

fair deal

for mental health



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fair deal

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**Our manifesto for a 3 year campaign
dedicated to tackling inequality
in mental healthcare**



People with mental health problems don't get a fair deal

Funding shortages

Limited access to services

Discrimination remains
widespread

In-patient services
not up to scratch

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Introduction

- ▶ Good mental health is a priority for us all. However, mental health services have lagged behind those in physical health. There is scope for change; all UK governments have provided added investment for mental health services over the past decade and some impressive reforms have already occurred. Progress has also begun in relation to the social costs of mental health, including issues of discrimination, stigma and social exclusion.
- ▶ With the 60th anniversary of the National Health Service (NHS) in 2008 and new planning for mental health in all the countries of the UK, it is timely to take an overview of where we need to improve. Over the past year, we asked psychiatrists across the UK what they thought the key challenges and opportunities were for mental health and learning disabilities services (usually known as intellectual disabilities internationally and in the scientific literature). Psychiatrists who work with all the different service user groups (in hospitals, communities and prisons), responded. The service users and carers also contributed their views and thus eight priority areas emerged. In each area we identified key issues (the 'What we are calling for' sections) and some of the actions that the College will take ('Examples of what the College will do'). The common thread that links them all is a drive for equality.

This then became our manifesto for a fair deal for mental health. It is a framework for the work that the College will do, in individual projects and specific campaigns, over the next 3 years within eight priority areas:

Funding

Access to services

In-patient services

Recovery & rehabilitation

Discrimination & stigma

Engagement with service users and carers

Availability of psychological therapies

Linking physical and mental health

These areas are all connected. Better **funding** will help **access** to services in the community and in hospitals (**in-patient** services); user **engagement** will improve the quality and design of services which will also affect access and **availability**. Tackling **discrimination** will assist **recovery**. **Linking** physical and mental health through training and service changes will help reduce stigma. Better availability of psychological therapies for all patient groups will aid recovery. More research funding will underpin all areas by improving our understanding of mental disorders.

▶ **Achieving a fair deal: awareness**

▶ The campaign will involve a programme of public education and communications work to raise awareness of the eight priorities in the UK Parliaments, in the media and among the general public.

▶ **Achieving a fair deal: action**

▶ The College will undertake key projects and actions to address each of the eight priorities, including partnership work with organisations such as Mind, the Sainsbury Centre for Mental Health, Young Minds and the Mental Health Foundation.

▶ **Achieving a fair deal: involvement**

The Fair Deal campaign was founded on the views of psychiatrists, service users and carers. We want to continue this involvement and also invite service providers, policy makers, politicians, journalists and the general public to take part. To do this:

- ▶ sign up to our campaign at www.fairdeal4mentalhealth.co.uk and receive Fair Deal updates
- ▶ email us with your views, experiences and case examples: fairdeal@rcpsych.ac.uk.

Why a Fair Deal?

The **common thread** running through the entire Fair Deal campaign is that of a drive for **equality**. Work is needed to address the inequalities that people with mental health problems and learning disabilities encounter daily in terms of their health, life chances and inclusion. Psychiatrists across the UK report disparities in providing accessible and high-quality services for all social groups. The campaign aims to address such inequalities and disparities and to bring about a fairer deal for mental health.

Funding of mental health research and services needs to increase. It should more fairly reflect the costs of mental health problems in society and the need for improved knowledge of mental disorders.

Access to services should be made easier across the lifespan for all people with mental health problems. The most overlooked groups include those in transition from adolescent to adult services, older people, prisoners, people with learning disabilities and those with substance misuse problems.

In-patient services should be improved, with sufficient capacity for patients to be admitted locally into an appropriate ward. Improvements in ward conditions and the expansion of child and adolescent and intensive care beds are key.

Recovery and rehabilitation should be integral to mental healthcare and treatment. A coherent policy based on recovery-orientated practice is needed for people experiencing long-term mental health problems.

Discrimination and stigma need to be tackled throughout society. The NHS should lead by example in promoting equality and human rights in all of its work as an employer and provider of health services.

Engagement with service users and carers must be meaningful, not tokenistic. People with direct experience of mental health problems or learning disabilities should have a central role in the design and delivery of mental health services.

Availability of psychological therapies should be equitably implemented across all ages, patient groups and settings. A particular focus is needed on older people, hospital in-patients and prisoners.

Linking mental and physical health must be part of every doctor's practice. This will require education, training and collaborative working between mental health and other medical specialties.

Professor Sheila Hollins, the Royal College of Psychiatrists' President 2005–2008

'In 2008 our annual meeting has been timed to coincide with the 60th anniversary of the NHS. What a wonderful milestone to be celebrating and what an opportunity to review the contribution of the NHS to understanding, preventing and treating mental disorders and to promoting mental health.

We asked our members and College carer and service user networks to tell us what they thought. A recurring theme in their responses was that people with mental health problems and learning disabilities do not get a fair deal. Although there has been real progress, particularly in the past decade, they are still not afforded dignity and respect equal to other citizens.

This manifesto lays the groundwork for our campaign, which I hope will help to achieve a fair deal for people with a mental illness and people with learning disabilities through a new partnership with everyone concerned about these issues.'

Raymond Brookes-Collins, Chair of the Carers Forum

'The Fair Deal campaign is an opportunity to seek an improvement in the quality of health for both carers and the cared for. Especially welcomed is trying to obtain more funding to increase research into mental ill-health. Access to services for often overlooked groups is essential. Carers are looking forward to supporting the campaign, the College, and others, to make a real difference in the future.'

Colin Gell, Chair of the Service User Recovery Forum (SURF)

'Service users have, for many years, felt that they were considered as second-class citizens. Not just by the public, but by people working in mental health services themselves.

However, things are changing. Service users are getting together, getting organised and saying "we have real knowledge, experience and expertise that needs to be listened to and acted upon."

Now the doors of 17 Belgrave Square are open and we are inside. The Service User Recovery Forum is established and we are looking forward to working with the College and others to make the words a reality.'

Professor Dinesh Bhugra, the Royal College of Psychiatrists' President 2008–

'I begin my presidency of the Royal College of Psychiatrists at a time when awareness of mental health issues has never before been so high in UK Parliament, across the media and in wider society in general.

As psychiatrists, we have an opportunity and also a professional responsibility to help shape the services in which we work and advocate for service users and carers. I am delighted that the impetus and direction of this campaign has been steered by the experiences and talents of our members and represents the opportunities that they foresee. But no change can, or should, happen alone. That is why through our Fair Deal for mental health campaign we want to work closely with anyone who shares our vision.'

Funding

Recent figures show that mental health research received 6.5% of total research funding compared with 25% for research of cancer and 15% for neurological diseases

Unlike other common diseases, there is no disease-specific charity in the UK that funds research into mental disorders

9% of the total National Health Service's and social services' spending in Northern Ireland, 11% in Scotland, 12% in England and an estimated 12% in Wales is allocated to mental health services. This is disproportionate to the human and economic costs of mental disorders

Funding of mental health research and services needs to increase. It should more fairly reflect the costs of mental health problems in society and the need for improved knowledge of mental disorders.

The need for a fair deal

Mental disorders cause enormous human suffering for individuals and their families and impose major economic costs for the population. The lack of understanding of mental illnesses and other conditions contributes to the stigma experienced by patients and influences the quality of service provision and availability of effective treatments. It is essential that funding of both research and service provision is increased in line with the funds allocated to improving physical health. This will improve people's overall quality of life and reduce the social costs of mental health problems, including those related to economic inactivity.

While all governments in the UK have increased their spending on mental health in recent years it is still not in proportion to the level of disability or prevalence of mental health disorders. Financial uncertainty and pressures on resources can result in low quality, lack of choice and gaps in service provision. Commissioning of mental health services is variable and local differences and regional variations in funding result in uneven service reform and implementation.

What we are calling for

- ▶ Major increase in research funding to improve understanding of mental disorders and lay the foundations for better treatments and services and reduced stigma.
- ▶ Continued increases in public expenditure on mental health services to reflect the human and economic costs of mental illnesses in society.
- ▶ Development of long-term sustainable funding strategies for mental health service provision at every level (including commissioning and payment by results) to make the delivery of these services realistic.
- ▶ The commissioning practice of mental health services to be fairer, more transparent and based on the best evidence available.

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Examples of what the College will do

- ▶ The College will strive to improve the awareness among professionals, politicians and the public of the need for substantially increased funding for research into mental disorders.
- ▶ We will work with partners to facilitate the establishment of a major research charity that will focus on the understanding of mental disorders.
- ▶ We will work with partners to promote commissioning of mental health services that meet the needs of people with mental disorders.

Knowledge for action: mental health research funding

There are few data sources on levels of mental health research funding. A review of the 2004/5 research portfolios of the largest UK funders of health research indicates that mental health research received 6.5% of total funding (compared with 25% for cancer, 15% for neurological diseases, and 9% for cardiovascular conditions).¹ When considered relative to its influence on an individual's quality of life, mental health is allocated substantially less funding than its impact on overall health should demand.²

Unlike for other common diseases, there is no disease-specific charity in the UK that funds research into mental disorders. In contrast, diseases of comparable health burden have major research charities that fund research centres, professorships, fellowships and major grants. For example, Cancer Research UK provides £315m per year for cancer research and the British Heart Foundation £50.4m per year for research in cardiovascular disease.^{3,4} Thus, although both Medical Research Council and the Wellcome Trust provide grant support for mental illness research, the field cannot reach the level of funding available for research in other common illnesses. If mental illnesses are to benefit from the major scientific advances and improved public profile and understanding, as for example cancer and heart disease did over the last generation, it will

be important to establish a major research charity that will support research to improve understanding of the causes, diagnosis and treatment of mental disorder.

