle the disparity between mental and physical health at its core, and address the aforementioned ‘institutional bias’ against mental health in the key areas covered by this inquiry.

“In its most simple form, parity of esteem is defined as mental health having ‘equal value’ to physical health.

What this would mean in practice is that taking a holistic view of an individual’s health (seeing the interdependencies between both their physical and mental health needs) would be the norm.”

Chapter 1

Reducing premature mortality for people with mental health problems

People with serious mental illness die, on average, 15-20 years earlier than the rest of the population, often because of preventable physical health conditions.⁹ Moreover, compared with the general population, people with serious mental illness are at an increased risk of developing a number of physical health problems.¹⁰

People affected by mental illness are twice as likely to have type 2 diabetes,¹¹ three times more likely to die from heart disease.¹² There is also a ten-fold increase in deaths from respiratory disease for people with schizophrenia.¹³

Such stark health inequalities can be attributed to a range of factors, most notably the failure of health service providers and professionals to adequately understand the link between poor physical and mental health. This leads to inadequate provision of the integrated, holistic care people need.

KEY FINDINGS

Despite the indisputable evidence that people with mental health problems are one of the most at-risk groups in our society when it comes to avoidable deaths, the majority of respondents to our inquiry highlighted unacceptably poor levels of physical health care. A number of respondents did provide examples of good practice, for example annual health checks for people taking antipsychotic medications and access to physical health activities in inpatient units. However we found that these simple, cost effective solutions, which could save thousands of lives, are not being implemented across the board.

The needs of the ‘whole person’ are not being treated in a holistic way

“Physical and emotional health should be treated equally and they are not mutually exclusive. Good physical health can help towards good emotional health.”

The APPG heard how many people with mental health problems felt that the needs of their ‘whole person’ were not being addressed. This was a particular issue in inpatient mental health settings, where unhealthy food and limited access to fresh air and exercise feature heavily. One carer told our inquiry that her son took up smoking whilst being treated on an inpatient ward due to sheer boredom and lack of any other meaningful activity. Indeed, smoking is viewed by many as the ‘only pleasure’ people in mental health settings have.

This attitude is not only costing lives, but is also completely at odds with the tobacco reduction measures implemented in the wider society, for example the banning of smoking in public places and the plans to introduce plain packaging for tobacco products. Likewise, the lack of attention paid to mental health problems in physical health settings was also raised as a key issue.

Of particular concern was the 'patchy' funding and availability of liaison psychiatry services which provide mental healthcare to people being treated for physical illness in general hospitals. One of the witnesses at the inquiry's public evidence session, Lynn Burling, spoke of the traumatic experience her son Alex, who has schizophrenia, had whilst being treated on a critical care ward following a thyroidectomy.

He became acutely unwell with psychosis and with no care plan in place to support his mental health needs, or any staff who were trained in mental health, his condition worsened and he was eventually detained under the Mental Health Act. This is a situation which caused both Alex and his family considerable distress and which could easily have been avoided if a more holistic support plan was in place.

'Diagnostic overshadowing' causes delayed diagnosis and treatment for physical health problems

"It's very hard to get doctors and consultants to take physical health symptoms seriously – they dismiss all symptoms as 'in your head'."

Even when people with mental health problems are able to access health services, evidence to our inquiry indicated that too often their physical health needs are ignored, or simply attributed to their mental health condition, rather than seen as a separate health issue. This 'diagnostic overshadowing' leads to physical conditions failing to be treated. The inquiry heard of a case where it took five years for a brain tumour to be diagnosed as the person's concerns were dismissed by doctors as 'all in their head'.

Moreover, concerns raised by family members or carers are also often ignored by health professionals. In Lynn's oral evidence to our inquiry, she described the poor treatment and care that her son has received throughout his life. Following the refusal of his GP to recognise both the cause and extent of Alex's physical ill health, it was Lynn herself who diagnosed her son's type 1 diabetes over ten years ago. Lynn believes this delay was a key contributor in his recent diagnosis with Stage 4 non-Hodgkin's lymphoma and thyroid cancer.

This 'diagnostic overshadowing' is having a particular impact on young people with mental health problems. In her oral evidence to the inquiry, Dr Arokia Antonysamy, a Consultant Psychiatrist, drew attention to a recent international study which showed that young people with mental health problems are refusing to seek help for physical health issues. This is due to the stigma, discrimination and prejudice that pervades the health system, and which has a significant impact on their physical health.

The physical side effects of antipsychotic medication are failing to be monitored and managed

"My GP should have been aware that my medication could potentially cause my appetite to increase and my weight too. By the time this was discovered I was already diabetic and on my way to having a stroke."

