

Royal College of Psychiatrists Consultation Response



DATE: 8th January 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: The London health inequalities strategy

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by Prof Kam Bhui and the London division of psychiatry.

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London's Health Inequalities Strategy

The Royal College of Psychiatrists welcomes the opportunity to respond to this consultation. The comments below are given in response to the consultation document under the London Health Inequality Strategy. These comments are offered alongside those contained in the response to the Marmot Review as appended.

1. Overall the case for addressing inequalities in London is well made. The aims and objectives of the strategy are welcomed, especially the notion of empowering individuals and communities, building the capacity and skills of individuals and communities taking control of their own health. This will inevitably interlink with managing lay health beliefs and working on health promotion and public engagement with healthcare decision making.

1.1 However, the case for addressing inequalities in health and more specifically mental health is not made sufficiently strongly. The section on mental health is very brief, is not comprehensive and does not capture the complexity of the issues being put forward as targets of action. Alcohol and drug use is recognised as a significant issue and a case vignette talks of homelessness but neither are fully and comprehensively considered.

1.2 The College's response to the Marmot Review of Inequalities (see appendix) is helpful in this regard and can provide much more background information alongside other strategies for addressing inequalities in mental health status; this has a particular focus on addressing the physical health needs of those with mental health problems, as well as encouraging people to manage their lifestyles and their communities to promote wellbeing and recovery in the face of episodes of illness.

1.3 More specifically, the background literature does not fully grasp how to identify special at risk groups, for example people with a learning disability. Those in contact with mental health services may be a special at-risk group and so presents a challenge: how to address their needs in a public health and universal strategy as a key objective with appropriate costs and resource modelling. The resources required may be met from a range of public services in non-mental health settings.

1.4 Strikingly, ethnic inequalities in mental health status and care are not given a great deal of space. This may also be an omission in the Marmot Review when applied to London where the majority of ethnic minorities and migrants and subsequent generations live. This is an important omission that should be addressed, specifically around mental health status and care needs.

1.5 The emphasis on education, health risk behaviours, lifestyles, and housing might be overstated to fully deal with all the challenges faced by migrants, asylum seekers, refugees and minority ethnic groups. These groups may not

have a voice, and may not engage with policy making or political decision making. It is likely these groups could be poor at utilising primary healthcare services. The role of stigma and discrimination against those with mental health problems is compounded by the inequalities faced by ethnic minority groups and marginalised and socially excluded groups. We perhaps need to think of new terminology and language for social groups who are not sufficiently well engaged politically to influence policy to work for their best interests. The same applies to groups that might not fully engage with public services to ensure that these remain focused on their care needs to deliver appropriate and effective care.

1.6 A particular emphasis needs to be given to interventions that are targeted and adapted so that these are actively taken up by those on the lowest incomes and those who are already suffering higher rates of health and social problems. These groups are likely to be least able to use universal public health interventions. Therefore, any universal strategy may indeed lead to least benefit for these groups, consequently widening inequalities in the face of improvements in status of other groups. Any new policies and strategies would, therefore, also fail equalities impact assessments if they had not considered that some groups may be especially disadvantaged.

1.7 There is also scope to emphasise the health and well being of young people where drug and alcohol misuse, as well as smoking, are continuing causes for concern. In regards to mental health care specifically, there are associations between substance misuse and a range of child psychiatric disorders and for young adults, substance misuse is so common as to be statistically normal in services offering early intervention in psychosis.

2 Engagement of the voluntary and social care sector and non-governmental organisations is essential. It's important to ensure that specific organisations that are included in any policy development and implementation are fully representative of the range of populations which they aim to serve rather than representative of only the larger groups or charities. It's also important to build capacity in these organisations for policy work. The notion that such organisations should be invested in for research purposes and evaluation is controversial. If sufficiently well resourced and sustainable, this is welcomed, but given the financial climate, it may be better to enter into partnerships across different sectors.

2.1 The voluntary sector generally is excellent at providing grounded community based care, information, and knowledge that reflects the needs of local communities which are not addressed by public bodies and statutory authorities. However, these may not be best placed to undertake evaluations and research. Funding for research and evaluation in the voluntary sector is available through charitable organisations or should be including in the service commissions. Perhaps what is required is partnership between academic centres, public services and voluntary sector organisations, perhaps within the new Academic Health Science Centres. For example these might be required to

ensure active engagement with the voluntary sector. This might also be a way of providing leverage to academic institutions and demonstrate local relevance as well as the international excellence. This might be more cost efficient and build capacity in a feasible way rather than replicate infrastructures and governance structures in the voluntary sector.

2.2 The strategy appears not to overtly address safety of the public, potential violence, violent incidents and crime; nor does it address disenfranchised youth and the concerns of youth who feel unable to engage politically or influence care organisations, their own learning and career trajectories, or environments in their early lives. A life course approach, therefore, to addressing inequalities is helpful. Again reference to the Marmot Review and the Royal College of Psychiatrists response to it supports these proposals.

2.3 The strategy also needs to consider more critically what sorts of public spaces, organisation processes and activities are effective at linking people with diverse ethnicities, incomes, professions and social spaces. The arts and the media may help but this needs to be given some concerted effort, particularly as inequalities are so evident across different parts of London, across and within the same borough.

2.4 It is proposed to hold a mental health summit to discuss and influence the next step in national mental health policy, and the role of regional and local leadership. This process has also already begun. The current strategies as addressed in the College's response to the Marmot Review might well inform the development of the mental health summit in order to evolve new policy.

2.5 The agreement of priorities for investment in young people at risk of mental health problems and social exclusion should be a separate objective, properly integrating the community sectors, public services, academic and private sectors. A summit contributing to this should not only agree priorities but also agree specific actions.

2.6 A key issue for the entire document would be to consider what targeted interventions would be necessary, for which high priority group, and how these will be adapted for people with common mental health problems as well those with more severe disabling mental health problems who are socially excluded and often discriminated against, purely on the basis of a diagnosis. Programmes to encourage return to work amongst these groups, in an otherwise competitive environment in London would need careful consideration by the private sector and businesses in London, alongside charities and public services. The relationship with the voluntary and community sector and work places, therefore, is crucial to show adequate support for returning to work with community and individual benefit.

2.7 A shift of resources to those areas of London with the highest needs is welcomed although the basis of doing so needs to be clarified. Perhaps partnerships across high and low deprivation areas or delivery of care by single

organisations working across high and low deprivation areas will be necessary to ensure that shift of resources.

2.8 The emphasis on the reduction of waiting times for translators for non-English speakers is welcomed, as is the emphasis that English should be encouraged as a skill to access public services but that those not speaking English should not be disadvantaged.

3. Finally, the consultation document seeks guidance around possible health inequalities indicators.

3.1 Regarding mental health and healthcare systems, access to cognitive behavioural therapy is mentioned rather idiosyncratically as a very specific indicator without consideration that CBT may need to be adapted. It may not be appropriate for all groups. Access to this alone cannot be an indicator of an effectively functioning healthcare system which addresses inequalities. Access to psychological therapies and specialist mental health interventions, irrespective of ability to pay would be more appropriate. Access to a comprehensive mental health system from primary care to specialist care, for example, irrespective of ability to pay would also be helpful. Access to CBT for complex mental health problems irrespective of age, gender and ethnicity would also be helpful.

3.2 There are numerous mental health service characteristics that might be used as indicators nationally; data are collected by the Care Quality Commission on a number of parameters that might be adapted. This includes service access and contacts, in-patient admissions and outpatient admissions, community contacts, access to interventions including psychological therapies.

January 2010