Case for change: human and economic costs

Mental health problems affect people across the life-span. In the UK, around one in ten children and young people aged 5–16 have a clinically recognised mental disorder.⁵ Among older people, the number with mental health problems in the UK will increase by a third over the next 15 years to 4.3 million, or 1 in every 15 people.⁶ Meanwhile, about 11 million people of working age in the UK experience mental health problems and about 5.5 million have a common mental disorder, with anxiety and depression being the most prevalent.^{7,8} Even people with such common mental disorders are four to five times more likely to be permanently unable to work than the rest of the population.⁹ They often live on low incomes, are three times more likely to be receiving benefit payments, frequently are of poorer physical health and overall well-being, and also report social exclusion and discrimination.¹⁰ Severe mental health problems – such as schizophrenia, bipolar disorder or severe depression – affect about 1% of the working-age population.⁸ People with these conditions usually require continuing and sometimes intensive treatment and care, and only an estimated 10% to 20% of this group are in paid employment.^{9,10}

The effect of poor mental health on the general population can be measured in human and economic cost. The World Health Organization estimates that mental health problems account for 13% of all lost years of healthy life globally and as much as 23% in high-income countries.^{11,12} Mental health conditions are only second to HIV/AIDS in terms of making an individual the object of discrimination.¹³ Monetary estimates of the adverse effects of mental illness on people's quality of life range through £41.8 billion in England,¹⁴ £4.6 billion in Scotland¹⁵ and £1.6 billion in Northern Ireland.¹⁶

The economic costs of mental disorder related to people's ability to work have ranged through £789 million in Northern Ireland,¹⁶ £2.3 billion in Scotland¹⁵ and £23.1 billion in England.¹⁴ These account for non-employment (unemployment and economic inactivity), sickness absence, unpaid work and premature mortality. Around 60% of people who have a common mental disorder are working, compared with 70% of people who do not have a common mental disorder.¹⁰ Only 10% of people with a psychotic disorder are working full-time and about 20% part-time.¹⁰

Resources for change: expenditure on mental health

Despite recent improvements, governments do not spend enough of the total NHS and social services budgets on mental health given the extent of the burden of mental illnesses. Only 9% of total spending in Northern Ireland,¹⁶ 11% in Scotland¹⁵ and 12% in England¹⁴ is allocated to mental health services. We were unable to obtain comprehensive data on funding for mental health in Wales, though a figure of 12% has been estimated.¹⁷

In England, since 2003, geographical inequalities have emerged in NHS spending on mental health services, with considerable differences between the south and the north of the country.¹⁸ Inequalities are also reported across England in the funding of prison in-reach services, where the same specialist community mental health services provided to the general population are also offered to prisoners.¹⁹ In London and in the North-East, Yorkshire and Humber, the NHS spends more than twice as much per prisoner than it does in the East Midlands and the South-West. These differences cannot be explained by needs or costs that vary across the

CASE STUDY

DR DAVE ANDERSON, CHAIR OF THE OLD AGE FACULTY, ROYAL COLLEGE OF PSYCHIATRISTS

Since the publication of the National Service Framework for Mental Health & Older People, older people with mental illness have been excluded from service developments and investments. Cuts in services are occurring at a time of unprecedented rise in the number of older people. They not only have not received investment commensurate with increasing numbers but are instead seeing their services reduced.

The ageing population presents one of the most pressing challenges to the health and social care economies of the world. Having been a leader in developing specialist services for older people, the UK is now going backwards along a disastrous path that will relegate older people to the inferior care they received three decades ago when the speciality of old age psychiatry had to develop to address that neglect. This is age discrimination reborn and the injustice experienced by older people is unfortunately set to grow.

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country, but rather represent a 'postcode lottery' in mental healthcare.¹⁹ Meanwhile, mental health services for older people often receive unequal and unfair funding and may frequently be more vulnerable to financial cuts than other services.⁶

Need for vision: long-term strategy

The development of long-term policies for mental health is welcomed. However, from the outset, such policies need to be based on a realistic estimation of the future costs of delivering health and social care services for people with mental disorders. For instance, a recent analysis of financial assumptions underpinning the 10-year National Service Framework for Mental Health in England found a shortfall in mental health services funding of approximately 20% and indicated that to fully deliver the National Service Framework in 2010/2011 a 38% increase in the number of staff was required.²⁰ Similarly, the King's Fund estimates of the cost of providing mental healthcare in England up to 2026 indicate that current service costs are set to rise 111% (from £22.5 billion in 2007 to £47.5 billion in 2026, taking into account real pay and price increases).²¹ This increase is primarily due to the estimated rise in the number of people with dementia in England and the accompanying increase in service costs. Further work is needed in England to assess the implications of these estimated costs and find ways of addressing the problems thus incurred, while similar estimates and projections are called for in Scotland, Wales and Northern Ireland.

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Access to services

One-in-four older people living in the community have symptoms of depression that are severe enough to warrant help, but only half of these are diagnosed and treated

Mental health services frequently fail to identify patients who also have drug use problems, and a third of substance misuse patients with mental health needs do not receive any interventions

In England and Wales 90% of prisoners have at least one diagnosis of mental disorder, but a 2007 HM Inspectorate of Prisons review concluded that there were still too many gaps in provision and too much unmet and sometimes unrecognised need

Access to services should be made easier across the lifespan for all people with mental health problems. The most overlooked groups include those in transition from adolescent to adult services, older people, prisoners, people with learning disabilities, and those with substance misuse problems.

The need for a fair deal

Fair access to healthcare – through the principles of universal eligibility and the removal of financial barriers – underpinned the formation of the NHS. Sixty years on, national government strategies continue to stress the importance of these founding principles.

Despite many improvements, the reality of equitable access to healthcare by people with mental health problems and learning disabilities remains far removed from political rhetoric. Psychiatrists nationwide report frustration at the lack of places available for patients in community services and are further discouraged when services are closed down. In a target-driven culture the recent funding shortages in some NHS trusts are felt to have particularly prejudiced mental health.

The nature and degree of difficulty people face in receiving the care and treatment they need varies considerably at regional and local levels and the solutions lie with the regional and local service providers. There are nevertheless country-wide issues; in England, these issues are being addressed as part of the Darzi and Bradley reforms.^{1,2} Comparable initiatives are taking place in Northern Ireland and Scotland.^{3,4} The College welcomes these plans.

What we are calling for

- ▶ Better access to high-quality physical and mental health services for all age groups and for people with different conditions and needs including people with learning disabilities, addictions, sensory disabilities and personality disorder.
- ▶ All health services to ensure 'reasonable adjustments' (as required under the Disability Discrimination Act) are made to facilitate greater access to services by people with mental health problems and learning disabilities.
- ▶ Adequate mental health services for convicted and remand prisoners, including for those with substance dependence, of a comparable standard to those provided in the general population.
- ▶ The development of policy and services to divert mentally disordered people in the criminal justice system into appropriate healthcare services.
- ▶ The transition of young people with mental illness to adult services to be achieved as part of a seamless pathway of care.
- ▶ Access to care for older people to be enhanced to meet the level of need.

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Examples of what the College will do

- ▶ The College will work through its Divisions to highlight areas of deficiency in order to improve access to care where there is a significant need.
- ▶ We will continue to work with partners to identify the standards required to provide an equivalent level of care for convicted and remanded prisoners.
- ▶ We will consider options for service delivery at the interface between child and adolescent services and adult services.
- ▶ The College will continue to survey, monitor and develop standards to improve access to child and adolescent mental health services and learning disability community services.

Availability of services

Despite improvements, significant gaps in access to healthcare remain. Older people,⁵ people with learning disabilities,⁶ prisoners,⁷ substance misusers,⁸ and Black and minority ethnic groups⁹ have all described a lack of services. A shortfall in provision for people with personality disorder has been longstanding. Community rehabilitation services have been jeopardised, particularly through the use of out-of-area services. There are also barriers – personal, physical, financial and organisational – which prevent different groups from full use of existing services.¹⁰ Difficulties are compounded where individuals are in transition (e.g. from child and adolescent to adult services),¹¹ or require care across service boundaries (e.g. prisoners requiring transfer to a psychiatric hospital bed).⁷

There is also much local and regional variation. For example, there has been a serious deficit in child

and adolescent mental health services in Northern Ireland: staffing levels and the quality, consistency and accessibility of services are inadequate due to shortfalls in investment.¹² In England, although the total staffing levels of professionals working in child and adolescent health services increased overall by 15% from 2003 to 2004, local staffing levels were geographically variable.¹³ In some areas, staff reductions of 5% were recorded, while elsewhere, staff levels were increased by 40%.¹³

Consultant Child Psychiatrist in Yorkshire

There is a poor availability of tier four beds for CAMHS for children and young people with moderate to severe learning disabilities. Having supra-regional resources for these young people is not helpful. All other young people have local services, yet this group who have the highest need to be near their families developmentally do not. It is not logistically possible to set up ad hoc arrangements for each young person, and is poor practice. Local solutions need to be sought and found, and adequately commissioned.

Older people are a particularly neglected group. Over the next 15 years, more than 1 in 15 of the population will be an older person experiencing a mental health problem.⁵ However, although 1 in 4 older people living in the community have symptoms of depression that are severe enough to warrant help, only a half are diagnosed and treated.⁵ Services for older people have been

CASE STUDY 1

JULIET DUNMUR, CARER

A care trust provided an excellent adult acute day hospital. It was a place you could go if in crisis for a day or up to several weeks. There was a high ratio of staff; the staff were caring and the environment was safe. It was not one of the National Service Framework standards and therefore did not count towards any targets or standards. In the interests of 'equity' this service was discontinued.

particularly affected in terms of funding. A 2008 UK survey of old age psychiatrists found that 58% experienced service cuts in 2007 with financial losses up to £2 million in individual services, and 31% report commissioning intentions to dismantle older people's mental health services.

Older people have further been excluded from new cash injections for assertive outreach, crisis home treatment and early intervention services. They do not have the same access to rehabilitation, psychotherapy and general hospital liaison services. As reported in *Living Well in Later Life*:¹⁴

'...the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups... Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available.'

Around 70% of people with learning disabilities may have one or more unmet needs for mental or physical healthcare, and there is a shortage of

mental health services.⁶ Limited access to general practitioners has also been identified among people with learning disabilities who also have mental health problems and who live in more restricted environments such as in residential or nursing homes, 'supported living' accommodation and secure accommodation.¹⁵

In Northern Ireland, the College reports that there is a critically inadequate supply of supported living and other services to respond to the needs of people with long-term, complex and life-limiting mental health problems. As a result they have to spend extended and unacceptable periods of time in acute admission wards.