The use of antipsychotic medication has been shown to have significant side effects, such as changes to metabolism and associated weight gain. Indeed, research has found that people gain an average of 13lbs in the first two months of taking antipsychotic medication.¹⁴ This weight gain continues throughout the first year and can dramatically increase the risk of obesity, heart disease and type 2 diabetes.

However, in spite of the significant impact medication can have on an individual's physical health, our inquiry found that health checks are rarely conducted to monitor the impact of medication. Moreover, little information is given to people about how to manage these side effects and make informed decisions about their care and treatment. In his evidence to the inquiry, Rt. Hon. Norman Lamb MP referenced the 2012 National Audit of Schizophrenia which found that only 29% of people had received all the recommended physical health checks. Since the evidence session, the second round of this audit has been published, which showed little improvement since 2014.

In the latest set of results, only 33% of people had received all the relevant checks.¹⁵ The inquiry also heard of a case where individuals have requested to see a nutritionist to help them address their weight gain as a result of medication, but such requests have never been acted upon. This failure by health professionals to undertake even the most basic checks to monitor the impacts of medication can lead to significant physical health complications developing, and represents a huge missed opportunity to improve the overall health of people with mental health problems.

There is poor choice and access to physical health services

“We are told that we should try to exercise by healthcare workers but there is very little or very poor quality services in this area. In almost 10 years I have been offered one course through mental health services called ‘healthy living’ which was poor to say the least.”

The lack of available services to improve the health and wellbeing of people at a higher risk of poor health due to mental health problems was a key issue raised in our inquiry. This scarcity of provision was most pronounced with regards to smoking cessation programmes.

People affected by mental health problems have much higher levels of smoking than the general population – with an estimated 42% of all of the tobacco in England being smoked by this group.¹⁶ And while the smoking rate in the general population has fallen dramatically from 45% in 1974 to 20% in 2010,¹⁷ for people with mental health problems the rate has barely changed in the last 20 years.

But in spite of the disproportionately high smoking rates of this group, people with mental health problems are less likely to be offered smoking cessation interventions than the general public.

This lack of support to stop smoking is particularly concerning as many of the witnesses at the inquiry's oral evidence session spoke of the impact that smoking has on the effectiveness of antipsychotic medication. People on antipsychotic medication who also smoke require higher doses of medication to have the same effect, thus increasing the risk of side effects.

Likewise, once someone stops smoking, their medication dose can be reduced which will result in fewer side effects for the individual. It is therefore crucial that people affected by mental health problems are able to access effective smoking cessation services.

More broadly, Rt. Hon. Norman Lamb MP spoke about how nationally available screening programmes for physical illness have a much lower take-up among people affected by mental health problems. The reasons for this must be determined and subsequent action taken to help remove any barriers to access.

PROGRESS TO DATE

Achieving Better Access to Mental Health Services by 2020 document

The Government's recent five year plan for mental health committed to a £30m targeted investment in effective models of liaison psychiatry in 2015/16 to improve the mental health care to people of all ages who are being treated for physical health conditions in general hospitals.¹⁸

Moreover, the five year plan sets out a vision for greater integration of mental and physical healthcare, though this is subject to the views of the next Government and within the context of the next spending review. Their vision includes:

- NHS England exploring commissioning approaches with CCGs to better integrate the prevention of physical ill-health into mental health services for all ages.
- NHS England and Public Health England to signal how smoke free policies can be implemented, and how access to smoking cessation services can be delivered in secure mental health services.
- All mental health inpatients to have a thorough assessment of their physical health needs on admission, which over time would extend beyond inpatient care to community patients and primary care.

The APPG strongly urges the next Government to implement such a vision.

Living Well for Longer strategy¹⁹

Care Minister Rt. Hon. Norman Lamb MP emphasised the current Government's commitment to reducing premature mortality, as demonstrated in the Government's 2014 'Living Well for Longer' strategy. The strategy includes the aspiration for England to have the lowest rates of premature mortality in Europe, with mental health featured as one of the strategy's key priority areas.

This is also backed up by the inclusion in the NHS Outcomes Framework of a specific objective around preventing people from dying prematurely and a measure on reducing premature mortality

for adults under 75 with a serious mental illness. However, as this measure has not yet been quantified, it is difficult to mark progress at this time.

Improved coordination and inspection of mental health care

The work of new Integration Pioneers to improve the coordination of care was highlighted by the Minister as a key way of ensuring health services work together better. Furthermore, the new Government Mandate to Health Education England published in 2014 outlines the need to increase awareness amongst health professionals of the links between a person's mental and physical health and the impact of this co-morbidity.