Among the 4.6 million people from Black and minority ethnic groups in the UK, barriers to access relevant services include socio-cultural (health beliefs and mistrust of services), systemic (lack of culturally competent practices in mental health services), economic, or individual barriers (denial of mental health problems).¹⁶ The interplay of

CASE STUDY 2

QUALITY IMPROVEMENT NETWORK FOR MULTI-AGENCY CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (QINMAC)

QINMAC is a quality improvement programme which aims to improve the specialist provision of community-based child and adolescent mental health services (CAMHS). Young people with learning disabilities and mental health needs have often been excluded from CAMHS and accessible mental health services are the starting point in their getting help at the earliest stage. The QINMAC service standards are used to evaluate CAMHS across the care pathway, starting at the point of referral and access.

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CASE STUDY 3

CONSULTANT PSYCHIATRIST SPECIALISING IN EATING DISORDERS

As commercial pressures within the NHS grow, less profitable areas of mental health fall into neglect. Arenas that lack explicit government 'targets' become vestigial to mental health services and, more pertinently, those who commission them. Eating disorder services are one such area. There is a danger that the primary purpose of mental health becomes management of 'risk to others', and psychiatric units become agents of social control. There are many notable eating disorder services being downgraded or else re-framed to meet quasi-political rather than clinical targets.

these factors means that minority ethnic groups in particular may have higher rates of mental health problems, lower rates of referral and treatment, and higher rates of compulsory treatment and forensic service contact.¹⁷

The transitional period from older adolescent to adult is a crucial stage of development, and can coincide with the emergence (or continuation) of serious mental health problems.¹¹ However, during this difficult time, adolescents have to transfer from child and adolescent to adult mental health services. Some commentators contend that adult services have a different philosophy and operational basis, and are not appropriate. However, dedicated older adolescent services are rarely available.

The availability of services for people with mental health and substance misuse (addiction) problems also remains an issue. Studies in the UK indicate that 44% of people receiving community mental healthcare have substance misuse problems, and 34% of people receiving treatment for addiction also have a mental health problem.⁸ Yet mental health services frequently fail to identify patients who also have drug misuse problems, and a third of substance misuse patients with mental health needs do not receive any interventions.⁸ Critically, where problems are identified, cross-referral

between mental health and addictions services can be poorly managed.

It has been estimated that in England and Wales 90% of prisoners have at least one diagnosis of mental disorder and the prevalence of severe mental illness is up to ten times that in the wider community.¹⁸ Government policy for prison healthcare is based on the principle that the standard of services in prison should be equivalent to that available in the wider community, relative to need. Despite extra investment and many more staff, prison in-reach teams are still unable to reach those in need.¹⁸ In 2007, an HM Inspectorate of Prisons review concluded that there were still too many gaps in provision and too much unmet and sometimes unrecognised need.¹⁹

Furthermore, the review noted that need will always remain greater than capacity, unless mental health and community services outside prison are improved and people are appropriately directed to them before, instead of, and after custody. Those are the two parallel tracks that must be followed. Unless those gaps are filled, mentally ill people will continue to fall through them and into our overcrowded, increasingly pressurised prisons. In England and Wales, initiatives such as the Bradley Review of Diversion provide opportunities for a substantial improvement in the situation.

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In-patient services

Although official statistics indicate bed occupancy levels among adult patients of between 85 and 92% in each of the four UK countries, independent surveys find levels ranging from 100 to 140%

Patients may remain in hospital for months after their need for hospitalisation has ended while they await transfer to local authority accommodation

In 2008, the Mental Health Act Commission reported that the busy acute wards 'appear to be tougher and scarier places than we saw a decade ago'

In-patient services should be improved, with sufficient capacity for patients to be admitted locally into an appropriate ward. Improvements in ward conditions and the expansion of child and adolescent and intensive-care beds are key.

The need for a fair deal

Mental health services for adult and young people in the UK do not meet current demands for in-patient beds. Over-occupancy – where a ward has more patients on its admission list than available beds – remains a key problem. It can delay urgent admissions and prevent people being discharged on short-term leave or transferred to a more appropriate ward or hospital. It can hinder patient treatment and well-being, may affect ward atmosphere and patient safety, and place heavy demands on staff time. The College considers that lower occupancy levels for both adult and young peoples' services of about 85% are necessary for effective and safe care.¹ Aligned with this issue is that of standards of in-patient care and quality of the environment, particularly for detained patients.

What we are calling for

- ▶ Bed occupancy levels that are sufficient to enable services to respond to and accommodate emergency admissions and which meet local levels of need.
- ▶ The development and adoption of common national standards for effective and efficient in-patient mental health services for adults and young people.
- ▶ Robust monitoring by the Care Quality Commission of bed occupancy and conditions for patients detained under the England and Wales Mental Health Act 2007.
- ▶ Legislation on delayed transfers of care to local authority housing, extending the scope of the Community Care Act 2003 to include mental health wards, thus removing the disparity between patients with mental and physical conditions.

Examples of what the College will do

- ▶ The College will, through its Centre for Quality Improvement, continue to survey, monitor, and develop standards for adult, forensic and child and adolescent mental health services (CAMHS) and learning disability in-patient services.
- ▶ We will campaign for more realistic capacity targets (recommended 85%) and better ward conditions for all patients, including those who are detained under mental health legislation.

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Capacity: adult in-patients

A high or excessive rate of bed occupancy brings risks to patients and others because services are unable to admit patients in an emergency and may discharge others prematurely in order to create an available bed. It can prevent the opportunity to discharge patients on short-term leave. The consequent overcrowding can compromise the safety, dignity and privacy of patients and their clinical treatment. Being moved between beds, wards or even hospitals because of over-occupancy clearly disrupts a patient's care. Staff may find that the demands of bed management divert them from their primary nursing role. The Mental Health Act Commission found that the frustration and stress experienced by staff in over-occupied wards was harmful to staff morale, and that this had an indirect effect on the quality of patients' experience on the ward.²

Although official statistics indicate bed occupancy levels among adult patients of between 85 and 92% in each of the four UK countries,³⁻⁶ independent surveys have repeatedly found far higher occupancy levels ranging from 100 to 140%.^{7,8} Mental health services in England and Wales also report a critical shortage of child and adolescent in-patient beds.⁹

In 2005/2006, more than two-thirds of the NHS budget for clinical mental health services in England was spent on in-patient psychiatric hospital care.¹⁰ However, in England, there are fewer in-patient beds now than at any other time since the introduction of the Mental Health Act in 1983.¹⁰ The Mental Health Act Commission found that between 2005 and 2007, 37% of all wards they visited were running at over 100% bed occupancy.¹⁰ Wards in

London frequently had occupancy levels of 100% or more.⁹ Crisis resolution teams are intended to reduce the need for hospitalisation. However, as yet, they do not have sufficient staff to meet this aim.¹¹

In Wales, official statistics indicate that between 2005 and 2007 acute care wards were operating at 92% bed occupancy.⁵ However, the Mental Health Act Commission found that over the same period 40% of acute wards were operating above their bed capacity, with around 10% operating at more than 120% capacity.¹⁰

In Scotland, official statistics indicate an adult in-patient occupancy level for 2005–2006 of around 84%.⁴ However, the Scottish Mental Welfare Commission found average bed occupancy of 92% on in-patient wards, with 42% of wards having occupancy rates of 100% or more.⁸ Finally, in Northern Ireland, official statistics indicate average bed occupancy rates of 91%;⁶ however, published reviews suggest occupancy rates exceed 100%.¹² The Acute Bed Project, a survey conducted every 5 years by the Northern Ireland Division of the College, found in 2004 that:

Nick Nalladori, a carer on a College review of wards

'I am no clinician and do not know much about the operational aspects of an acute ward but what I observed was a well-motivated cohesive team working with an inspired leader who appeared quite flexible'. Nalladori observed a 'culture of friendliness' and the positive attitude of the staff: 'they really cared and took pride in the work they did.'

'bed occupancy in Northern Ireland has increased since 1999, approaching 100% saturation on average. It often exceeds 100% occupancy rates, meaning that two patients are allocated to one bed, and the frequency of this occurring has increased'.¹²

High bed occupancy does not arise only because the numbers of in-patient beds has been reduced but also because of 'bed blocking'. It occurs usually when there is no local authority placement for a person with complex mental health needs or for a person

who is homeless. Patients may remain in hospital for months after their need for hospitalisation has ended while they await transfer to local authority accommodation.

This has a lasting effect upon their own quality of life, prevents shorter-term patients from admission, and is expensive for mental health providers.¹³ In 2003, the government introduced the Community Care (Delayed Discharges, etc.) Act to address the problem of bed blocking in England and Wales. The Act introduced financial penalties for local authorities who failed to provide services to enable a patient to be discharged. However, this only applies to people with physical illness and does not cover people who are cared for in psychiatric hospitals.

Acutely ill patients may require short-term treatment in a secure psychiatric intensive care unit when their level of disturbance is such that they are unmanageable on open wards. A 2005 survey of psychiatric intensive care units in London found average bed occupancy rates of 90%, and on some wards rates of up to 140%.¹⁴

Capacity: child and adolescent in-patients

There are insufficient mental health beds available to meet the current needs of children and adolescents in the UK. Between 2000 and 2005, 34% of child and adolescent mental health units were unable to admit emergency patients,¹⁵ 44% were unable to admit out of hours, and in 2005 consultants estimated they turned away 72% of referrals for emergency admission.¹⁶

Colin Gell, Chair of Service User Recovery Forum (SURF)

'The atmosphere on most wards is, at best, tense and at worst, dangerous. Walk onto any ward and you immediately feel this. We need to create a calmness and interest on wards that is beneficial. People exhibiting the more extreme behaviour are seen as a nuisance and there is a double stigma. These people are already stigmatised by being on the ward but are seen as the "nutter" by other people on the ward. They then find their behaviour very embarrassing when they are better.'