Dr Arokia Antonysamy from Lancashire Care NHS Trust told the inquiry of how her Trust had introduced 'clinical treatment teams' to promote integration across primary and secondary care, and between mental and physical health professionals as a means of ensuring the needs of the whole person are addressed.

The Care Quality Commission (CQC) has appointed a Deputy Chief Inspector of Mental Health to improve standards in mental health care, and ensure the necessary treatments and services – such as physical health checks – are being carried out.

Everyone Counts: 2014/15-2018/19 Planning Guidance for Clinical Commissioning Groups²⁰

NHS England has issued 'Everyone Counts' planning guidance to Clinical Commissioning Groups (CCGs) which specifically requires CCGs to include details of how they intend to reduce the 20 year gap in life expectancy for people with severe mental illness in their commissioning plans. NHS England has published resources for CCGs which detail clinical evidence on what services are most effective in terms of reducing premature mortality for people with serious mental illness. They have also funded a mental health leadership development programme to help ensure that leaders in CCGs understand issues relating to parity and therefore commission appropriate services.

Introducing greater incentives for mental health services to improve the physical care they offer

In April 2014 NHS England introduced a new payment reward system – CQUIN (Commissioning for Quality and Innovation) – to incentivise mental health services to improve the physical health care they offer. In the inquiry’s oral evidence session, the CQUIN was highlighted as being a ‘very powerful’ tool in ensuring a greater focus on physical illness in mental health services.

Improved mental health training at the local level

Dr Arokia Antonyamy outlined the work being done by Lancashire Care NHS Foundation Trust to improve understanding of the links between mental and physical health – notably the introduction of a mental health training programme for GPs and a training programme for mental health nurses on physical health. This was seen as a key factor in the Trust being one of the top performing Trusts in terms of physical health monitoring in the 2012 National Audit of Schizophrenia.

RECOMMENDATIONS

From the evidence gathered by the APPG, it is clear that people with mental health problems face systematic discrimination in terms of access to physical health care, impeding any progress being made in reducing premature mortality for people affected by mental illness. Key to tackling this must be the development of a more integrated, holistic ‘whole person’ approach to healthcare – with a concerted and sustained effort to tackle the mindset that the physical health problems of people with mental health problems are simply ‘too difficult’ to resolve.

WE THEREFORE RECOMMEND THAT:

- 1** The Government should introduce an objective setting out a quantified national reduction in premature mortality among people with mental health problems so progress against this commitment can be measured. This should be supported by long-term alignment of key policy levers, such as CQUINs and the Outcomes Frameworks, under this objective.
- 2** All mental health professionals should receive basic physical health training as part of their mandatory training. Likewise, mandatory continuous professional development in mental health should be introduced for all doctors and nurses, (similar to, for example, the annual mandatory resuscitation training for psychiatrists).
- 3** People with mental health problems should be offered tailored support to quit smoking, and staff in mental health services should be provided with training to support them. Targets such as the current 18.5% target for smoking reduction by the end of 2015 should apply equally to people with mental health problems.
- 4** To support people to make informed choices about their treatment, they should be offered clear and accessible information about the side effects of antipsychotic medication. Their physical health should be monitored closely so that any identified health needs are quickly acted upon.
- 5** Commissioners and service providers must ensure that systems are in place locally so that primary and secondary care services are clear about their respective responsibilities for monitoring and managing the physical health of people with mental health problems.

Chapter 2

Improving the quality of mental health emergency care

A mental health crisis can encompass suicidal behaviour or intention, panic attacks and extreme anxiety, episodes of psychosis and other behaviour that seems out of control or at risk to the individual themselves or other people. It is a hugely distressing experience for individuals and those around them. However emergency mental health care is one of the starkest examples of the lack of parity between mental and physical health.

Appropriate responses to a mental health crisis range from telephone help lines to Crisis Resolution and Home Treatment teams (which provide intensive support at home), or admission to A&E or acute inpatient wards. However many people do not receive the appropriate support at the time they need it when experiencing a mental health crisis.

Currently, Section 136 of the Mental Health Act allows police to detain someone they believe to be experiencing a mental health crisis in a public place. They must take the person to a 'place of safety' for a mental health assessment. In the legislation, police cells are only supposed to be used as a 'place of safety' in exceptional circumstances.

However, recent research by the Health and Social Care Information Centre has found that between 2013 and 2014, more than a quarter of people detained by the police under Section 136 were taken to a police cell and not a health based place of safety, such as a safe suite in A&E, mental health trust or children's hospital.²¹ This is something which would be unthinkable in a physical health emergency.