Of further concern are reports of children and adolescents being admitted and treated on adult mental health wards because of a lack of in-patient beds. A third of admissions of mentally ill young people are inappropriate admissions to adult psychiatric or paediatric wards.¹⁷

Between 1999 and 2006 the number of in-patient units has increased in England and Wales. However, the majority (69%) of this increase is

attributed to the private sector whose market share rose from 25% in 1999 to 36% in 2006 often involving placements a long way from home.¹⁶ There is also considerable geographical variability in the number of beds available across England and Wales. The Royal College of Psychiatrists recommend a minimum of 20 CAMHS beds per million population.⁹ In 2006, however, four regions within England were still well below this minimum.¹⁶

Conditions in in-patient wards

Conditions in wards have been criticised in recent reports.^{7,10,18,19} Incongruities between official environmental audits and anecdotal evidence suggest there are many challenges to improving the quality of care in wards. A 2004 survey by Mind found that almost a quarter of recent in-patients in England and Wales had been accommodated in mixed-gender wards, and 27% of respondents said they rarely felt safe while in hospital.¹⁹

In 2008, the Mental Health Act Commission reported that the busy acute wards 'appear to be tougher and scarier places than we saw a decade ago'.¹⁰ Despite concern about the adequacy of

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CASE STUDY

MENTAL HEALTH ACT COMMISSION FINDINGS 2006–2007

We have found wards that are unventilated and hot in summer but cold in winter; wards where there is little natural light; noisy and smoky wards; broken, worn and stained furniture, sticky floor and bad smells; vermin and cockroach infestation; peeling paint and graffiti; non-existent or broken lockable storage for patients' belongings. We have had cause to comment on broken and dirty toilet facilities and on inadequate numbers of toilet and bathroom facilities.

staffing levels in mental health services, there are no universally agreed standards.

The Mental Health Act Commission and nursing staff themselves considered some staffing levels to be unsafe. Patients complained that staff shortages reduce opportunities for escorted leave from the ward and that it was very difficult to develop a rapport with a constantly changing nursing staff.¹⁰

As the Commission points out, patients who are detained under Mental Health Act powers are placed in a quite different situation from many other NHS in-patients. They have not agreed to come into hospital and in some cases do not accept the need for admission, and may not discharge themselves from a ward that they find intolerable.

The new Care Quality Commission will take over the functions of the Mental Health Act Commission to monitor the care and treatment of detained patients in England and Wales. It will be important to ensure that their work is of a similar rigorous standard as that of the Mental Health Act Commission.

What the College is doing: College Centre for Quality Improvement

The Centre for Quality Improvement is developing and promoting standards for a range of in-patient settings including:

- ▶ Acute In-patient Mental Health Services (AIMS) is a ward-based accreditation service which engages clinical staff, service users and carers in recognising and sharing good practice. It accredits wards that demonstrate that they provide a 'timely and purposeful admission in the context of a safe and therapeutic environment': of 129 member wards, 37 have been accredited, 5 with excellence.
- ▶ Learning Disability Accreditation Programme aims to raise standards in specialist residential services for adults and young people with learning disability. It is a response to a Health Care Commission review of 638 units across 72 NHS trusts and 17 independent providers which concluded that there were unacceptably wide variations in the standards of care.
- ▶ Adaptations that adult wards must make to accommodate young people who are admitted to adult wards despite the requirement for admission to an age-appropriate environment. This will be helpful in the short-term (and for exceptional circumstances), while hospitals plan in the long term for accommodation for CAMHS patients.

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Recovery & rehabilitation

People can, and do, recover from mental health problems. They can take control of building a meaningful life for themselves even while continuing to experience mental health problems or following a period of poor mental health

However, mental health services are not good at promoting recovery and professionals are not trained in a 'recovery-orientated approach'

Psychiatrists report that specialist rehabilitation services are often not available across the UK, or are under threat, and that a clear strategy for their development is lacking

Recovery and rehabilitation should be integral to mental healthcare and treatment. A coherent rehabilitation policy based on recovery-orientated practice is needed for people experiencing long-term mental health problems.

The need for a fair deal

'Recovery' has been used in two ways in mental health.^{1,2} First, recovery is the intended consequence of the skilful application of medicine, nursing and social care on a specific illness. Second, recovery is where individuals actively build a meaningful life for themselves while either continuing to experience mental health problems, or following a period of poor mental health.

A recovery-based approach is not primarily about returning to a pre-illness state, but is a process where the individuals and professional collaboratively work towards a meaningful and satisfying life. It is one where people with mental health problems regain active control of their lives, and where services support this through negotiated decisions about the best ways of meeting a person's medical, social and personal needs.^{1,3}

Social inclusion is the goal we all share for people with mental health problems. A recovery-based approach is fundamental for this to be achieved.

What we are calling for

- ▶ The formulation of a clear UK rehabilitation policy.
- ▶ Recovery to become a better understood and accepted approach across all mental health specialties.
- ▶ Clear and practical guidance and standards on how mental health services can be recovery orientated.³
- ▶ Further research on successful methods of supporting self-management and recovery.

Examples of what the College will do

- ▶ The College, with its partners, will work to develop guidance, advice and audit to support recovery-oriented practice in local mental health services.
- ▶ We will ensure that training for psychiatrists promotes the recovery approach.
- ▶ We will press for the formulation of a clear UK policy on the provision of rehabilitation services for people with long-term mental health problems.

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Recovery: what is the evidence?

People can and do recover from severe mental health problems. Research studies have followed the progress of individuals with different mental health problems over several years. A large review of longitudinal research studies of those with schizophrenia found that complete recovery (a return to pre-illness levels of functioning) occurred in 20–25% of participants, and social recovery (regaining economic and social independence) in 40–45%.^{4,5} Studies of individuals with bipolar disorder suggested that around 40% of participants did not experience detectable inter-episode psychosocial impairment.⁶ An important finding is that personal outcomes may depend on considerably more than effective treatment – social and cultural factors play an important role, as do personal commitment, hope and peer support.

Dr Glenn Roberts, member of the RCPsych

We frequently do not know what is possible until we try.

Rehabilitation services

Rehabilitation services include the community rehabilitation team, which will often work closely with crisis resolution teams, community mental health teams, assertive outreach, residential services and acute in-patient facilities.⁷ They will also cultivate a network of connections with ordinary services and resources that promote social inclusion. However, psychiatrists report that specialist rehabilitation services are often not available across the UK or are under threat and that a clear strategy for their development is lacking.⁸ They are critical of the large distances their patients have to travel from their homes to receive rehabilitation services.⁹ Out-of-area treatments also affect many thousands of long-term in-patients who are, as a consequence, likely to experience social exclusion.

Recovery: a common purpose for services and users

Recovery features prominently in public discussion and in the national mental health policies of all four UK countries. The importance of putting patients at the centre of their care is the main tenet of the new government approach in England and Wales. It includes an expansion of social measures such as individual budgets and self-assessment, including widening of direct payments.^{10–12} The principles of recovery are being put into practice across mental health and social care services including specialist rehabilitation services in the community and hospitals.

Placing recovery at the centre of mental health services requires change in the way organisations operate and individuals practice their profession. Patients will expect professionals to listen to them on general life issues and provide them

CASE STUDY 1

JAMES WOOLDRIDGE

My army career ended the day I went on parade in my pyjamas at Sandhurst. Within 24 hours I was sectioned and pinned to a bed while a sedative was injected into my arm. For the next 20 years, I was in and out of acute wards, and in 2003 I committed an offence and was transferred to a medium secure hospital. It was here that I, along with excellent hospital staff, was able to recover and work towards maintaining my mental health and well-being. I now use my experience of living with mental distress and my commitment to recovery as the basis for my successful business as a freelance trainer, speaker and motivator.

CASE STUDY 2

THE DEVELOPMENT OF RECOVERY IN DEVON

Devon has been developing recovery-orientated services across the whole health and social care community since 2003. The Devon Partnership NHS Trust has declared one of its key aims as to 'put recovery at the heart of everything we do', and underpinned that with a requirement that ALL staff have awareness of the recovery approach and appropriate skills, leading to a whole workforce training strategy. Similarly, the Joint Health and Social Care Commissioners have developed a recovery-orientated commissioning strategy and set in motion a year-long exploration of how to embed recovery outcome measurement in routine practice. The Commissioners, the Trust and the third sector have agreed on a set of ten core standards for recovery-orientated services.

with the information, skill and support needed to manage their condition and become active and responsible in their own recovery; they will expect help to access what they think they need to live meaningful lives. Recovery is an important means of promoting social inclusion and challenging marginalisation, stigma and discrimination within health services and in the wider society. Social inclusion is important for recovery and it is not possible without the opportunity to be part of a community, to be a valued member of that community, to have access to opportunities and to contribute.

Although improvement in individual symptoms and clinical outcomes is important and may play a key role in a person's recovery, the overall quality of life, as judged by the individual, is central. There is a necessary shift of emphasis from being

clinically and professionally centred to being user- or person-centred. With this comes an increased emphasis on the need for satisfactory housing, employment, education, personal finances and participation in 'mainstream' community and leisure activities: each or any of these areas could become central objectives.

This approach does not undermine professionals' opinions nor require them to pretend that something is possible when they genuinely believe it is not. However, they should support people in trying to achieve the goals they set for themselves, even if they believe the goals are not realistic. The hopes and expectations for recovery held by service providers are potent mediators of the opportunities of recovery for individuals.

Confusion about the meaning of recovery, concerns about a perceived lack of evidence about recovery-based services and fears about risk¹³ have impeded the development of recovery-orientated services.¹ These need to be addressed. We must differentiate between risks that must be minimised (self-harm, harm to others) and risks that people have a right to experience. In a recent report on risk management, the College has expressed concern about forms of clinical

CASE STUDY 3

NATIONAL INITIATIVES ON RECOVERY – SCOTLAND

The Scottish Recovery Network (SRN) is developing recovery 'audit tools' for mental health nurse leads. This will complement the NHS Education Scotland recovery training initiative for mental health nurses. To achieve this, SRN is adapting an existing international assessment tool – the Recovery-Oriented Practices Index – to assess the extent to which practice is focused around the promotion of recovery.