The House of Commons Home Affairs Select Committee also published its report on Policing and Mental Health in February 2015.²² The report found that the prevalence of people with mental health illness in the criminal justice system is too high. It recommended that changes be

implemented to ensure that nobody who has reached crisis point should be put in a police cell or be transported in a police van because appropriate health services aren't available.

KEY FINDINGS

The inquiry received evidence indicating pockets of good quality emergency mental health care across the country, where dedicated and passionate health and social care professionals, and indeed police officers, go to great lengths to ensure an individual in crisis receives the support they need. However the lack of clarity (from both health professionals and people using mental health services) over what care people should expect in a mental health crisis is greatly inhibiting the provision of safe and speedy care. Such inconsistent and inadequate provision of care is in stark contrast to physical health emergency care where such situations rarely arise and, most importantly, would not be tolerated.

A lack of clear route into crisis services

“Finding help – especially for someone not already in the system – was chaotic and distressing.”

Evidence to our inquiry indicated that many people simply do not know where to turn to for support when they experience a mental health crisis. In many areas there is a lack of clear referral routes and no single points of access. Indeed, we heard of a variety of scenarios with some people in a crisis being admitted to inpatient units, some being taken to police cells, some people being told to see their GP, some being seen by a crisis team, and others facing long waits in A&E. We also heard of cases where people were simply told to just go home.

In her evidence to the inquiry, Dr Ann Hicks, an Emergency Department Consultant, highlighted the stark difference in care experienced by someone in a physical health crisis, compared with someone in a mental health crisis. In the case of someone with pneumonia, for example, Dr Hicks described how ‘I can explain to them what’s wrong... I can explain to their family what’s going to happen... I can pretty much now guarantee that I’ll get them a hospital bed, what their care will be, and that we can start their treatment.’ This is in contrast to those in a mental health crisis, who are too often unclear on what treatment they should receive, whether they need to travel a great distance to access a mental health bed, and how long the waiting times should be.

Lack of appropriate treatment and support in emergency departments

“After seeing two different doctors and admitting my immediate suicidal intentions I was denied a bed due to lack of space and told to go home without any alternative.”

Severe staff shortages and a lack of availability of mental health crisis services have meant that people are often forced to turn to A&E for help and support where they face long waiting times with few available mental health professionals to treat them. Such pressure on A&E services also leads to people in a crisis often being discharged before they are ready – significantly worsening their chances of recovery.

“I voluntarily took myself to A&E because I was afraid I would hurt myself. As soon as I arrived at reception I was immediately dismissed and told that I ‘would have to wait, there are people with more serious problems here.’ I waited until 3am before I met with members of the crisis team. They were unhelpful and dismissive. I was sent home at 5am and told to just contact my GP.”

The inquiry also heard of many cases where emergency departments refuse to treat people in a mental health crisis who are also intoxicated. Robert Cole from the West Midlands Ambulance Service asked ‘why that’s different in the world of mental health’, as someone who, for example, suffers a broken leg whilst intoxicated would still be treated in an A&E department. This is another clear example of the disparity between attitudes to mental and physical health care emergencies.

Moreover, while telephone support and crisis lines were identified as being a great support for people in crisis, they are not always available 24-hours a day, and the inquiry heard cases where they can be difficult to get through to, ‘either constantly engaged or unanswered’. Again, this is something that would not be tolerated for a 999 call in the case of a physical health emergency.

Police settings are too often used for people in a mental health crisis

“He was locked in a police cell overnight very frightened and highly distressed. He was told by a police officer that he is ‘a drain on society’ and was not assessed by a mental health professional until the next day.”

The role of the police in mental health crises was widely discussed in the inquiry. In addition to the powers the police have under the Mental Health Act, Commander Christine Jones of the Metropolitan Police highlighted the extent of police involvement in her evidence to the inquiry. Commander Jones stated that at least 40 per cent of policing time was currently being devoted to dealing with people who are vulnerable as a result of mental ill health and that ‘the police are taking far too big a role in how we deal with crisis.’

In his evidence to the inquiry, the then Minister for Policing, Rt. Hon. Damian Green MP, told the inquiry that during 2012/13 nearly 8,000 people were detained in a police cell under Section 136 of the Mental Health Act, because no other ‘places of safety’ were available. This was more than a third of the total overall number of detentions under Section 136, despite the Mental Health Act Code of Practice stating that police cells should be used only in ‘exceptional circumstances’.

While the inquiry heard many stories of the compassion of police officers during a crisis, the majority of evidence submitted to the inquiry emphasised that police cells are not suitable ‘places of safety’ and that police do not have the correct training or experience to deal with people in a mental health crisis.

However, it should be noted that the APPG did hear from people who found police cells to be positive ‘places of safety’ for them. One person described how they ‘prefer to spend my section at a police station, where the police put me on continuous watch... and usually talk to me all night’. That people experiencing a mental health crisis would choose to be in a police setting instead of a health setting can be seen as indicative of the poor quality of mental health crisis services.

Poor quality after care for people experiencing a mental health crisis

“Our mother was usually discharged without any offer of help beyond the doctor telling us we should go and see the GP (who usually redirected us back to mental health services elsewhere with waiting lists in excess of three months).”

Significant concerns were raised in our inquiry about the care people receive in the aftermath of a mental health crisis. We heard of cases where there was little or no communication between crisis services and a person’s GP or health team, thereby placing the onus on the individual themselves to request follow up support and treatment. In her oral evidence to the inquiry, Sue Goddard described being discharged from hospital with ‘no crisis plan, no community referral... and I’ve got no GP’.

Particularly worrying were examples of people being discharged alone in the early hours without any support in place. This is something which is clearly inappropriate for someone recovering from a mental health crisis and who is likely to be in an extremely vulnerable state.

A lack of data sharing between agencies involved in mental health crises

Given the significant role that the police currently have in dealing with mental health crises, the lack of data sharing between themselves and health services to ensure that individuals get the most appropriate support is particularly concerning. In his evidence to the inquiry, Rt. Hon. Damian Green MP stated that ‘all agencies, including the police and ambulance staff, have a duty to share essential information’, for example if someone is already known to mental health services and has a crisis care plan in place.

The Minister went on to argue that there are currently too many ‘inappropriate uses’ of data protection policies, leading to professionals failing to share data when it would in fact be beneficial to the individual experiencing the mental health crisis. The inquiry did however hear from many people who have experienced a mental health crisis and would be concerned about their personal data being shared between different agencies. Therefore efforts must be made to ensure the right balance is struck, and data protection laws are not abused.

On a more strategic level, Commander Christine Jones also highlighted the need for the different agencies involved in mental health crisis care to be more ‘sensible’ about the way that they share data, so that commissioners have all the information they need to commission sufficient crisis care services and meet the levels of demand in their local area.

Inappropriate transportation used in a mental health crisis

The use of a police vehicle rather than an ambulance to transport someone during a mental health crisis was highlighted as a key concern in our inquiry, with the effect of making individuals feel like a criminal rather than someone experiencing a health crisis. Rt. Hon. Damian Green MP told the group that a ‘higher proportion of people are taken to hospital for assessment in a police car than an ambulance’. Again, this is a situation which would be unthinkable in the case of a physical health care emergency.

Progress to date

Mental Health Crisis Care Concordat²³

The joint Department of Health and Home Office Mental Health Crisis Care Concordat published in February 2014 is an agreement signed by twenty two national bodies, including the police, to commit to working better together to improve crisis care. The aim of the Concordat is to ‘improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need

– whatever the circumstances in which they first need help – and from whichever service they turn to first.’

While some organisations have committed to making much needed improvements to ensure people receive the care and support they need in a crisis, it is vital that local concordat action plans are now agreed and implemented on the ground by responsible agencies across England.

Achieving Better Access to Mental Health Services by 2020 document

The Government’s recent document, setting out a vision to deliver parity of esteem by 2020, commits to an extra £33 million investment in support for people in a mental health crisis to accelerate the full implementation of local crisis care concordats, and focuses on two key areas that they believe will have the biggest impact: liaison psychiatry for all ages in accident and emergency departments; and crisis resolution home treatment teams.

S135 and S136 of the Mental Health Act

In December 2014, the Department of Health and Home Office published their report of their reviews on Section 135 and 136 of the Mental Health Act.²⁴ Their report includes recommendations to amend Section 136 so that it applies anywhere except a private home, to reduce the maximum length of time a person can be detained under S135 and 136 and to outlaw the use of police cells as places of safety for children and young people.

In January 2015 the Department of Health published an update to the Mental Health Act (1983) Code of Practice.²⁵ This reiterates many of the messages of the S135 and S136 review and promotes the use of locally agreed policies for S135 and S136 use. These policies should include plans for sufficient provision of health-based places of safety, appropriate transportation to and from places of safety and the safe management of people who are intoxicated.

Mental health training for police

The Home Office are working closely with police agencies, particularly the Metropolitan Police Service and the College of Policing, to develop effective training and screening tools to enable them to better identify people with mental health problems and other vulnerabilities.