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CASE STUDY 4

NATIONAL INITIATIVES ON RECOVERY – WALES

The Powys Equals Partnership have drawn on local, national and international stories of personal recovery, service development, tools and training to create a framework for the inclusion of skills associated with acknowledged lived experience (ALE) within recruitment practice of statutory and voluntary organisations (for example, support time and recovery workers). Day services, within the county, are developing their capacity to support personal recovery, based on a pilot, Active Lifestyles, in Welshpool, that draws on the themes above, and supports people to be more active in their own communities.

practice that attempt to eliminate risk.¹⁴ It is felt that preoccupation with risk and a consequential tendency towards risk-averse practice is stifling creativity and innovation. The report emphasised that constructive and creative risk-taking is a vital part of a patient's rehabilitation and that risk-averse practice is detrimental to this process.

CASE STUDY 5

NATIONAL INITIATIVES ON RECOVERY – ENGLAND

Initiatives include that of the South London and Maudsley Foundation Trust. Their social inclusion, rehabilitation and recovery strategy has been recently adopted. It states that 'recovery is something the individual defines and experiences. A mental health service cannot make someone recover, though it can support the process. The primary aim of SLAM in its work with service users is to support them in their recovery'. A training programme has been developed, field-tested and funded for roll-out and evaluation across Lambeth and Southwark.

CASE STUDY 6

NATIONAL INITIATIVES ON RECOVERY – NORTHERN IRELAND

Rethink has established a self-help programme to support and facilitate people's endeavours to take active steps towards their own recovery. It is run by people who have experienced mental illness, and people on the courses can either self-refer or be referred by a social worker or community psychiatric nurse. The programme operates from six centres across South Belfast, with the intention for it to be extended to other parts of Northern Ireland.

Making recovery a reality: developing policy implementation guides

The Royal College of Psychiatrists is committed to a recovery-based approach to mental health services. In 2007, the report *A Common Purpose: Recovery in Future Mental Health Services* was published with the Social Care Institute for Excellence and the Care Services Improvement Partnership.¹ In 2008–2009, the Sainsbury Centre for Mental Health will take this forward, with College input, in their work programme Making Recovery a Reality. This will involve the development of implementation guidance for NHS trusts.^{1,3} Measures of recovery-orientated practice are being developed, standards proposed and training needs identified, and guidelines will be produced at individual, team and service level. The College supports these initiatives.

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Discrimination & stigma

When people with mental disorders are asked to name the greatest obstacle to recovery, discrimination and stigma is by far the most common response

People with a mental illness (however mild or long ago) can be denied entry into some professions as 'not fit to practise' even though they meet all the competencies for the profession

In the media, reporting of mental illness is unbalanced, contributing to distorted and inaccurate perceptions of the violence caused by people with mental health problems

Discrimination and stigma need to be tackled throughout society. The NHS should lead by example in promoting equality and human rights in all of its work as an employer and provider of health services.

The need for a fair deal

When people with mental illness are asked to name the greatest obstacle to recovery, discrimination and stigma is by far the most common answer. Stigma is a prejudice, based on stereotypes, leading to discrimination. Discrimination remains endemic throughout UK society despite many campaigns to eradicate it. For some groups that discrimination is compounded because of the person's race, disability, cultural background or sexuality.

The practical result of discrimination is the everyday avoidance of people with mental illness: we choose to walk on by rather than engage with the most isolated people in society. Many people with mental illness are so accustomed to these rejections that they have stopped making the effort to meet new people. But a lack of adequate social networks for themselves can increase the chances of relapse and reduce overall recovery.

Tackling discrimination and stigma is thus crucial in order for people with mental health problems to live as equal citizens in society. Employers, local authorities, schools and colleges, and public services need to take steps to eradicate discrimination in their ranks; indeed they are bound by law to do so. Finally, the media is a source of negative stereotypes of people with mental illness and should use its considerable influence to combat rather than to exacerbate stigma.

Dignity and respect are values we all seek for ourselves. For patients who have been treated well in their illness or conversely patronised, neglected or coerced, these values have special resonance. Human rights and non-discrimination are inseparable principles for people with mental health problems and learning disabilities. They need to be addressed together. With the formation of the UK Commission of Equality and Human Rights the time is ripe for a new approach.

What we are calling for

- ▶ The NHS (as an employer and as a service provider) to take the lead in reducing discrimination against people with mental health problems and learning disabilities, and promoting human rights.
- ▶ The health authorities in all parts of the UK to ensure that their disability equality schemes adequately address their disability equality duties in relation to people with mental health problems and learning disabilities.
- ▶ The Press Complaints Commission to carry out periodic reports documenting the volume and content of complaints where mental illness was a factor.

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Examples of what the College will do

- ▶ The College will campaign to eliminate discrimination against health professionals on the grounds of their mental health in employment. Through training and guidance for psychiatrists we will seek to reduce discrimination against service users and to promote their use of a human rights-based approach to healthcare.
- ▶ We will campaign for anti-discrimination legislation to be extended in order to protect people against discrimination by service providers on the grounds of age.
- ▶ We will campaign against the distorted presentations of people with psychosis and other mental disorders in the press.
- ▶ We will participate in the Moving People campaign and new Scottish initiatives.

The case

The Report on Social Exclusion and Mental Health cited stigma above poverty, isolation and homelessness as the main source of social exclusion for people with current or previous mental health problems.¹ Attitudes towards people with mental health problems remain in most respects as profoundly negative as they were a decade ago, although public awareness of mental illness has improved.² For some people, problems are compounded by additional discrimination on grounds of their race, cultural background³ or sexuality.⁴

Negative attitudes (prejudice) to people with mental health problems have been recorded throughout society – in homes, schools, colleges, universities, our workplaces and our local communities; from civil servants and doctors to landlords and neighbours.¹ Discrimination in the workplace drives the low employment rate among people with severe mental illness.^{5,6} People with mental health problems have both a lower rate of employment^{7,8} than other disabled groups and are more likely than other groups to want to be in employment.^{9–11}

Qualifications to enter the professions which impose health standards as well as competencies can cause discrimination. A person with a health record of mental illness (however mild or long ago) can be denied entry to these professions on the grounds they do not meet these standards. Local opposition to group homes/community living ('not-in-my-back-yard') appears to be prevalent across

CASE STUDY 1

MISS RESHMA PATEL, SERVICE USER

In my experience mental illness seems to have a negative quality connected to it. I think the reason for this is a lack of knowledge of the ordinary general public in understanding the issues linked to mental health. If people were educated more about the subject, fewer judgements would be made and there would be a better understanding of mental health issues. I myself have experienced discrimination particularly when applying for jobs and promotion, and have not always obtained the fairest of deals.

CASE STUDY 2

KYM PETERS, SERVICE USER

I had an episode of depression and anxiety in 1991 which resulted in an admission to an acute ward for 2.5 weeks. A couple of years later, I commenced training as a nurse at Kingston University. Unfortunately, I again experienced depression, which resulted in occupational health advising me to discontinue my studies.

I went to work as a healthcare assistant at Springfield Hospital and while there I was put in touch with the User Employment Programme (UEP). They provided one-to-one support, as well as a regular group support session. I found this extremely helpful, as it enabled me to be objective about any difficulties I was experiencing at work. It also enabled me to share and validate my experiences with other supported employees. Most importantly, it provided positive feedback and encouragement. Over the course of the next few years, I was supported in various positions at Springfield and Kingston Trusts by the UEP. I was able to complete my studies, graduate, and now I work in a new role as a staff nurse at Broadmoor Hospital. It has not always been plain sailing, and while I have found it difficult in my new role not having the support I found so valuable at Springfield, I have maintained my links with the UEP and the informal support has proven invaluable.

the country.⁸ A label of mental illness makes it harder to get life, personal or holiday insurance.¹²

Across some media, mental illness is typically represented in distorted stereotypes which can foster fear and stigma among the general public. It also contributes to false and very damaging perceptions of the violence caused by people with mental health problems.³

Despite this depressing picture there are positive signs of a greater tolerance, knowledge and understanding about common mental health problems, and the taboo against raising them is being whittled away. This is the time for renewed energy in the fight against discrimination.

The NHS: getting its own house in order

Stigma and discrimination can occur within the health service at both institutional and individual levels. Negative attitudes to mental health can adversely affect policy development, usually through omission of relevant mental health issues. (For instance the exclusion of older people with

mental health problems from access to new mental health services.)

Death by Indifference, a Mencap Report in 2007,¹³ condemned 'institutional discrimination' against people with learning disabilities in the NHS. Its call for better training of general practitioners in learning disabilities is strongly supported by the College.

People with mental illness and learning disabilities can face stigma from medical practitioners, including psychiatrists.⁵ Expressions of this include 'diagnostic overshadowing' (where a person's comorbid illness is not diagnosed because the doctor doubts the reliability of their account of symptoms) and being underinvestigated. People with learning disabilities can be overlooked because the doctor or nurse lacks the skill of communicating with them; they can have difficulties in being 'taken on' by a general practice surgery.¹³ Such treatment, resulting to a certain extent from lack of training, is not only unfair but can be potentially illegal.

The NHS needs to lead on the reduction of stigma and discrimination. Extending the coverage of

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antidiscrimination law to protect people who suffer discrimination on the grounds of age from service providers (such as the NHS) would ensure that age barriers were not used to deny treatment to older people with mental health problems.

Existing public sector duties under the Disability Discrimination Act require the NHS as an employer and a service provider to work to eliminate unlawful discrimination, promote equal opportunities, eliminate disability-related harassment, promote positive attitudes towards disabled people and encourage participation by disabled people in public life. The strategic health authorities and primary care trusts should address all these issues in their disability equality schemes. Among other things, they have the duty to remedy the low employment of people with mental health problems in their workforces and to involve them in shaping services. They have been slow to comply with these legal duties. It was 'a disappointing picture'.¹⁴

The NHS, through its regional structures, should take the lead in ensuring that the Disability Discrimination Act is complied with in all its activities. Annual reports should be required from all acute, mental health and primary care trusts documenting their actions to reduce discrimination. These reports should include examples of local experiences and best practice, including positive stories of overcoming stigma in that region.

NHS and employment

The stigma of mental illness affects employment in the NHS. For instance, to become accredited as a nurse, an applicant must comply with the 'fitness to practice' criterion. The 2007 Disability Rights Commission's formal investigation found these accreditation criteria to be a formidable and an unnecessary barrier for people with mental illness.¹⁴ The report recommended that they be abolished, having found that a general competence

CASE STUDY 3

MEMBER OF SERVICE USER RECOVERY FORUM

Next door neighbours move in. Seem OK with us until they learn of our mental health problems. Four years of harassment follows. No agencies (police, council, etc.) do anything – is that because we tell them that we have mental health problems? Next door neighbour even comes over to ask us what our diagnoses are!

standard was sufficient to protect the public and other staff.

As Dr Perkins, Director of Quality Assurance and User Carer Experience, South West London and St George's Trust, has commented:

'In particular people with mental health problems should be employed in mental health services. People who have successfully lived with mental health problems have expertise that is valuable to others who are facing similar challenges; they offer images of possibility to both service users and staff and they break down the "them" and "us" divide.'

Current work on discrimination and stigma

The College has campaigned against stigma and discrimination for many years. Most recently the See Me campaign in Scotland (www.seemescotland.org.uk/), in which the College was a partner, was a national publicity programme with local and national anti-stigma action.

Currently, at both national and local levels there are government and stakeholder campaigns in which we will participate. The Moving People campaign in England, launched in 2008, aims

to create a measurable shift in public attitudes, and to improve the physical well-being of tens of thousands of people with mental health problems. The College is participating in this initiative.

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Engagement

with service users and carers

While person-centred care and service user involvement is promoted in the NHS, in practice it often remains tokenistic and service users are not adequately supported, trained or paid for their time

Involving service users in the delivery of health services is beneficial. Research shows that service users who work with health services have fewer hospital admissions and better quality of life

Engagement with service users and carers must be meaningful, not tokenistic. People with direct experience of mental health problems or a learning disability should have a central role in the design and delivery of mental health services.

The need for a fair deal

Government policy in the UK strongly endorses the engagement of service users and carers in the design and delivery of mental health services.¹⁻⁴ Policies exist concerning the participation of users and carers in the training of health and social care professionals⁵ and in the planning and undertaking of research.⁶

These policies stem from the recognition that patients' involvement can empower service users and carers. It can ensure that policies and service design reflect patients' needs and preferences and lead to a more effective healthcare system. They also reflect wider NHS commitments to democratic and effective decision-making.

Government policy is, however, less clear about what constitutes involvement and how it should be achieved in the NHS. Models of service user engagement around the country – for example Mersey Care NHS Trust – provide a blueprint for how things could be done.

What we are calling for

- ▶ Mental health trusts to involve patients and carers in the design, commissioning and delivery of mental health services, staff training and research or audit programmes.
- ▶ Trusts to engage service users in evaluating the service users' involvement in their trust and in taking steps to remedy barriers revealed.
- ▶ Trusts to ensure that a champion of patient involvement is a member of the trust's board.

Examples of what the College will do

- ▶ The College will continue to integrate service users and carers into their main areas of work (including research, training and quality improvement) and will develop and share best practice with other medical Colleges.
- ▶ We will audit and promote the involvement of service users and carers in the training and education of all junior psychiatrists.
- ▶ We will develop an assessment tool for measuring the well-being of carers.
- ▶ With other partners we will further best practice between psychiatrist and the patient on the use of and withdrawal from medication.
- ▶ We will work to support the physical and emotional well-being of carers of people with learning disabilities who present challenging behaviour.

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Design and delivery of services

Service users and carers have an important role to play in the design and delivery of mental health and learning disability services. This should lead to more accessible and acceptable services and ultimately improve the service users' health and quality of life. Numerous case studies have detailed the benefits of service user involvement, but there is little systematic evidence of the effects of such involvement on the quality and effectiveness of services, underlining the need for research.⁷

Barriers to involving users and carers in the design and delivery of mental health services are well known and are being addressed in some NHS trusts.^{8,9} Some good work is already under way, focusing on:

- ▶ the need for users and carers to integrate into the trust's meeting and management procedures
- ▶ lack of concrete incentives in which users could participate
- ▶ organisational attitudes to how representative individual users and carers are of the wider group of service users and carers, or their ability to make useful or rational contributions
- ▶ lack of investment in supporting and building capacity among carers and users
- ▶ issues about independence and freedom of users and carers to act (such as the absence of user-defined agendas, independent funding sources, or user or carer-only forums).

Service users – including those with schizophrenia and bipolar disorder – have been employed in clinical teams to engage with and coordinate the care of other service users. Studies indicate that

employing users in case management or outreach services is beneficial; the individuals they work with appear to have fewer hospital admissions and an improved quality of life than comparable groups.⁸

Dr Dave Fearnley, consultant forensic psychiatrist, Medical Director & Deputy Chief Executive of Mersey Care NHS Trust

'I have been promoting the involvement of service users and carers in consultant appraisals in the Trust for the past 2 years. We are also planning for service users and carers to meet consultants during the appraisal year to undertake a semi-structured interview about the ways they try to involve service users and carers in their work.'

A well-known and often cited model of service user involvement is the Mersey Care NHS Trust.¹⁰ The 'Mersey care way' is spearheaded by a director for service user and carer involvement who sits on the trust board, but is driven by a network of lead officers for involvement across all trust services. Furthermore, users and carers are involved in

all aspects of staff training and recruitment and a Service User and Research Evaluation Group was established to develop user-led and controlled research.

Training

The benefits of involving users and carers in the training of healthcare and social care professionals stem from their unique understanding of mental health problems and their ability to help assess

CASE STUDY 1

ENGAGEMENT WITHIN THE ROYAL COLLEGE OF PSYCHIATRISTS

The Royal College of Psychiatrists is committed to involving service users and carers in all its activities. Service User Recovery and Carer forums have been established to support and provide input into the work of the College. A national network of service users and carers has also been developed to inform policy development.

CASE STUDY 2

DEVELOPING AND TESTING THE CARER WELL-BEING AND SUPPORT QUESTIONNAIRE

Researchers at the Royal College of Psychiatrists' Research and Training Unit (CRTU) have been funded by the Department of Health to develop and test a questionnaire for accurately measuring the well-being of carers and their satisfaction with the support they receive. The aim is to produce a credible instrument for assessing important aspects of a carer's experience which carers themselves will like because it will ask relevant questions in the right way. The questionnaire will be used to assess a carer's need for support and to monitor whether the services provided are meeting those needs. The CRTU is undertaking the study in partnership with Rethink and the Alzheimer's Society.

professionals' social and communication skills.¹¹ In 2005, the Royal College of Psychiatrists advocated that all psychiatric trainees must receive training from service users and carers.¹² However, 3 years on, the College has found that in existing training this is still patchy and under-funded. In response, we are developing training materials with examples of good practice to be adopted by psychiatric trainers across the UK.¹²

Research

Involving users and carers in research is equally important, as they bring to studies their insights, experience and skills.^{6,13} This includes users' personal knowledge of what it feels like to undergo treatment or manage the side-effects of medication. It also requires serious consideration of the often neglected experiences of carers. Furthermore, service users' and carers' priorities for research can be very different from those of academics.

Users and carers can become involved in research in different ways, for example by:

- ▶ acting as partners in the research study
- ▶ advising on the key questions and methods to address these
- ▶ assisting with data collection and analysis.

More rarely, research projects can be led by users and carers themselves, with service users who are

trained and supported to undertake the research. However, in practice, it is often the case that users and carers are not meaningfully involved in the research process in any form, with lip service being paid to their involvement.

Clear guidance is needed on how researchers could meaningfully involve users and carers in their studies, as this is still lacking. Furthermore, a range of groups should be involved in research, including hard-to-research-with groups such as prisoners or individuals in secure mental health services. Finally, funding needs to be made available within trusts and nationally to ensure that barriers to involvement, such as payment, are overcome and

CASE STUDY 3

ENGAGING WITH SERVICE USERS

The College's quality improvement programmes are increasingly engaging with service users and carers, who help to inform and shape the work of the College Centre for Quality Improvement. Users and carers are represented on steering groups and standards development workshops and many also take part in peer-review visits to other mental health services, interviewing staff and service users. For some projects, participating trusts are only permitted to take part if they commit to recruiting and supporting service users to work with them locally, to help improve services.

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CASE STUDY 4

MERSEY CARE NHS TRUST¹⁰

Mersey Care NHS Trust provides specialist mental health and learning disability services for the people of Liverpool, Sefton and Kirkby. Their success in involving service users and carers was recognised in the clinical governance review carried out by the Healthcare Commission. It described the level of service user and carer involvement in all aspects of the Trust's work as, 'exemplary' and 'impressive'. The Trust has also won awards for its work.

Service users and carers are not involved in Mersey Care because it will be good for them, good for the Trust, or because it is the policy flavour of the government of the day. Service users and carers are involved because they are valued citizens with a whole range of knowledge and experience as people as well as knowledge and experience of Trust services.

The Trust Board has adopted a 'rights based approach' in its work. Their strategy makes it clear that, 'We must think about people's rights in everything that we do. Legal rights such as the right to life; carers' right to an assessment of their needs; the right to aftercare. Social rights that are important to us all like the right to be heard; the right to be free from poverty; the right to a meaningful life.'

Central to this approach is a Board-level commitment to the rights of service users to be involved in decisions that affect their lives. This has involved appointing a Director for Service User and Carer Involvement. Leads in service user involvement have also been set up for different parts of the service.

Service users and carers are offered payment for their time (£12 an hour plus expenses). This sends a clear message that their time and effort and contribution to the Trust is of equal value to that of staff and managers. The Trust Board agreed an initial budget of £50 000 for this purpose but has now increased it to £120 000 – based on a detailed 3-year development plan.

In a series of informal road-shows, the Trust listened to how service users and carers wanted to be involved. Overwhelmingly, they wanted a say about the staff that work with them – the people who come into their homes and their lives when they are sometimes at their most vulnerable. They said that they wanted people with skills and experience but also with empathy and understanding.

So the Trust began there – with training service users and carers in all aspects of recruitment and selection and enabling them to take part as equals in the selection of Mersey Care staff. Over 100 service users and carers have now been trained in recruitment and selection by other service users and carers and have been involved in the appointment of over 1500 staff – about a third of the Trust workforce.

The SURE (Service User Research and Evaluation) Group was set up and supported to take on research projects of their choosing. These included, among others, acute solutions, an audit of in-patient wards in adult mental health services, an audit of service user and carer involvement in recruitment and selection, a review of the in-patient detoxification unit in the drugs service. Others were concerned about the right to make informed decisions and choices and the quality of information provided by the Trust, so the group became involved in the development of the Trust's website and the development of an information strategy.

that user and carer-led research studies become more commonplace.

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Availability

of psychological therapies

Psychological therapies are increasingly recognised as being effective in the treatment of a range of mental disorders

Only 9% of those with common mental health problems received any counselling or therapy

Government initiatives, however welcome, are unlikely to overcome the lack of provision for some groups (older people, children and adolescents, prisoners, people with learning disabilities and in-patients)

Availability of psychological therapies should be equitably implemented across all ages, patient groups and settings. A particular focus is needed on older people, hospital in-patients and prisoners.

The need for a fair deal

It is increasingly recognised that psychological therapies are effective in the treatment of a range of mental disorders¹⁻⁸ and they are favoured by many service users.⁹ However, in both primary and secondary care services, psychological therapies are lacking and they are rarely provided in a timely fashion. Waiting times of over 12 months for people in crisis (unacceptable for physical health problems) are reportedly commonplace.⁹ We welcome the fact that governments within the UK are taking steps to address this.

Certain groups, such as older people, hospital in-patients, individuals from minority ethnic backgrounds, asylum seekers, prisoners and people with learning disabilities have a high level of unmet need and the new government initiatives (including the IAPT (Improving Access to Psychological Therapies) programme) may not reach them. A distinct strategic plan is needed for these disadvantaged groups and for those with other mental disorders.

What we are calling for

- ▶ Strategic planning to ensure that service users in secondary care, older people, people with severe and enduring mental illnesses, those with dual diagnoses, learning disabilities or in custody and people from Black and minority ethnic communities, can gain timely access to effective treatments.
- ▶ Organisations providing psychological therapies should promote the development of psychological mindedness and therapeutic skills among **all staff**, preferably through the appointment of a champion at a high level within the organisation.
- ▶ The training of all general practitioners to include delivering effective therapeutic and supportive interventions and shared training with trainee psychiatrists where possible.
- ▶ Support for research into frequently used and promising psychological interventions is required.

Examples of what the College will do

- ▶ The College will ensure that psychiatric training confers psychotherapeutic understanding and skills appropriate to each psychiatric specialty.
- ▶ We will ensure a clearer and more defined role for psychiatrists in actively monitoring the availability of psychological therapies and assisting with the training and supervision of others.
- ▶ We will seek a well-thought-out collaboration with stakeholders, including colleagues in psychology, primary care and the voluntary sector in the development and provision of psychological therapies.

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- ▶ We will audit programmes to document practice and progress within the provision of psychological therapies and seek research funding to address promising psychological interventions.

Psychological therapy: availability and accessibility

There is considerable evidence in support of the effectiveness of psychological therapies across

CASE STUDY 1

DEBORAH HART, CARER

My daughter had been self-harming for several years. One day, aged 17, having drunk heavily, she had a terrible argument with her boyfriend and ended up in the middle of the night at accident and emergency having cut a major vein in her wrist. She was told to go to see her general practitioner for a referral to a child and adolescent psychiatrist. The general practitioner sent a referral letter to the local child and adolescent team and in the meantime prescribed her some antidepressants which she refused to take. A few days later we were contacted by the team to say that there was a waiting list of between 6 and 9 months in order to get any psychological help. I eventually found someone privately who helped her through this very difficult period in her adolescence. I was very lucky that as a working mother I could afford this, although it created a lot of personal hardship.

a range of presenting problems, therapeutic modalities and settings.

Psychological therapies are recommended by the National Institute of Health and Clinical Excellence (NICE) for mild and moderate depression and anxiety, obsessive-compulsive disorder, bipolar disorder, post-traumatic stress

disorder, eating disorders and schizophrenia.¹⁻⁸ They encompass a broad range of treatments, including talking therapies of different models (e.g. cognitive-behavioural, psychodynamic and systemic models) and different forms of delivery (e.g. individual, family and group). The most appropriate treatment may vary according to the person's age, situation, diagnosis and personal preference.

Not only can psychological therapies reduce symptoms, they can also help a person to cope with adversity and make lasting changes to their behaviour and personality. The Department of Health provides evidence-based guidelines⁹ for practitioners to make informed assessments about the potential effectiveness of treatment options for common mental disorders and some somatic syndromes. The Cochrane Collaboration (www.cochrane.org/) provides a more extensive review of the evidence for and against psychological therapies in physical and mental health. These therapies can be part of a holistic care package that together promotes recovery. Although people with mental health problems repeatedly report that better access to psychological therapies is a priority, waiting times of well over a year are not uncommon.¹⁰ There is considerable unmet

need for treatment with psychological therapies of different modalities, in all patient populations, for various mental conditions, in both primary and secondary healthcare.

Northern Irish Division, I

'Like most general adult psychiatrists, I am deeply frustrated, and at times highly embarrassed, that owing to a lack of psychotherapists I am unable to offer patients the evidence-based treatments which many would prefer to receive. Too often all I can offer is an antidepressant and supportive psychotherapy.'

CASE STUDY 2

COLLEGE RESEARCH AND TRAINING UNIT

The Royal College of Psychiatrists' Centre for Quality Improvement has been awarded funding by the Healthcare Commission to run a national audit of psychological therapies services. The audit will run for 3 years and will centre on the care being delivered to people with depression or anxiety disorders. This will complement other national initiatives, including the new Public Service Agreement indicator for psychological therapy services, and the English Department of Health's Improving Access to Psychological Therapies programme.

In England, Scotland and Wales, government surveys indicate that of individuals experiencing common mental health problems (one in six of the UK population) only 9% received any counselling or therapy.¹¹ In prisons only half of all prisoners were found to have access to supportive discussions with staff.⁹ Lord Layard's 2004 report stated that untreated depression and anxiety had significant costs for individuals and for the economy (in terms of unemployment), but access to treatment was severely restricted.¹²

Psychiatrists report particular difficulties in accessing psychological therapies for older people (individuals with dementia being an additional priority) and for children and adolescents (especially those aged 15–18 years, in the transition to adulthood). Family therapy is particularly needed for these groups. People with learning disabilities have frequently been denied access to psychological therapies despite a growing

body of evidence suggesting that therapeutic models and processes can be adapted to work with people with a range of learning disabilities.¹³ There is also an unmet need for treatment for conditions such as resistant depression, chronic psychosis, eating disorders and severe personality disorders.¹⁴

Policy responses

The Scottish government has made a commitment to 'increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers'.¹⁵ This will deliver therapies through primary care to adults with anxiety and depression. The Scottish Division of the College accordingly favours the introduction of a target waiting time of 18 weeks from assessment to treatment. In Wales, local health boards have been tasked to improve access to psychological services within primary care and to collaborate with voluntary and specialist services.¹⁶

In Northern Ireland, the Department of Health is establishing a mental health service framework and performance targets that include the expansion of psychological therapies.¹⁷ In England, a £170m 3 year programme has been launched to increase the number of trained psychological therapists, concentrating on cognitive-behavioural therapy, to help cope with anxiety and depression.⁹ These are very welcome but should not

happen at the expense of other forms and modes of psychotherapeutic provision for other service users' groups. The waiting times for physical and mental health treatment should be comparable.

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CASE STUDY 3

COGNITIVE-BEHAVIOURAL THERAPY: STRUCTURED SELF-HELP

Each year the College Education and Training Centre delivers a series of workshops with Dr Chris Williams (Glasgow). They are designed to support staff in the use of structured self-help cognitive-behavioural materials to help patients who are suffering from depression, anxiety, long-term physical illness and medically unexplained symptoms.

Roles for psychiatrists

Psychiatrists need to monitor the availability of psychological therapies on behalf of service users, drawing attention to any gaps in services. They need to give well-informed advice on appropriate therapies and supervise colleagues providing supportive interventions. Their role should include collaborating with colleagues in the primary and voluntary care sectors, especially where service users require high-intensity psychological treatment but fall between primary care and specialist services.

Further, all general practitioners and psychiatrists should have mutual experience of each other's work, with opportunities for a placement in different settings across the two specialties during

training. Appropriate training in psychotherapeutic understanding and skills should be available throughout the postgraduate training of all psychiatrists.

Needs for services for substance misuse are even greater than the experience of these services suggests, as approximately 40% of in-patients in general adult facilities have substance misuse problems. There is also a lack of provision of therapies for those with complex and often serious emotional problems who require high-intensity psychological treatment but fall into the gap between primary care and specialist services.

Establishing a therapeutic culture

Although not everyone will be offered therapy, all patients and staff benefit from a service which understands psychotherapeutic principles and provides opportunities for containment and reflection, where the fears of the patients and also of the staff who care for them are recognised. Psychotherapeutic techniques can be valuable in the general clinical work of mental health professionals. The skills include those associated with communication, the ability to listen, to empathise, showing an openness to patients' emotions, making sense of patients' experience and using personal emotional response as a source of understanding. Training is also needed for

CASE STUDY 4

TYPICAL SCENARIO

At a ward review to discuss the care of Mrs Green, admitted with a moderate depressive illness, staff from different disciplines seemed annoyed. They considered that Mrs Green should be discharged as she had turned down all attempts to help her. The consultant tended to agree. However, after taking a more extensive history, it appeared that the staff may be re-enacting rejection Mrs Green had experienced in her early life. Once they understood this, staff became more patient with her. In her turn she started to accept suggestions offered to her as part of a slow but steady recovery. As a result she was discharged at a time that was right for her health.

professionals to raise their knowledge of emotional problems and the potential role of psychological interventions.

Psychological mindedness is key to therapeutic relationships. It can motivate clinicians who, having little previous training, take an interest in psychological therapies. Good psychological therapies require therapists working in psychologically oriented organisations. Progress will depend upon acknowledging psychological mindedness as a common value that all parties can adopt. Historically, attitudes have been as large an obstacle to the use of psychological therapies as have a lack of resources. These attitudes have included the stigma against people who seek therapy, unjustified skepticism about its effectiveness and the failure of different groups of clinicians and therapists to respect one another's work. In each case changes in attitude have been necessary for services to improve

Knowledge for action: audit and research

Research is needed into frequently used and promising psychological interventions. Psychological treatments need to better reflect effectiveness rather than simply the amount and quality of research undertaken. There need to be investigations which will evaluate the acceptability and availability of psychological therapies. Information on services and patient experiences should be audited and assessed in order to increase the range of choices of treatments.

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Linking

physical and mental health

Mental and physical health are inextricably linked and we need to develop a 'whole person' approach to integrate rather than separate them

People with certain physical illnesses (such as cancer or diabetes) often report high levels of mental health problems and, while mental illness is associated with poor physical health, people with a mental illness report that healthcare professionals can dismiss their physical symptoms as being unreliable

Around 150 000–170 000 individuals who self-harm report to accident and emergency departments in the UK each year, but staffing and staff training are often not adequate to provide necessary mental healthcare

Linking mental and physical health must be part of every doctor's practice. This will require education, training and collaborative working between mental health and other medical specialties.

The need for a fair deal

Overall, there needs to be a fundamental shift in understanding in the NHS about the relationship between mental and physical health. All health professionals have a role in addressing the mental **and** physical health needs of their patients. People with certain physical illnesses often report high levels of mental health problems.¹ Conversely, individuals who have mental illnesses, such as depression, schizophrenia and others, have excessive rates of physical health problems.² Mental health problems may also present as physical illness.

Despite this, both the mental health needs of individuals treated for physical illness and the physical health problems of people with mental illnesses can be undetected and overlooked by primary care and specialist staff. This happens because there is a lack of staff training and too little collaboration between mental health professionals and those in primary care and hospitals. Psychiatrists, as medical practitioners, should play a role in the management of their patients' general health problems.

Professor Dame Carol Black

'The same standard of urgent assessment, diagnosis and intervention should be provided for mental healthcare as is expected for physical healthcare.'

What we are calling for

- ▶ All health professionals to have training in mental health.
- ▶ The curricula of all doctors in training and the continuing professional development of qualified doctors to reflect the relationship between mental and physical health, both in general and in specific conditions.
- ▶ National guidelines – including those issued by the NICE and SignHealth – about conditions treated in general hospitals to cover the mental health of individuals with these conditions.
- ▶ Patients in acute hospitals to have the same level of access to a consultant psychiatrist as they would have from a consultant specialising in physical health problems.
- ▶ All care pathways for delivering physical healthcare to have a mental health component and pathways for commissioning practice to ensure the services to deliver them.
- ▶ Education to be provided for service users, carers and the public to develop community awareness of the psychological aspects of physical conditions.
- ▶ People with learning disabilities and people with severe mental illness to receive an annual physical health check.

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Examples of what the College will do

- ▶ The College will work with our partners in other medical and health Colleges to improve mental health training for health professionals.
- ▶ We will campaign for a liaison service to be established at each health community.
- ▶ We will develop a comprehensive set of standards for liaison mental health services that provide advice, assessments and care for individuals of all ages, including those with learning disabilities.
- ▶ We will continue to promote key standards for the physical healthcare of individuals in a range of psychiatric services and the responsibilities of psychiatrists for monitoring the physical health of service users.

The mental health of people with physical health problems

Mental health problems are not uncommon among individuals with physical conditions. In hospitals, medical and surgical wards and accident and emergency departments have high levels of activity and encounter some of the most seriously ill people at greatest risk. However, the current provision of mental health services to people attending these

departments is inconsistent. Acute services have not adequately commissioned services of liaison psychiatrists and some existing liaison services have been under threat of closure.³

Staff in general practitioners' surgeries and hospitals will frequently encounter individuals with depression, particularly among those who are chronically ill. Approximately 10% of the general population are reported to have major depression, but among people with cerebrovascular disease rates of major depression are twofold, threefold in individuals with diabetes or cancer and fivefold among those with recurrent epilepsy.² In older people depression can often be comorbid with chronic physical disorders. In addition to the distress it causes, depression may hinder recovery because it suppresses the immune system or reduces a person's motivation to adhere to treatment or medication.⁴ Some conditions, like chronic fatigue syndrome, have both mental and physical origins. Unexplained medical symptoms often have a psychological component.⁵

Conditions such as the ones discussed currently use a high volume of NHS resources in both primary care and out-patient services. Although only a minority of service users with physical

CASE STUDY 1

WHAT THE COLLEGE IS DOING: PHYSICAL HEALTH IN MENTAL HEALTH SCOPING GROUP REPORT, 2008

As doctors, psychiatrists have a responsibility to provide their patients with good standards of practice and care. The Royal College Scoping Group's report sets key standards for the physical healthcare of patients in a range of psychiatric services and outlines the responsibilities of psychiatrists for monitoring the physical health of patients, including physical side-effects of psychotropic medication. The report recommends that psychiatrists are trained and kept up to date in relevant physical health matters. The College will continue actively to promote these standards.

health problems require referral to a psychiatrist, a well-staffed liaison psychiatry service provides the support and advice that health professionals in primary and secondary care need in order to manage their patients' mental health needs. National standards that will inform the commissioning of services are urgently needed. This will guarantee that people in need receive prompt assessment and management by professionals who have been appropriately trained.

People who have deliberately injured themselves or taken a drug overdose are treated by staff in primary care or hospitals – around 150 000 to 170 000 individuals who self-harm present annually to accident and emergency departments in the UK.⁶ However, these departments are not staffed to cope well with those who are mentally distressed.

The physical health of people with mental illnesses

Mental illness is associated with poor physical health, arising in part from the side-effects of medication^{7,8} and an unhealthy lifestyle. It can occur alongside physical illness and can lead to it. Yet people with a diagnosed mental health disorder too often find their symptoms of physical illness dismissed as simply being 'all in the mind'.⁹

Compared with the general population, people with depression are twice as likely to develop type 2 diabetes, three times more likely to have a stroke and five times more likely to have a myocardial infarction.²

For individuals with schizophrenia, life-expectancy is on average 10 years shorter than in the general population. They also experience high rates of

obesity, diabetes, osteoporosis and cardiovascular conditions.^{8,10-12}

People with learning disabilities have high levels of physical and mental health needs, in particular in epilepsy, dementia and polypharmacy.¹³

Robert Westhead, service user

'I have bipolar disorder or manic depression, so as studies have shown, I'm likely to die 10 years before people without a mental health problem: we're a marginalised group, doctors think we're hypochondriacs and standards in psychiatric services are lower than in the rest of the NHS. On one occasion I went to my general practitioner with stomach pain. He clearly thought it was 'psychosomatic' and did nothing. It turned out it had been caused by an antibiotic he'd prescribed. All I ask for from the NHS is the same treatment – as a person and a patient – as everyone else.'

Individuals with eating disorders have an increased risk of premature death, skin conditions, gastrointestinal complications, cardiovascular and pulmonary difficulties, osteoporosis and nutritional problems.¹⁴

In light of this evidence, the government's health inequality agenda should broaden its indicators of disadvantage to include mental illnesses and learning disability. In particular, as recommended by the Disability Rights Commission,⁹ people with learning disabilities and mental health problems should be screened for, and receive, appropriate physical healthcare. This includes ensuring that current policy initiatives such as the annual physical health check for people with a learning disability are realised in practice.

No health without mental health – the role of NHS professionals

It is time to end dualistic thinking within the NHS which rigidly separates mental and physical health. We need to develop a 'whole person' approach to integrate mental and physical healthcare from

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CASE STUDY 2

WHAT THE COLLEGE IS DOING

The Academy of Medical Royal Colleges project No Health without Mental Health aims to help ensure that people of all ages attending general hospitals receive the mental healthcare they require. The project aims: to produce a report that summarises the relationship between physical and mental health, with recommendations for hospital practice; to review the training curricula for medical doctors and the national guidelines on physical conditions for any gaps in mental health content; and to produce a comprehensive set of quality standards for liaison mental health services, which will later be used to form an accreditation programme.

cradle to grave. A new approach should incorporate and reflect the evidence base for whole-person health and provide the training and education in order to develop it. Service commissioning and delivery of general mainstream services should incorporate a multidisciplinary approach and have mental health embedded in all care pathways.

All health professionals have a role to play in improving the mental health of their patients. This involves being trained to understand the complex interactions between mental health and physical health, and being familiar with the means to address and manage these conditions. Health professionals need knowledge of the evidence base about physical and psychological comorbidity. They also need practical competence in the prevention, detection and treatment (including specialist referral) of relevant conditions.

National guidelines and health policies for physical health conditions – including NICE and the Scottish Intercollegiate Guidelines Network (SIGN) – should also set standards to meet the mental health needs of these service users.

Sally

'When in accident and emergency, I have been kept waiting for hours in cases of self-harm and have been discharged straight from accident and emergency after an overdose without seeing anyone. I have been left for more than 24 hours after an overdose in urine soaked clothes, with a doctor telling my husband in critical tones that I'm "going to kill myself one of these days".'

Service user

*'My doctor struck me off her list last week because she sent a letter saying I was upsetting her staff. I try to put my points across clearly but none of them listens to me...'*⁹

The role of the psychiatrist

As doctors, psychiatrists have a key role to play in improving and promoting the physical health of service users and, when appropriate, referring them to other medical specialists. However, the level and range of expertise in physical healthcare among psychiatrists varies considerably and service users – depending on factors such as age and existing mental health condition – will present varying diagnostic and treatment challenges. General health provision within psychiatric settings needs to be improved and common standards need to be developed with which to evaluate care.

In hospital settings, patients and staff may benefit from specific psychiatric liaison support service to facilitate integration of their psychological and physical care.

Standards should be developed to assess the quality of such provision. Finally, psychiatrists and other mental health professionals should work together with primary care professionals to ensure a seamless and collaborative approach to the well-being of their patients.

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