Transfer of police custody healthcare services to NHS England

Police forces across England are making arrangements to transfer the management of their custody healthcare service to NHS England from April 2015, which is designed to provide better links to GPs, community healthcare services and treatment providers.

RECOMMENDATIONS

Mental health crisis care has received significantly more political attention in the last few years and there have been very welcome developments, particularly the Mental Health Crisis Concordat. However more must be done to clarify roles and responsibilities in this area, and ensure that mental health crisis care services are of a comparable quality to physical emergency care. The APPG believes everyone in crisis should be able to access safe and speedy access to quality crisis care 24 hours a day, 7 days a week, regardless of where they turn to first.

THIS SHOULD BE ACHIEVED BY:

1

Delivering training in mental health to all professionals that may come into contact with people in crisis, with a focus on interagency training to ensure police, ambulance and health staff understand their respective roles and responsibilities. The delivery of this training should also involve people using mental health services and carers to emphasise the importance of compassion and understanding in assisting an individual's recovery.

2

Increasing the use of joint crisis plans. These are developed by patients and staff together and contain an individual's preferred treatment in the case of a mental health emergency, thereby embedding the principles of choice and control in crisis care provision.

3

CCGs should commission a wider range of community-based support services for people in crisis, for example crisis care houses, ensuring they have appropriate staffing levels. They should also ensure sufficient mental health inpatient beds are commissioned to avoid people being turned away or forced to travel out of their local area to receive support.

4

A commitment from the next Government to ensure the implementation of the Crisis Care Concordat beyond 2015, including the roll out of effective liaison psychiatry services in those remaining hospitals currently without such services.

5

A commitment to continued funding for a national network of liaison and diversion mental health services, to ensure close working between mental health nurses and other mental health professionals and the police and courts.

Chapter 3

Ensuring mental health is a public health priority

Public health is about improving the health of the whole population through preventing disease, prolonging life and promoting health. Public mental health interventions therefore focus on the prevention of mental health problems (both stopping them from arising in the first place, as well as intervening as soon as mental health problems arise) and mental health promotion. This can include universal approaches such as parenting support, school and work based mental health promotion programmes, and interventions to promote social interaction.

But while mental health problems affect more than 1 in 4 of the population at any one time and costs the English economy an estimated £105 billion a year, only £3m is currently spent annually on mental health promotion (less than 0.03% of the mental health NHS budget).²⁶

Indeed, a recent Freedom of Information (FoI) request has found that local authorities are spending on average only 1.36% of their public health budget on mental health.²⁷

This is of particular concern given that the prevalence of mental health problems is set to rise in the next decade, with the number of people affected increasing by 14% from 8.65 million people in 2007 to 9.88 million by 2026.²⁸

KEY FINDINGS

The Implementation Framework for the Government's No Health Without Mental Health strategy 2012 states that 'Local Public Health Services need to develop clear plans for public mental health, to ensure they integrate mental health and wellbeing into all aspects of their work, and to provide local leadership in supporting better mental health for all.'²⁹

However, there is little evidence to suggest that this aspiration to put mental health at the heart of the public health system is being reflected on the ground. Evidence to our inquiry strongly indicated that public mental health was failing to be adequately prioritised by Health and Wellbeing Boards, which bring together those responsible locally for commissioning NHS, social care, public health and voluntary sector services. A key reason for this disparity is the failure of Health and Wellbeing Boards to collect adequate data on the level of mental health need in their area which would help inform public health strategies.

This is particularly worrying with regards to the lack of local data around children and young people's mental health. Given that we know half

of all mental health problems begin by age 14,³⁰ public mental health interventions can have the most impact in this area.

Insufficient data is being collected on local mental health need

“Commissioners need to understand what the local need is... data is too often outdated and incomplete.”

The inquiry found that local services which prevent mental ill health and promote mental health are scarce. This is despite the cost effectiveness of many public mental health interventions, for example stigma prevention campaigns can save £421 per person with depression.³¹

Joint Strategic Needs Assessments (JSNAs) should assess the local health needs of an area and inform Joint Health and Wellbeing Strategies (JHWBS), which in turn guide public health commissioning. However, our inquiry heard evidence that JSNAs rarely collect data on local mental health and wellbeing – something also raised in the Chief Medical Officer’s 2014 annual report.³² In his oral evidence to the inquiry, Dr Jonathan Campion, Director for Public Mental Health at South London and Maudsley NHS Foundation Trust and Director of Population Mental Health at UCLPartners, referred to a recent audit of JSNAs in 23 boroughs, covering a population of six million.

The audit found that information on local mental health needs was inadequately and inconsistently covered in JSNAs, with most mental health problems often mentioned only in passing and lacking in sufficient detail to inform commissioners on local public mental health needs. This lack of data is particularly stark with regards to the mental health and wellbeing of children and adolescents. Evidence submitted by the Children and Young People’s Mental Health Coalition (CYPMHC) found that 2 in 3 JSNAs did not measure levels of children and young people’s mental health locally, and that 1 in 3 JHWS do not prioritise children and young people’s mental health.³³

Given the prevalence of mental health problems in England, it is unacceptable that JSNAs, which are the key drivers of public health commissioning, are failing to include accurate, up-to-date information on the mental health of local areas. This is a key reason why only a minority of people with mental health problems are currently receiving treatment.

Public health professionals are failing to understand the importance of mental health promotion and the prevention of mental health problems

“Public mental health is still a relatively new issue, and given that there are so many other priorities for public health departments, it is easy to see why mental health is being overlooked.”

The transfer of responsibility for public health from the NHS to local government, and particularly the introduction of Health and Wellbeing Boards, was viewed by the majority of those that responded to our inquiry as a positive step for public mental health. Many of the responses highlighted that this structure will allow for greater attention to be paid to the social factors that affect health, including broader issues such as housing, employment and domestic violence.

However, in terms of the attitudes of public health professionals, the majority of respondents to our inquiry felt that much more needs to be done to raise awareness of mental health in this group. Many noted that local commissioners simply do not recognise that good mental health is key to improving physical health outcomes, leading to competition for limited public health resources between the two areas. Indeed, the notion that public health bodies ‘need to avoid promoting a false and unhelpful dichotomy between physical health care and mental health care’ was alluded to in many inquiry responses. In her oral evidence to the inquiry, Shalini Bhalla argued that ‘we know we have to train our bodies to keep fit, so why not our minds too?’

Local authority ‘Mental Health Champions’, introduced as part of the Mental Health Challenge to ensure good mental health is promoted across all council business, were also identified as key players in raising awareness about the importance of mental health at the local level.³⁴ However, given the importance of Health and Wellbeing Boards as the medium through which public mental health strategies are delivered, the absence of mental health professionals/champions on the vast majority of Boards was identified as a key barrier to ensuring mental health is adequately prioritised in public health strategies.

There is a lack of focus on early intervention and children and adolescent mental health services

“We must stop treating early years’ mental health services as luxuries. We should target these at young people and families just as we invest in vaccination. The effects of these interventions have the capacity to affect all aspects of health and wellbeing for the next generation.”

Given that 50% of mental health problems, excluding dementia, begin before the age of 14 years,³⁵ the APPG is particularly concerned with the lack of priority given to preventing mental health problems, treating them as soon as they arise and promoting mental health amongst children. While schools were seen by many as being best placed to deliver such interventions, for example via Personal, Social and Health Education (PSHE), helping students to understand how to maintain their mental and emotional health was seen as a relatively neglected aspect of the curriculum. This was also identified in a recent Ofsted report.³⁶ Moreover, it was also felt that little progress would be made in this area unless mental health education is made compulsory, with Ofsted therefore able to hold schools to account on the delivery of such programmes.

In her oral evidence to the inquiry, Meradin Peachey, Director of Public Health for the London

Tri-borough, raised her concerns that schools are not getting the support they need to promote the mental health of their pupils and deal with those children with signs of early behavioural issues. In particular, she emphasised the need for better online-based support and guidance which could play a key role in promoting good mental health and wellbeing in schools.

The quality of parenting was also noted by many as a critical determinant of children’s mental health. Parenting programmes were specifically highlighted in evidence submitted to our inquiry as an effective public mental health intervention, especially in terms of preventing severe behavioural problems and conduct disorder in children (which has a lifetime cost to society of around £260,000).³⁷ However Meradin Peachey emphasised that much more needs to be done to ‘get these basics right’, for example all children’s centres offering parenting programmes to ensure that mental health promotion is considered a priority right from the start of family life.

PROGRESS TO DATE

Living Well for Longer guidance for local commissioners

In her oral evidence, Public Health Minister Jane Ellison referred to the 2014 launch of the Department of Health’s Living Well for Longer document, which contains guidance and good practice for local authorities on how to tackle the ‘5 big killers’ – cancer, stroke, heart disease, lung disease, liver diseases. Mental health, and the need to tackle the health inequalities faced by those with mental health problems, features prominently in the document. It was emphasised by the Minister as being a ‘key resource’ for Health and Wellbeing Board commissioners to improving health outcomes.

Mental Health Intelligence Network

Described by Dr Jonathan Champion in his oral evidence as a ‘fantastic’ piece of work which will ensure better coordination between public, primary, social, and secondary health care, the Mental Health Intelligence Network was launched in 2014 by Public Health England.

The network provides commissioners, local decision makers and other health professionals with authoritative intelligence, research and evidenced best practice, providing indicators about risk factors, prevalence, access to services, outcomes and finance, and profiling tools.

MindEd: e-learning to support young healthy minds

Launched in March by the Department of Health in collaboration with a range of third sector organisations, MindEd provides practical 'e-learning' guidance to any adult working with children, young people and families, to help them identify, understand and support children and young people with mental health issues.

This programme was identified in written evidence to our inquiry as an invaluable source of online support, playing a key role in raising awareness of mental health for a variety of professionals.

What Works Centre for Wellbeing

What Works Centre for Wellbeing will commission universities to research the impact that different interventions and services have on wellbeing. The centre is an addition to the What Works Network, which was launched by the government in 2013 to improve public services through evidence-based policy. It builds on the work of the Office for National Statistics to measure national wellbeing, and of the Commission on Wellbeing and Policy

RECOMMENDATIONS

Given that mental health problems account for 23% of the total impact of ill health in the UK, mental health is without doubt a significant public health issue. However, the inquiry found little evidence that mental health was being sufficiently prioritised in public health strategies, with the failure to collect adequate data on local mental health needs which underpins the commissioning of public health services, greatly impeding any progress in this area.

THE APPG THEREFORE RECOMMENDS:

1

Mental health education should form a core part of the Personal, Social and Health Education (PSHE) curriculum, to promote wellbeing and resilience in children and young people and prevent mental health problems developing. This should also include training for teachers to recognise early signs of mental health problems and ensure they can signpost students to appropriate services.

2

The Department of Health should require all Joint Strategic Needs Assessments (JSNAs) to include information about the size, impact and cost of local mental health needs to ensure the commissioning of sufficient public mental health interventions.

3

Every Health and Wellbeing Board should have a designated Mental Health Champion to ensure public mental health is a priority in Joint Health and Wellbeing Strategies (JHWBS).

4

The Government should commit to national investment in evidence-based parenting programmes to improve the life chances of children and the wellbeing of families.

Conclusion

Having heard evidence from politicians, health professionals, people with lived experience of mental health problems and voluntary organisations that work with them, the APPG has found that a lack of parity for mental health is embedded throughout the healthcare system in terms of physical health care, crisis care and public health.

Whilst we do recognise that the Government has made some truly important commitments to reducing this disparity between mental and physical health, we cannot be complacent. People experiencing mental health problems have the right to the highest attainable standard of health but in the three areas the inquiry looked into, this is far from a reality.

The recommendations contained in this report seek to ensure that a holistic view of a person's health – both physical and mental – is taken as the norm, so 'parity' does not merely become a meaningless soundbite but is embedded in the mindset of all health professionals and policy makers.

Indeed, the true mark of success will be when 'parity' is a redundant term, as a person's health and wellbeing will be seen in its entirety. Until then we urge the Government, policy-makers and professionals at all levels to take on board our recommendations to secure a cultural change in the provision of both physical and mental health services that refuses to accept a second class service for people with mental health problems.

Acknowledgements

With thanks to the 1500 individuals who submitted written evidence to the inquiry and to the following speakers at the three oral evidence sessions:

Rt. Hon. Norman Lamb MP, Minister for Care Services

Matthew Fagg and Dr McShane – NHS England

Dr Arokia Antonysamy – Lancashire Care Trust

Lynn Burling – Expert by experience

Rt. Hon. Damian Green MP, former Minister for Policing, Criminal Justice and Victims

Christina Jones – Metropolitan Police

Robert Cole – West Midland Ambulance Service

Vicky Skeldon – Making Space

Dr Ann Hicks – Mental Health and Liaison services, Plymouth Trust

Sue Goddard – Expert by experience

Jane Ellison MP – Minister for Public Health

Dr Jonathan Champion – Director of Public Mental Health and Consultant Psychiatrist at South London Maudsley NHS Foundation Trust

Meradin Peachey – Tri-borough Director of Public Health

Shalini Bhalla – Expert by experience

The written and oral evidence for this inquiry is available at:

<http://www.mind.org.uk/about-us/policies-issues/in-parliament/appgmh/>

<http://www.rcpsych.ac.uk/policyandparliamentary/parliamentandpublicaffairs/appgonmentalhealth.aspx>

www.rethink.org/appg

Thanks to the three secretariat organisations, Mind, Rethink Mental Illness and the Royal College of Psychiatrists, for supporting this inquiry.

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This report has been produced in association with:

