

New Horizons

Towards a shared vision for mental health

Report on responses to the consultation



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Foreword by the National Clinical Director for Mental Health

New Horizons: a shared vision for mental health was published on 7 December 2009. During the public consultation that preceded it, we received more than 1,100 responses. One of the remarkable things about the process was the large number of people who took the time to write, come to meetings or in other ways comment on how mental health and mental health care in England could be improved, often referring to their own experiences of services and always giving serious thought to the questions we asked. I want to offer particular thanks to all those who did so.

We heard from service users who wanted to explain what had worked for them and what had not. We heard from carers who knew well the strains and rewards of seeing a loved one in distress or helping them recover. Roughly half of the responses came from organisations. It was encouraging to see that in some areas of the country several organisations held their own consultative events or responded jointly with others. The span of organisations went beyond the mental health community and included housing organisations, ambulance trusts and the fire service, reflecting the message of *New Horizons* that mental health matters to all of us.

The majority supported the twin themes of *New Horizons* – better mental health services for those who need them and the importance of good mental health for the community as a whole. It seems that we have reached an important stage in the reform of mental health, when it is possible to go beyond specialist care, vital though it remains, to the mental health needs of broader society.

Over the last ten years, the National Service Framework (NSF) has helped transform mental health care. It has helped more people to get the right treatment at home rather than hospital and to reduce the number of suicides. England is now recognised as an international leader in mental health services. The challenge of *New Horizons* is to build on these achievements and to keep up the ambition and momentum of the last decade.

We would not have achieved so much without the support of thousands of stakeholders. This report explains how we have consulted people so far but we are committed to continuing the dialogue. The consensus around *New Horizons* will be vital to its delivery.



A handwritten signature in black ink that reads "Louis Appleby". The signature is written in a cursive, slightly slanted style.

Professor Louis Appleby
National Clinical Director for
Mental Health

Executive summary

The consultation document *New Horizons: towards a shared vision for mental health*, published in July 2009, set out a vision for the future of mental health in England. The consultation asked for people's views on the vision and on the twin themes of improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health. This report is the full consultation response and is about who responded, what they said and what the Government is doing about it.

The formal consultation followed 18 months of events and focus groups, and during the consultation more events and online discussions were held to gather in views. There were 1,120 responses to the consultation, of which 653 were from individuals and 467 from organisations. Sixty per cent of the individuals had experience of mental health problems.

Overall, most of those responding agreed with the vision and provided a rich diversity of experience and ideas as to how to bring it about. Many were concerned about how it would be funded, however, often highlighting the gap between current reality and the vision. Different groups and communities were identified as needing greater focus, and carers as well as service users wanted to be better heard and supported.

The Consultation Questions

Three most important changes

People wanted to see greater priority given to mental health and well-being, better public understanding and awareness and improved access to mental health services and therapies.

Public mental health/prevention and mental health service development

There was a great deal of support for the twin theme approach as long as it was not to the detriment of people with existing mental health conditions. There were concerns about how to achieve it in the current economic climate.

Guiding values

Most people who answered this question agreed with the four guiding values and were concerned to see them put into practice.

Personalised services

People said that personalised services could be promoted through listening to service users, providing information and choice, improving access to a wider range of services, involving service users more, and integrating systems for health and social care.

Value for money

A range of services and therapies were suggested as providing value for money, particularly in prevention and the third sector, and there were many recommendations for adjusting the balance of the workforce and streamlining organisations.

Innovative technology

People suggested a range of uses of technology for mental health promotion, support and therapy, care planning and management, and improving quality of life.

Gaps in research evidence

Respondents identified many gaps in mental health research and wanted to see more investment in it and a wider range of methodologies valued.

Local leadership

People said that local leadership could be supported by: a cross-government approach to mental well-being; community involvement in local strategies; joint training and joint working; support for clinician leadership; support for service user leadership; and opening up leadership programmes to the third sector.

Joint working

Recommendations included: better communication and coordination; national indicators for mental health and well-being; more accountability; and more collaboration between the statutory and third sectors. People did not want to see any additional bureaucracy.

Inequalities

Respondents raised many different aspects of inequality. Recommendations included: tackling both social and health inequalities; driving the race equality agenda harder; making adjustments to comply with disability equality law; strengthening the law against mental health discrimination; and assessing the impact on mental health of policy and legislation.

Age transitions and interfaces

There was strong support for addressing young people's transitions to adult services and for providing non-discriminatory treatment and care across the whole age spectrum. Overall, respondents wanted flexibility so that people could access the services and skilled staff best suited to their needs.

Stigma

Many people wanted to see public education and campaigns, including in schools, and often referred to the role of the media and the importance of people 'coming out'. Some focused more on mental health promotion and others on improving services and/or making mental health services less stigmatising. A lot of people wanted stronger rights against discrimination, especially at work.

Government response

New Horizons has been developed further as a cross-government programme of action with the twin themes of improving the mental health and well-being of the population and the quality and accessibility of services for people with poor mental health. The strategy document *New Horizons: a shared vision for mental health*, published in December 2009, marks the first stage of the programme.

Key Government actions are a Ministerial board to ensure high-level oversight of progress; Department of Health support and advice on mental health to government departments and other statutory agencies as they carry out health impact assessments on their policies; and a New Horizons Ministerial Advisory Group for inequalities and mental health.

Introduction

The consultation document *New Horizons: towards a shared vision for mental health*, published in July 2009, set out a vision for the future of mental health in England. It outlined the importance of improving the well-being and mental health of individuals and the population, and took a life span approach from laying down the foundations of good mental health in childhood, through promoting prevention of mental health problems to effective treatment and recovery from severe mental illness. Building on the previous ten years of the National Service Framework (NSF) for Mental Health in England, it proposed next steps in improving services for those with mental health problems and illness.

The consultation sought views on the vision and on the twin themes of improving the mental health and well-being of the population and improving the quality and accessibility of services for people with poor mental health. It invited respondents to identify gaps and to provide examples and ideas that could be built into the New Horizons programme to help realise the vision.

Following consultation, the cross-government strategy *New Horizons: a shared vision for mental health* was published on 7 December 2009. Setting out actions across government and by different government departments, it marks the first stage in a programme of action.

This report is the full response to the consultation that the New Horizons strategy committed to produce. It describes the consultation process including who responded to it, summarises the responses received, and sets out the Government's response to the issues raised. Please refer to the strategy document *New Horizons: a shared vision for mental health* for full details of how the messages from the consultation are being taken forward.

Other related documents are:

- *Working our way to better mental health: a framework for action* (December 2009) – the first ever national mental health and employment strategy sets out commitments from government and expectations of others to improve well-being at work for everyone, and deliver significantly better employment results for people with mental health conditions;
- *Realising Ambitions: better employment support for people with a mental health condition* (December 2009) – an independent report by Rachel Perkins;
- *Work, Recovery and Inclusion* (December 2009) – a cross-government delivery plan to help people in contact with secondary mental health services, informed by the *Realising Ambitions* report mentioned above;

- *New Horizons Equalities Impact Assessment* (December 2009);
- *Flourishing People, Connected Communities: a framework for developing well-being* (due for publication);
- *Delivering Race Equality (DRE) in Mental Health Care – A Review* (summary report December 2009);
- *Keeping Children and Young People in Mind: the Government's full response to the independent review of CAMHS* [Child and adolescent mental health services] (January 2010);
- *Realising the Benefits: IAPT at Full Roll Out* (February 2010) – the national update plan for Improving Access to Psychological Therapies;
- *New Horizons: towards a shared vision for mental health* (July 2009) – the consultation document, which contains the fullest articulation of the vision.

These documents are published or are soon to be published on the New Horizons website (www.dh.gov.uk/newhorizons), which will continue to be developed as a resource for everyone involved in mental health.

Consultation process

Activity prior to the formal consultation

The formal consultation was preceded by extensive engagement activity¹ over the 18 months before the consultation document *New Horizons: towards a shared vision for mental health* was published. This helped shape the document and inform the continuing thinking on the project. Activities included:

- a round table discussion with stakeholders on race and mental health chaired by the Minister of State for Care Services;
- consultation events organised by the then Care Services Improvement Partnership;
- listening events involving the National Clinical Director for Mental Health, Professor Louis Appleby;
- service user and carer engagement events organised jointly by Mind and Rethink on behalf of the Department of Health and attended by senior officials;
- a service user and carer review panel facilitated by Rethink;
- focus groups on mental well-being; and
- discussions with stakeholders including the Future Vision Coalition.²

The consultation document *New Horizons: towards a shared vision for mental health* built on the 'visions' for mental health produced

by the Strategic Health Authority Clinical Pathway groups and many other reports, reviews and studies. These included the Future Vision Coalition's *A future vision for mental health*, which was based on extensive consultation and published ahead of the New Horizons consultation and as a response to it. The Coalition is a key stakeholder in New Horizons. It was represented on the Programme Board and, at the Department of Health's invitation, proposed that the author of this report³ work on the consultation as part of the co-production of New Horizons.

Carrying out the consultation

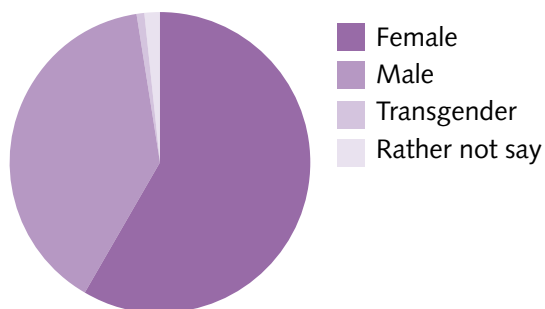
The formal consultation document was published on 23 July 2009 and was publicised widely through the media, online promotion, government communication channels such as Directgov, local NHS and local authority websites and stakeholder channels to service users, carers and mental health professionals. An easy read version was published and a summary of the document was published in Arabic, Bengali, Chinese, Polish, Punjabi and Urdu as well as English. Discussion was generated through the Department's Facebook page and other web forums. The Healthy Communities community of practice on the Improvement and Development Agency (IDeA) website www.communities.idea.gov.uk hosted weekly themed discussions on the public mental health framework, between 7 September and 13 October.

The Department of Health's Mental Health Division supported and took part in some 20 events⁴ organised by other agencies or DH teams. These ensured that a range of sectors and communities were involved in the consultation, in particular those from black and minority ethnic (BME) communities (such as events organised by the Afiya Trust, whose response contained criticisms of the consultation process), people with learning disabilities and staff working with them, housing and local government audiences and public health professionals.

Who responded

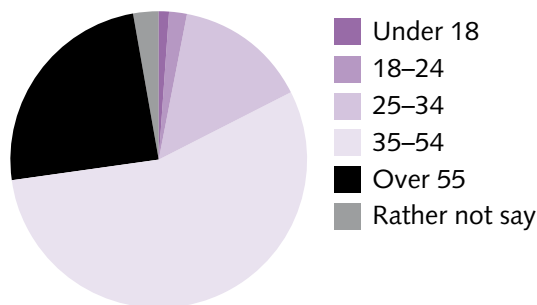
There were 1,120 responses to the formal consultation, of which 653 were from individuals and 467 from organisations. About half of individual respondents gave demographic information. Figures 1–5 show the breakdown according to gender, age, ethnicity, disability and experience of mental health problems.

Figure 1: Gender



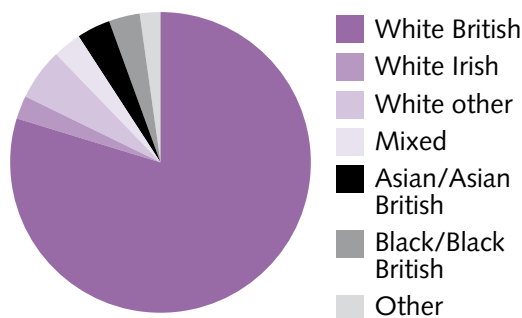
More women than men responded (59:39 per cent) and three respondents (one per cent) were transgender.

Figure 2: Age



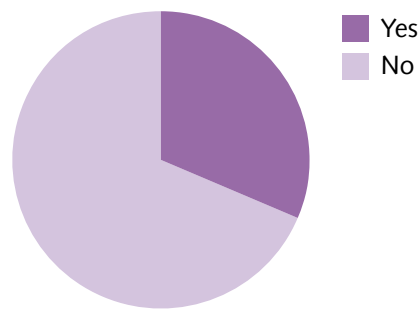
Eighty per cent of respondents were aged 35 and over. Four respondents (one per cent) were aged under 18.

Figure 3: Ethnicity



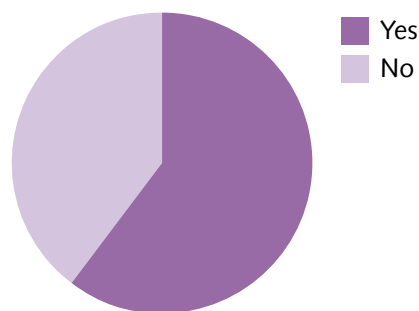
Eighty per cent of respondents were White British and approaching 20 per cent were from BME communities.

Figure 4: Persons with a disability



Thirty-one per cent of individuals who responded had a disability. In many cases this was a mental health problem, but a wide range of impairments or conditions were included.

Figure 5: Experience of mental health problems



Sixty per cent of individuals responding had experience of mental health problems.

The consultation responses represent a huge amount of experience, with 60 per cent of individuals having experience of mental health problems and many others drawing on experience as carers or workers in mental health services and other organisations. There were of course carers, workers and organisational representatives with experience of mental health problems. The range of organisations included the third sector (national and local), NHS trusts (spanning public health and mental health services), local authorities, commissioners,

provider forums, professional bodies, service user organisations, local implementation teams, unions, pharmaceutical companies and a range of strategy groups, networks and ad hoc local groups who came together to respond. Specific areas of interest represented included BME issues, housing and homelessness, age equality, the built environment, substance misuse, the natural environment and the military. There were parts of the country where several organisations and sectors responded (for example Leeds and Nottingham) and where joint responses were developed.

Analysing, describing and using the responses

Over a thousand responses came in through the website and/or followed the consultation questions; two of these were on the easy read questionnaire. Others commented without following the format of the questionnaire. In addition to the website, responses came in by post and email or were handed in at events. Gathering all postal responses was made more complex by postal strikes, and extra time was given to accommodate delays in deliveries.

Themes emerging from the responses were summarised. Where the consultation questions asked directly about agreement with the vision (Questions 2 and 3) responses were rated according to levels of agreement. While there was this element of quantitative analysis, the emphasis overall was, in accordance with guidance, on summarising the qualitative content of people's responses and on channelling views, ideas and examples to officials.

Almost everyone who answered the consultation questions responded to the first two about the three most important changes for mental health and mental health care in the next ten years, and about the twin themes of public mental health/prevention and mental health service development. All the other questions were answered by about one half of the respondents.

This report summarises the responses to the consultation questions. Issues raised by respondents who did not follow the questions are included where they are most relevant. Respondents gave many experiences, recommendations and service examples that helped in developing the strategy. The report summarises the main points raised but cannot include them all. Direct quotes are used both to illustrate representative views and to show the range of opinion and respondents.

New Horizons is a cross-government programme, so officials across government have been asked to consider responses and have contributed to shaping the wider strategy.

The responses remain as a resource for informing development of the programme of which *New Horizons: a shared vision for mental health* marks the beginning.

Overview of messages from the consultation and Government action

Many responses expressed a real hunger for change, whether for building a society that promotes and openly discusses well-being and mental health, winning stronger rights against discrimination or assuring timely access to high-quality care and treatment from respectful, caring and skilled staff. Organisations described how they have contributed to improving mental health and well-being and to providing treatment and care. They also described some of the barriers to change. Some individuals suggested practical steps that would assist their own recovery and improve their lives.

Overall, most of those responding agreed with the vision and provided a rich diversity of ideas and experience for bringing it about. Many were concerned about how it would be funded or expressed other doubts about resources or Government commitment, however, often highlighting the gap between current reality and the vision.

Despite improvements in mental health services, and examples of excellence, many responses indicated that there was still a distance to travel. Respondents wanted to see equal priority for mental and physical health, as well as approaching them together in a holistic way. Some were concerned as to how existing work would be continued, for example the Delivering Race Equality strategy and the Suicide strategy.

The responses showed strong support for the view that mental health is 'everybody's business' at both community and government level. Organisations in particular see the cross-government approach as critical to achieving the vision.

Many responses called for greater involvement and empowerment of service users. There is a strong sense of people's expertise in their own needs not being recognised and utilised individually or collectively. Carers also wanted to be better heard and supported, while there were calls too for clinicians and other staff providing direct care to be more involved in leadership and decision-making.

There was a lot of enthusiasm for public mental health and more focus 'upstream', provided that it did not disadvantage people with existing mental health problems. In general respondents supported the life course approach and many called for investment in children and their parents and for ending age discrimination.

Concern about access was a recurring issue across different aspects of the consultation; specifically about the range, quality and availability of services, eligibility, and the inclusion of different groups within service provision, mental health promotion activity and wider society.

A number of respondents, particularly from third sector organisations, highlighted issues for specific groups, either saying that they had been missed in New Horizons, or that they needed further attention. These included people from BME communities; lesbian, gay, bisexual and transgender people (LGBT); people with learning disabilities, autism or Asperger syndrome; people who are homeless, have substance misuse issues and/or are in the criminal justice system; and veterans.

The greatest dissatisfaction expressed in the consultation responses was with levels and quality of service provision, the range of available therapies and discrimination rather than with the New Horizons vision. There were also strong criticisms in some responses about the benefits system, day centre closures and the Mental Health Act.

Government action

This positive response to the consultation has encouraged and enabled the development of New Horizons as a cross-government programme of action with the twin themes of improving the mental health and well-being of the population and the quality and accessibility of services for people with poor mental health.

Key Government actions are the creation of a Ministerial board to ensure high-level oversight of progress; Department of Health support and advice on mental health to government departments and other statutory agencies as they carry out health impact assessments on their policies; and a New Horizons Ministerial Advisory Group for inequalities and mental health.

Please see *New Horizons: a shared vision for mental health* for full details of the action programme. These include actions on issues highlighted by respondents for example on mental health in the Armed Forces, reserves and veterans (Actions 87–90), homeless people and dual or triple diagnosis (Actions 98–100), continuing work in 2010/11 to help deliver race equality in mental health care (Action 102) and suicide prevention (Action 65).

The cross-government approach was demonstrated by the launch of Government plans on mental health and employment published simultaneously with *New Horizons: a shared vision for mental health*. The cross-government framework *Working our way to better mental health* is designed to improve well-being at work for everyone, and deliver significantly better employment results for people with mental health conditions. *Work, Recovery and Inclusion* is a cross-government delivery plan for England to support people in contact with secondary mental health services into work. (See Actions 45–50 for a summary.)

Question 1: The three most important changes

“What do you think are the three most important changes for mental health and mental health care in the next 10 years? And why?”

Overall, people wanted to see greater priority given to mental health and well-being, better public understanding and awareness, and improved access to mental health services and therapies.

This question was answered by 88 per cent of all respondents.

Some respondents discussed the changes they expected to see in society over the next 10 years and their impact on mental health and mental health services. For the most part these were demographic changes, such as an ageing population or migration, and the recession and its impacts on demand for and funding of services. Others referred to developments in mental health policy and practice and what effects these might have. However, most replies to this question set out the individual respondent's priorities for change.

The following sections describe responses according to the most frequently cited themes and some key issues raised by a smaller number of respondents. There is a lot of overlap and interconnection between the themes.

Access to services and therapies

“In my recent experience I have seen both family members and others (when I worked as a volunteer counsellor) suffer due to being unable to access services early enough.” (Individual)

Almost a third of responses were concerned with access to services and therapies, in particular early intervention, access to psychological therapies, and access to help in a crisis. People talked about difficulties finding the help that was there, or about services not being available. Waiting times were an issue, especially for psychological therapies, where people spoke of waits of three months to two years. One young woman wrote saying that she had waited six months for therapy, and that despite overdoses, emergency admissions and urgent referral for review, had not seen her consultant in seven months.

A number of responses were about getting help either in a crisis or when a crisis is anticipated and might be prevented. One person with long-standing experience of mental health problems who could see they were heading for a bad period was told by their GP to come back when they were “properly ill”. This person turned to self-medication and now has “an expensive and possibly harmful drug addiction”. Respondents suggested greater options for self-referral or direct access, including to in-patient and alternative crisis care, and for more crisis support out of office hours. Brent Mental Health User Group said that services that were responsive to people’s requests for support before they went into crisis would enable people to discontinue contact “confident in the knowledge that if they felt they needed it in the future, that safety net of support would be quickly and easily available”.

Several people also raised out-of-hours access to therapy and support as important for people in work. Other access issues were eligibility thresholds for social care and access to physical health care. (Many comments were about types of therapy or access for different groups and these are described below.)

Public education and tackling stigma and/or discrimination

“...a firm process for employers to recognise and support employees with mental health problems to put an end to discrimination.” (Individual)

Over a quarter of responses were about the need for education and action against stigma and discrimination. Respondents wanted to see education to improve public understanding of mental health, so

that people would care for their own mental health, seek help earlier and be more aware of issues for people with mental health problems. This was seen as a whole community enterprise that needed to reach, for example, employers, teachers, the police and faith communities. Stigma and discrimination were clearly key issues for respondents, and this is covered in more detail in the section on Question 12.

Involvement, empowerment and personalisation

“As someone who has experienced mental health problems, I found that my own voice seemed to become irrelevant in the proceedings. My views were treated as symptoms of mental illness to be analysed and diagnosed.” (Individual)

A quarter of responses addressed the involvement and empowerment of people experiencing mental health problems, and personalisation.

Some people talked about listening to service users and recognising their expertise in their own needs, and many responses said that service users should have more say in and control over their own treatment and care. Some looked at service user involvement more widely and wanted to see it in all levels, including commissioning and service delivery. Ways of empowering people included offering information about treatments and rights, advocacy, choice, self-directed support, individual budgets, peer support and recovery models, promoting advance statements, and investing in user groups and involvement projects. Rethink called for key entitlements to care and treatment to be set out, and the Future Vision Coalition proposed

“a new relationship between mental health services and those who use them” as one of four principles to underpin mental health policy.

There was also some strong criticism of detention and treatment under the Mental Health Act, with several calls for compulsion or coercion to be ended or service users’ rights strengthened.

Treatments and therapies

Almost a quarter of responses were about treatment and therapies. There was a strong theme of shifting the emphasis from drugs to psychological and other approaches, although there were also numerous calls for improving drug treatment, for example through safer and more effective medicines with fewer side effects, better use of medicines, and better monitoring.

CBT (cognitive behaviour therapy) was mentioned very frequently. Some respondents emphasised making it more available, and sometimes referred to fully implementing NICE (National Institute for Health and Clinical Excellence) recommendations.

Others wanted to see a wider range of therapies available, for example counselling, psychodynamic psychotherapy, and mindfulness-based approaches. Respondents raised issues about therapy for complex needs, the number of sessions offered, diversity, quality and regulation of therapists, therapies geared to BME needs, the importance of the therapeutic relationship, and side effects of psychotherapies.

Numerous respondents wanted more holistic approaches, and there were

several references to the need to respect and encourage spirituality and provide spiritual care. Other approaches mentioned included nutrition, arts therapies and bibliotherapy.

Several people said the use of ECT (electroconvulsive therapy) should be reduced or ended.

Some responses were about improving the provision of therapies and/or services for people with particular conditions, diagnoses or needs. These included people on the autistic spectrum, adults with attention deficit disorder, people with personality disorder, people with eating disorder and people who self-harm.

Prevention and promotion

“The solutions to problems are rooted in the social and physical environments which promote protective factors and reduce exposure to known risk factors. The highest priority is that the evidence for common sources of difficulties such as income inequalities or poor working conditions are publicly acknowledged, communicated and addressed, as these are known to contribute to mental health problems.” (Northumberland Mental Health Partnership Board)

Almost a quarter of responses were about mental health promotion and prevention of mental illness. People said that there should be more focus on prevention, that it is cost-effective, and that mental health should be seen as an asset for society. There were calls for investment and/or to begin shifting funding upstream. Some wanted more specificity and clear responsibility, while others

emphasised working for a culture shift to make public mental health “everybody’s business”. Mental well-being impact assessments for all new major legislation were suggested.

Many responses were about work with children and parents (see below), including in schools, and there was support for the SEAL (Social and Emotional Aspects of Learning) programme.

Respondents wanted a community-wide approach to promoting mental health and well-being, and there were calls for more third sector involvement. North Tyneside Mental Health Partnership Board cited the Moving Upstream project (www.movingupstream.org.uk) which encourages staff in primary care locally to signpost people in mental distress to third sector agencies.

Specific routes to well-being that were mentioned include healthy living, income maximisation, social inclusion, increasing resilience, and access to the natural world.

The Mental Health Foundation said that New Horizons should aim to reduce the prevalence of mental disorder.

Inequalities and marginalised groups

Almost one in five responses identified equalities issues and sectors of the community who do not have equal access. Most commonly the issues were about older people and people from BME communities, but many other groups and aspects of inequality were raised too. Please see responses to Question 10 for more detail, and the Equality Impact

Assessment published alongside *New Horizons: a shared vision for mental health*.

Recovery, social inclusion and support

“We include a commitment to recovery here – and we would like to see recovery outcomes set in commissioning of all mental health services – because in a very real sense the statement publicly made by services which exclude is that recovery is not possible. Our experience is that it is, and that it is extraordinary how resilient people are given the right support and treatment. Services with a deep commitment to recovery will find a way to work with even the most challenging of clients.” (St Mungo’s)

“...make sure that providers invest in our improvement rather than withdrawing help and treatment at the first signs of change or seeming stability...” (Individual)

Almost one in five responses were about recovery or social inclusion and support. Many called for a recovery approach or model to be adopted and for services and targets to be based on recovery principles. Some wanted much more emphasis on social care, and some specified particular aspects of recovery, for example the service user group who wanted “support to go to college, work, hobbies, music, art and sport”. Some respondents wanted training and education in recovery work to be provided, for example to acute ward staff and outside the secondary services.

The Future Vision Coalition called for everyone with ongoing or

severe mental health problems or complex need to be offered a new 'quality of life' package of support to aid recovery.

Children, young people and parents

"To achieve real change in terms of preventing mental health problems and improving the lives of those with mental health problems, there needs to be a shift in funding towards early intervention in childhood, towards a family-focused approach and an industrial scale public health approach." (Sheffield Children's NHS Foundation Trust)

"Nobody ever mentions the patients or clients who have kids, or offers tailored support in this area." (Individual)

Issues for children, young people and parents also formed a major theme.

There was a strong emphasis on childhood prevention and the extension of early intervention services to young people with any type of mental health problem.

Support for parents, particularly those with mental health problems, was advocated through, for example, parenting programmes, perinatal support and closer links between children's and adults' mental health services. One mother suggested cheap holidays for parents and children, and respite centres to help during crises. Family Action cited its Building Bridges service in Tower Hamlets, where the families it worked with "had virtually no returns to hospital for parents" (that is, parents who had had previous admissions). There were comments

about the importance of specialist perinatal mental health services and their patchy availability; East Midlands Perinatal Mental Health Network was commended by the Royal College of Psychiatrists as "an example of specialist services developing a comprehensive and integrated model of care across all tiers of service delivery, driven by standard setting and clinical need".

People called for greater input in schools in terms of mental health education, stress reduction and providing counselling and other interventions. There were calls for good play opportunities, including outdoor activities in green spaces, greater availability of counselling for children and families, and speech and language therapy for children with emotional and behavioural difficulties.

Some respondents drew attention to young people with particular needs or vulnerability, for example children in care, children at risk of violence, and disabled young people making the transition to adulthood, especially those with learning disabilities. Several respondents, particularly carers, called for more support and understanding of those on the autistic spectrum and recognition of how vulnerable the lack of support makes them. A community nurse's response highlighted the needs of homeless children, and Nacro drew attention to issues for young offenders with mental health needs, concerned that these had not been addressed by the Bradley review. Newham Asian Women's Project highlighted the need for adequate funding and commissioning of culture and gender-specific support, such as they provide, for girls and women who have experienced domestic violence or other violence.

Stigma and discrimination was identified as an issue for young people, especially lesbian, gay and bisexual (LGB) young people, and also the need to overcome the isolation of young people with mental health problems.

There were concerns about funding for child and adolescent mental health services (CAMHS), including a comment that support for wider CAMHS initiatives had reduced provision of those services that have a specific remit to provide specialist mental health care for children and young people, and their families. Others supported broader initiatives as being preventive.

One trust suggested that the involvement of the director or a consultant in public health and the local authority's director of children's services helps improve the quality of commissioning of children's mental health services.

Drugscope wanted to see closer links between CAMHS and specialist drug and alcohol provision.

A lot of responses were concerned with transition from CAMHS, which is addressed in Question 11.

Partnership working and other organisational/system issues

"In respect of the cross-cutting nature of New Horizons, a critical change is to achieve connectivity between agencies. This needs to occur not only between statutory care providers (eg the NHS and social care) but to operate more widely (eg to encompass education, employment, etc). Only in this context can communities make inroads in achieving social inclusion targets (eg PSA 16) and delivering

outcomes for people." **(NHS Bradford and Airedale)**

Many responses (about one in seven) prioritised partnership working and other aspects of system change. Respondents said that cross-government prioritisation of mental health was needed, that blocks to more integrated care should be removed, and that joint collaborative working was crucial. Joint working should include the independent and voluntary sectors. Better joint working was needed to make the Care Programme Approach (CPA) work, and more integrated multi-agency working would help meet the needs of the most excluded groups. The Mental Health Network of the NHS Confederation suggested that local mental health services could be more vulnerable to cuts than other services in the economic downturn because of the structure of the NHS performance framework and lack of a national tariff. It called for a greater focus on system reform in mental health at a national level and support for skills development in commissioning. (See the responses to Question 9 for more on joint working.)

There were also comments about how care is organised and delivered, for example wanting flexibility from crisis teams about where they will meet people, and the abolition of ward rounds.

Work, income and benefits

"I was just extremely fortunate to have had a very understanding, supportive manager, that helped me through the difficult period. This helped my experience 100 per cent and so we need to equip all managers with this ability."
(Individual)

Work, income and benefits was another major strand, particularly the employment aspects. People talked about the need for workplaces to be more mentally healthy, for example challenging long-hours cultures, and they saw the workplace as a key arena for mental health promotion activity. They wanted stigma and bullying to be challenged, stronger workplace rights, mental health awareness for managers, and advice on reasonable adjustments. One suggestion was for it to be mandatory for there to be at least one person trained in Mental Health First Aid within every workplace.

There were criticisms, some very strong, of the benefits system and welfare reform, with calls for people with mental health problems to be better supported to get and keep work, some challenges to the work focus, and concern about the assessment of benefit entitlement.

Workforce issues

“Services and staff should possibly be given same training as early intervention staff and teams have. As a patient with early intervention myself with previous experience of community mental health teams and primary care, I believe that EARLY INTERVENTION TEAMS have in many ways hit the nail on the head with their approach to patient care, treatment, support, and everything, they make the patient feel cared for and they listen which is a key thing for all patients.” (Individual)

Workforce issues were frequently mentioned, and comments addressed staffing levels and mix, training, skills and attitudes.

Some people wanted there to be more staff and specified different groups including doctors, community

psychiatric nurses, counsellors, staff for social therapies, and support workers with life experience.

There were concerns about low morale and high staff turnover, and collaborative working was suggested as one way to reduce the burden of work.

Some wanted to see a shift in the balance from management and administration to clinical and care work.

Training needs identified were CBT, mental health training for GPs and other primary care staff, awareness training for mental health staff, and cultural competency.

Some service users described bad experiences (across sectors) and wanted greater staff accountability. They wanted respect and caring attitudes.

There were calls for good pay and conditions and promotion of working in mental health and the value of this role.

Other issues prioritised by significant numbers of respondents were:

Funding

Resources and funding also featured in this section. Some respondents focused on the potential loss of funding in the economic downturn and the difficult decisions that would have to be made; others on the need for further investment in mental health.

Carer support and involvement

The key priorities set out by the Princess Royal Trust for Carers were personalisation (including choice for carers as to how much of a

caring role they take on), access to and availability of services, and involvement and information-sharing with carers. Respondents drew particular attention to issues for young carers. Others' points included the need for emotional and financial support and respite care.

Crisis and acute services

“Many practitioners do not put a crisis plan in place, and even tell patients that home treatment teams are not able to come to the patients' homes when they are in crisis, leaving many patients feeling hopeless, alone and scared, and self-harming.” (Individual)

“Could you also please advise your mental health teams that if they are to utilise early intervention properly, they need to do more than suggest that people in crisis take perfumed baths and light candles, which my local crisis team seem to be fixated with.” (Individual)

There were strong messages about needing safe and therapeutic wards, crisis houses and other community-based support for people in crisis, and access to crisis teams out of hours. Staffing and morale were issues – a clinical governance and quality improvement manager wrote, “Our in-patient services are working on bare bones and have been cut back to breaking point.” The response from Bright and Star Wards recommended: proactive and genuinely 24/7 crisis teams, with staff trained by the Samaritans, “who provide services magnificent almost beyond belief”; better use of crisis staff's time by usually visiting singly rather than in pairs; and the option of crisis therapists for those at very high risk, which could be a potential use for direct payments.

They commended the Star Wards initiative as a way to improve in-patient care, and priorities on borderline personality disorder included the specialist respite/crisis houses recommended by NICE (as well as implementation of the rest of the borderline personality disorder guideline).

There were also very significant issues that were not necessarily covered by large numbers of respondents, but which some, usually specialist, organisations focused on, often providing detailed evidence and proposals. In particular:

Drug and alcohol issues

Numerous responses referred to drugs and alcohol as causes or contributory factors in mental health issues, and to people with drug and/or alcohol problems and mental health problems not having their needs met. Drugscope and Progress in particular wanted to see more prominence for these issues in the strategy. Respondents' recommendations were mainly about prevention (including alcohol-reduction policies), joint commissioning and working, integration of services, better understanding of substance misuse issues and their links with mental health, including in the criminal justice system, and adopting holistic, needs-led and recovery-oriented approaches.

Some organisations drew attention to gender issues: men's use of drugs and alcohol may be linked with mental ill health but not identified as such, while women's use of drugs and alcohol may be linked to abuse, and substance misuse is associated with perinatal harm.

Housing, homelessness and complex needs

A number of organisations working with homeless people and those with complex needs (including drug and alcohol issues and contact with the criminal justice system) highlighted the unmet needs of these groups. The Making Every Adult Matter Coalition⁵ argued for New Horizons to make a “strong statement of commitment to addressing the issue of mental health for people with multiple needs and exclusions”. It was particularly concerned about people with common mental health problems who fall below the threshold for case-managed support. St Mungo’s wanted open-access universal centres providing mental health assistance, to overcome the barriers of accessing support. Turning Point set out its vision of “connected care”, which involved community-level participatory research into needs, and support to commissioners to find and implement solutions.

Military personnel

“Combat Stress and the NHS should work together more so that somebody like me can have a community psychiatry nurse. Because I go to Combat Stress it seems that my local community mental health team cannot give me a community psychiatry nurse because they are not trained in military post-traumatic stress disorder. I think I am being discriminated against.” (Individual)

A health professional working for the Ministry of Defence commented on the omission of veterans in New Horizons, pointing out that veterans were entitled to priority health care treatment, and saying that

“Any plans for the future of mental healthcare in the UK must allow for cooperation and dialogue between the NHS, military mental healthcare providers, the veterans’ agency and the charitable sector providing services to British Armed Forces veterans.”

Dementia

A number of responses were concerned with dementia and levels of need. There were supportive statements about the National Dementia Strategy and calls for there to be improved awareness of dementia care so that people access care earlier.

Suicide prevention

Several responses included suicide prevention as a priority, with the Samaritans in particular arguing for maintaining specific measures and resources and a profile for suicide prevention beyond the life of the current suicide prevention strategy. Some respondents highlighted different groups of people at higher risk of suicide, and issues such as ward safety and support with treatment adherence.

Government response

Respondents' priorities aligned closely with the New Horizons strategy and helped shape it further; the whole of the action programme constitutes a response to the issues raised.

The following sections refer to Government actions on areas mentioned by many respondents or identified by respondents as gaps.

Access to psychological therapies: IAPT (Improving Access to Psychological Therapies) is expanding training on all therapies that are supported by recently revised NICE guidance on depression (Action 107). The national update plan for the IAPT programme, *Realising the Benefits: IAPT at Full Roll Out* was published in February 2010.

Recovery: the Department of Health is funding a project run by the Mental Health Providers Forum to implement widespread use of the Recovery Star, a tool to facilitate care planning based on user-defined goals and quality-of-life outcomes (Action 78). The National Mental Health Development Unit is working jointly with the Mental Health Network of the NHS Confederation and the Sainsbury Centre for Mental Health to pilot recovery-focused organisational development (Action 79).

Children and young people: a number of Government programmes are being rolled out across the country, providing universal and targeted support to children, young people and their families, including schools-based programmes and the expansion of Sure Start (Actions 16, 38–40). There are further details of early intervention work and the Department for Children, Schools and Families' investment in safe play opportunities in Action 16. Work to support effective transitions and good practice in services for adolescents and young adults is set out in Actions 41–44.

Many services have taken action to improve access to services by reducing the time children, young people and families have to wait for support. The Department of Health and Department for Children, Schools and Families' guide, *Improving Access to Child and Adolescent Mental Health Services*, aims to help services deliver this by showing how to achieve a low-wait CAMHS.

Keeping Children and Young People in Mind: the Government's full response to the independent review of CAMHS sets out in more detail the Government's plans for the future of children and young people's mental health.

Dual diagnosis: the Government is continuing current initiatives and training aimed at joint working and improving the diagnosis and care for people with a dual diagnosis (Action 85). Major research is under way to investigate the efficacy of a psychological intervention for people with a diagnosis of schizophrenia or psychosis with drug or alcohol problems (Action 86).

Acute care: the Department of Health welcomes the Acute Care Declaration, which was developed by the Mental Health Network of the NHS Confederation and the National Mental Health Development Unit, and was endorsed by a range of partner organisations. It states that good-quality acute in-patient and community mental health services are essential and achievable, and it affirms what organisations will do. The Department will be formally responding to the Declaration (Action 82).

Housing, homelessness and social exclusion: government strategies on housing and neighbourhoods are set out in Actions 56–59 and work by government departments on housing for those with serious mental illness is described in Actions 60–61. Work to better meet the needs of homeless people, including those with a dual diagnosis and/or personality disorder, to improve access to healthcare for homeless people, and to end rough sleeping is described in Actions 98–100.

Work and benefits: the cross-government mental health and employment framework *Working our way to better mental health* is designed to improve well-being at work for everyone, and deliver significantly better employment results for people with mental health conditions. *Work, Recovery and Inclusion* is a cross-government delivery plan for England to support people who are in contact with secondary mental health services to get into work. (See Actions 45–50 for a summary.) As these documents make clear, the Government is aware of the impact of the complexities of the benefits system. Changes have already been made to make it less stressful to navigate, but the Government is determined to simplify it further. The Department for Work and Pensions is launching a communications campaign to increase awareness among advisers of housing benefit as an in-work benefit, and the online 'better off in work' calculator went live on 21 September 2009 in the benefits adviser service site on Directgov.

Carers: initiatives within the 10-year cross-government strategy *Carers at the heart of 21st-century families and communities* include action to ensure that carers receive appropriate information, action to support young carers and training for frontline health professionals on supporting carers and families (Action 83).

Armed Forces, reserves and veterans: the Department of Health is working with the Ministry of Defence on a number of actions to improve access to mental health services for military veterans, serving personnel and reserves (Actions 87–90).

Suicide prevention: a refreshed strategy will be developed by the National Suicide Prevention Strategy Group under the chairmanship of the National Clinical Director for Mental Health, Professor Louis Appleby. The risks of different groups – for example young men leaving the forces, older men and rural communities – will be considered (Action 65).

Prevention and promotion were raised as major themes in Question 1 and developed further in Question 2. Much of the New Horizons strategy is about prevention as part of a new public mental health approach (please see next section).

Question 2: Public mental health/prevention and mental health service development

“Do you support the twin themes of public mental health/prevention and mental health service development? Please explain your views, giving examples if possible.”

There was a great deal of support for the twin theme approach as long as it was not to the detriment of people with existing mental health conditions. There were concerns as to how this could be achieved in the current economic climate.

Support for the twin theme approach

Response	Number	Percent
Yes	590	58
Qualified yes	122	12
No	26	3
Qualified no	15	1
Not stated*	119	12
Don't know	19	2
Not answered	125	12
Total**	1,016	100

*'Not stated' is where people answered the question but did not give a direct answer on the twin themes as an approach (for example they may have given views on service development or prevention but did not say whether or not they agreed with the approach itself). A number of people said they were unsure what the question meant and these have been categorised according to the views they then went on to give.

** The base total is those who responded online and/or responded following the consultation questions.

The majority of respondents (70 per cent) agreed with the twin theme approach – often with great enthusiasm – and very few explicitly disagreed (4 per cent). A substantial

number either did not answer the question directly or did not answer it at all.

"It is crucial for these two themes to develop together – New Horizons clearly evidences links between early life, environment, positive mental health plus emotional, physical and financial costs to individuals/society of poor coping skills and mental health problems. The main challenge is to achieve a spread of budget and resources to increase prevention and at the same time continue to provide a service to those who need it most."
(LGA, ADASS and IDeA)

"We 'sufferers' have to live in the community at large, with stigma and causes of ill health, and it is here – the entire population – that the changes are needed. Treat illness, yes (I am one of their success stories), but the emphasis MUST be on stopping the problems from arising in the first place!"
(Health improvement adviser)

"Yes, I fully support the twin themes. I particularly wish to see health service providers as being health promoting organisations, and being role models in patient/service user/carer, staff and community wellbeing. We cannot expect other organisations to embrace employee and community wellbeing without this effective leadership."
(Greater Manchester Mental Health Network)

Many respondents articulated the relationship between the two themes, in most cases seeing them as complementary or mutually reinforcing. Their view is that better public awareness of mental health will reduce stigma and encourage conditions and behaviour that protect mental health and encourage early support and/or treatment, and that this in turn will reduce use of secondary mental health services.

Some people said there was a tension between the two approaches while others said they needed to be integrated.

There were also numerous comments about the relative weight given to each theme, with some wanting priority given to one theme, and others welcoming their 'equal footing'. Several respondents emphasised the historical lack of priority given to public mental health. This is one of the core issues for the Future Vision Coalition, whose response advocated upstream investment without jeopardising mental health service development.

"We support the two themes and are pleased that the wellbeing aspects of the whole population are given equal weight. This was an area that received less attention in the NSF but is potentially the one where we can make the largest and most sustainable difference."
(NHS Cambridgeshire)

"Mental health needs to catch up with the work done in physical health/improving lifestyle."
(Gateshead Older People's Mental Health Services)

Others preferred to see mental health services have priority within a twin theme approach, for similar reasons to those who disagreed with the approach altogether – scepticism about prevention and the need to get services right, particularly in the context of financial constraint.

"Yes – BUT!!!! There are already NICE guidelines in force about how diabetes sufferers will be supported psychologically (and for all I know, others with long-term conditions). This doesn't happen in my PCT [primary care trust]. I think you

should concentrate on getting the services you already say should be there a) operational in the first place and b) working properly before you try to expand your services any more. I can't respond to the detailed questions as I have not been granted any access to mental health services." (Individual)

The message that people with mental health problems should not be disadvantaged by a focus on public mental health came out strongly in the consultation. Some service users disagreed with the approach because they feared funds would be diverted from services for people with mental illness. The Mental Health Foundation said that the economic climate risked jeopardising the development of promotion and prevention initiatives and that difficult decisions would have to be taken, but that this "cannot be used as an excuse to continue to underinvest in promotion and prevention services".

Other concerns expressed were:

- a lack of priority on excellence in clinical assessment and treatment as compared with the Darzi report;
- the risk of over-identification of people at risk and over-treatment with pharmaceuticals;
- the risk of excluding people with mental illness from the well-being agenda or an inadvertent anti-recovery message;
- the risk of giving the message that mental health problems are the individual's fault;
- that going into schools to talk about mental health is not definitely proven to improve attitudes and could have the opposite effect;

- the gap between the sophistication of the conceptual and ethical framework and the thinking behind some of the interventions proposed; and
- potential denial of mental illness, partly indicated by not using the language of severe mental illness.

Those who disagreed with the approach – sometimes very strongly – tended to want attention paid to getting current services right, or would prefer to prioritise mental health services if both were not possible. They did not trust the Government on mental health or were sceptical of the evidence for the effectiveness of prevention/promotion. Some service users saw the focus on public mental health as a put down and an unwarranted demand on limited resources.

This person (who partially agreed with the approach) set out some of the concerns:

"Although the promotion of awareness is essential it is vital not to overstate the possibilities of prevention. People will continue to suffer from mental health problems and certain events such as economic recession will actually increase the numbers suffering. It is extremely harmful to suggest that mental health problems are the result of failings or shortcomings on the part of individuals. In addition there is a great deal of scepticism that this document is another case of 'all mouth and no action'. Service users need to see demonstrable changes in the level and quality of provision." (Individual)

Content and implementation of twin theme approach

Structural causes, macro/micro interventions

There were several comments about structural causes of mental ill health with cautions against limiting public mental health to individual healthy behaviour and self-care – “it requires a serious approach to eradicating the corrosive effects of inequality, deprivation and unequal access to opportunities” (Sheffield Health and Social Care NHS Foundation Trust). There were numerous references to the Marmot review on health inequalities (February 2010) and the work of Wilkinson and Pickett on unequal societies (*The Spirit Level*, 2009).

Evidence for prevention

There were references within the responses to the evidence reviews by the Government's Foresight project on mental capital and well-being, as well as to specific studies. A number of respondents testified to the benefits of a preventive approach, both within mental health and in other fields. The South East Coast Ambulance Service referred to the 'well proven' connections between prevention and health promotion, alongside service design, in other areas of healthcare, while the Chief Fire Officers' Association said that the Fire and Rescue Service's shift to a preventive-based approach had resulted in “dramatic reductions in the number of fires and subsequent death and injuries”.

Equalities

“...The lack of cultural awareness around mental health issues and how these are perceived within different ethnic minority communities should not be under-

estimated when tackling greater public awareness of mental health issues and barriers that impact on access to services and people's experiences of these services.”
(Acocks Green Neighbourhood Forum, Birmingham)

Inclusiveness in mental health promotion as well as service delivery was a theme in some responses, and the Afiya Trust underlined the importance of making diversity central to public mental health. The online debate at IDeA also generated advice on, and examples of, equalities work within mental health promotion and prevention, particularly with BME communities. Responses addressing issues for older people were also concerned that they should be fully included in prevention/promotion and not only services.

At the same time, a public health approach was seen as a way of reaching groups who might not otherwise seek help, for example men and people with learning disabilities were both mentioned by Middlesbrough Local Implementation Team.

(Please see responses to Question 10 for more on equalities.)

Children, young people and families

Many people emphasised the importance of reaching children and young people in terms of education, support and early intervention. An individual respondent considers that addressing mental health in schools is important and reflected that: “I feel my own mental health wouldn't have deteriorated so drastically if I'd been taught the importance of having good self esteem, and had understood why it was important to look after my mental health.”

The College of Occupational Therapists, while advocating a wide range of preventive actions, said, “probably the single most important act to improve the nation’s mental health would be to invest in children’s mental health and well-being. Future investment here could reap long term benefits for children with fewer emotional or behavioural disorders and generating greater emotional resilience...”. Similarly, The Place2Be said that much adult mental illness could have been prevented or mitigated had better services been available during childhood. The NGO Forum advocated commitment to providing interventions such as the Pyramid model for young children who are identified as being at risk of developing mental health difficulties later in life (www.ebmind.org.uk/youthservices.asp). The Royal College of Psychiatrists called for a strategy to prevent drug misuse in young people.

My Time CIC pointed to the importance of family friendly services that are culturally inclusive and both support the family member who is not well and prevent the others following the same path. Similarly, the Association for Family Therapy refers to its work of supporting and developing resilience and strengths, and limiting the damage to other family members when adverse events occur. They also called for the evaluation of interventions to take account of the family and community effects.

There were calls to reach the neediest children through schools and Sure Start (as parents do not engage with CAMHS), and to use more creative rather than cognitive media with young children, that is play rather than CBT.

Many other aspects of public mental health, and also mental health service development, were raised; for example, adult learning, smoking, housing, staff training, substance use, religion, the workplace. (These are largely covered elsewhere in this report, in particular under Question 1 on main changes, 4 on personalisation and 10 on inequalities.)

“Public Service Agreements – we support the proposal that there should be a new PSA dedicated to mental health and well-being ... Without a clear forward plan to stimulate improvements, regulate standards and monitor outcomes, the vision and intentions of New Horizons, and the confidence of those who provide and use the services, will be undermined.” (NHS Commissioning Support for London)

Other key points in this section were that:

- a number of Trusts and local authorities wanted greater clarity or direction to ensure implementation of the vision;
- preventive and early intervention work needs to reach all sectors and settings, particularly, but not only, schools and workplaces;
- education and awareness for self help is an important part of promotion;
- the expertise of service users and the role of peer support should be valued; and
- the third sector has an important role to play and in particular there should be engagement with, and support for, smaller, specialist organisations (eg women’s and BME community organisations).

(Please see Question 9 on partnership working for more on PSAs and indicators.)

Examples from consultation responses

“The primary care eating disorder clinics in Sheffield are an example of how early intervention/prevention can work.” (Sheffield Mental Health Partnership Board)

South London and Maudsley Trust refer to its mental well-being impact assessment model, based on four key protective factors for mental well-being: enhancing control, increasing resilience, facilitating participation and promoting inclusion.

Action for Carers Surrey has been running a pilot project with a group of GP practices in South West Surrey to improve both identification of carers and support for them in the primary care setting.

Touchstone’s Minority Ethnic Mental Health Opportunities Project ran a virtual healthy living centre working specifically with BME community organisations, which gave small grants to non-mental health agencies working with over 3,000 people in Leeds to maximise their well-being, physical activity, diet and socialisation opportunities. Over 90 per cent of the funding went directly to small, under-funded BME organisations who had the biggest access to and engagement with this priority group. Also, its Sikh Elders Neighbourhood Network service provides befriending, referrals on to other agencies, physical activities and group work which enables elder Sikhs to remain in their own homes.

Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust is a partner in the shared development of a Physical Health/Public Health Practice Development Lead for mental health, which works across primary and secondary care. This is supported by a learning and development programme which brings mental health, primary care and commissioners together.

Broomfield Hospital in Essex provides a psychological service in an acute hospital setting, offering support, psychiatric liaison and a wide range of psychological interventions. “Our key aim is to minimise the psychological effects of physical ill health and trauma.”

Mental Health First Aid training – this was recommended by numerous respondents and there was a proposal for targets for population coverage.

Government response

Encouraged by this response, the Government has continued to develop New Horizons as a twin approach, and the whole strategy constitutes its response.

Actions to support the new public mental health approach, in particular commissioning and other decision-making, are described in Actions 4–11. These include a public mental health framework and Review of Supporting Evidence, an online cost calculator for population well-being, and steps to ensure that government policies consider the impact on well-being.

Children's mental health is addressed in Actions 38–40, well-being at work in Action 45, housing and environmental quality in Actions 56–59, climate change in Actions 62–64, prevention of violence and abuse in Action 67 and health promotion in Action 75. For the full strategy on work and well-being, see *Working our way to better mental health: A framework for action*.

Funding: the current difficult economic climate, which has followed a period of investment, demands attention to value for money. This is not about cutting resources but about making efficient use of the resources available. The Department of Health and other government departments are committed to ensuring that evidence of economic benefit is available to local health economies, local government and local strategic partnerships to inform their decisions about where spending can be most effective. Plans and strategies arising from New Horizons will be subject to a review of affordability in the light of the next Spending Review.

Question 3: Guiding values

“Are the guiding values described in Section 1 the right ones? Please explain your views giving examples, if possible.”

Most people who answered this question agreed with the values and were concerned to see them put into practice.

These guiding values are:

- equality, justice and human rights;
- reaching our full potential;
- being in control of our lives; and
- valuing relationships.

Almost half (48 per cent) of the respondents answered this question. The majority (over 70 per cent) agreed with the guiding values, often wholeheartedly, using expressions such as ‘fully endorse’ and ‘absolutely’. A large number of these also either suggested additional values or a particular aspect of the values for further emphasis or development. Very few explicitly disagreed with them, although a significant number (10 per cent) focused strongly on the test being their translation into reality, and in some cases expressed considerable scepticism.

“The values are right. Every relationship should be based on respect. Respect for ourselves and others.” (Individual)

“Yes it is brilliant the Government are going down the route. Prevention would be easier if there were heightened awareness and

respect. I was bullied and blanked in my workplace until I felt suicidal and could not function and ended up unable to work.” (Individual)

“I believe they are the correct values as they give focus fully on inclusion in the whole of society and that treatment of mental health problems requires an approach that takes into account all aspects of a person’s life. It also takes into account the community that they live in, and not just health and social care specific areas. It aims to tackle stigma and discrimination in all areas and will hopefully push mental health up the agenda.” (Southend Borough Council)

Some respondents mentioned alternative or complementary sets of values or principles. One advocated the Ten Essential Shared Capabilities and the guiding principles in the Mental Health Act Code of Practice. Others suggested organisational values to complement those provided. The Mental Health Foundation regards the “eight fundamental values underpinning mental health care as trust, care, safety, justice, autonomy, privacy, participation and solidarity.” (Good care in the community, Bauduin, McCulloch and Liégeois, 2002)

Suggestions for additional values or emphases were:

- safety;
- privacy;
- race equality;
- accountability (both to public/patients and in respect of the values themselves);
- service user engagement/empowerment;
- “the same standard of care, consideration and attention that we would expect for ourselves, our family and friends” (Richmond Fellowship; two other respondents made similar suggestions);
- “compassionate, quality care for individuals, families and carers” (SANE);
- “valuing life” (specifically suicide prevention) (NHS Leeds – Public Health and Suicide Prevention Group);
- personal responsibility;
- physical health and having physical needs met;
- “by giving we receive (including making valued contributions to society”) (Kirklees Council and Kirklees NHS Mental Health Partnership Board);
- “what is already working well should be preserved” (ie maintaining gains made through the Mental Health NSF) (South Staffs and Shropshire Healthcare NHS Foundation Trust);
- “the right person with the right skills seeing the right person at the right time” (British Medical Association);
- “we are all in this vale of tears together”.

One area where a number of respondents identified a gap is the importance of relationships beyond the caring relationship or care provided by families. Some focused on community and interdependence, and one drew attention to the needs of young adults with mental health problems around forming relationships.

“The chapter section on ‘valuing relationships’ seems to miss the point. Promoting mental health is about creating social opportunities where the creative and enriching parts of people’s personal relationships can flourish. This is nothing to do with the need for informal carers, important though that is when needed.” (Individual)

“Focus shouldn’t just be on Families/Carers – need a wider term to include friends/spiritual leaders/significant others – our suggestion would be Supportive Others.” (Bristol Primary Care Trust)

It was also suggested that the values could be used in relation to the workforce, service providers and commissioners, for example by respecting staff and valuing their work. Another response pointed to the need to recognise the “collective aspects of ‘just being human’” and of the need to tolerate uncertainty and the “human frailty and vulnerability” of staff.

Social inclusion is an area where some respondents wanted to see greater emphasis, for example in reaching out to the most excluded, including homeless people – “a blind spot”, older people, the LGBT community and those with a learning disability. The right to work, said one, is a “glaring omission”. There was also a caution against

being too centred on younger adults, particularly in considering the values of recovery – “What does recovery and hope mean to older people in a different life stage – with differing challenges and realistic negative thoughts about their future?” (Lancashire Care Foundation Trust’s Older Adult Network)

The Royal College of Psychiatrists called for a stronger human rights presence, pointing to the “highly valuable and quite specific set of protections” in human rights law that are afforded people with mental illness or learning disabilities, and the international standards by which the UK is bound. The Afya Trust called for a “clear articulation of how the human rights of people who access the mental health system will be protected” on the basis that “a large part of mental health care and service delivery is governed by the Mental Health Act, which contravenes, in many aspects, the idea of human rights”.

One or two respondents pointed out that people do have equal rights and the issue is exercising them and being enabled or supported to do so, with reasonable adjustments where necessary.

Others said that the values need to be applied to the whole population and not only those with mental health problems.

Some of those who focused on the need for action described how far their experience was from the guiding values, for example:

“...These principles are outside our experience so it was difficult to understand how these can apply on a practical level. ...Things are getting better but we still have a long way to go. You don’t have to line up outside the office for your medication anymore.”
(Loud and Clear)

Other points included the challenge of turning words into meaningful action and the lack of choice and control for those subject to the Mental Health Act.

Those who explicitly disagreed with the values did so because they found them vague or meaningless, or because they disagreed with what was or was not included, for example:

“Personalising services leads to non-evidence-based practice.”
(Individual)

“We are missing out David Bennett [and the] independent inquiry of his death on 30th Oct 1998 and the Delivering Race Equality (DRE) programme. Organisational change, institutional culture change, valuing diversity and acceptance of working with differences such as culture and values [have] totally [been] missed out.” (Individual)

Government response

The New Horizons programme is based on the guiding values, and the Actions – particularly those connected with recovery, personalisation, stigma and discrimination – are all aimed at turning these values into reality. The tone is set by the Prime Minister's foreword to *New Horizons: a shared vision for mental health* and the consultation document stands as the fullest articulation of the vision and values.

Other issues raised by respondents are also reflected in the programme, for example, the quality of acute care and the interface between physical and mental health, and there is a discussion of human rights in the Equality Impact Assessment.

Question 4:

Personalised services

“What should the Government do to promote more personalised services for people with mental health problems and their families? It would be helpful to hear about both what works in your area, and, if appropriate, what does not and what could be done in the future.”

People made a range of recommendations from greater involvement of service users to integrating systems for health and social care.

Over half of the respondents (57 per cent) answered this question.

There was strong support from respondents for personalising services, which was seen as providing the support a person wants, and how, where and when they want it. This includes the use of personal budgets but is broader than any particular mechanism. Several respondents said that personal budgets should be an option for service users rather than an expectation, and Citizens Advice suggested that choice should allow for different levels of control.

According to respondents, achieving personalisation means:

- listening to service users and adopting a ‘whole person’ approach;
- shifting mindsets so that the service user is at the centre of their own care;

- providing information and training to service users, families and staff;
- involving service users in service design and delivery;
- promoting personal budgets and the advocacy and support required to make them effective and accessible;
- providing a range of services, support and therapies from which to choose – and offering choices; and
- removing barriers to integrating health and social care.

Those whose responses were more negative were concerned about an over-individualistic approach, feared loss of services and funding for community groups, or considered that personal budgets have not been adequately demonstrated in mental health or that they were not viable for some people. While they strongly support person-centredness, the

Royal College of Psychiatrists said that improving service quality should take priority over the choice agenda.

Involve (a Doncaster-based service user group) encapsulated the benefits of personalisation and the potential risks to community groups: “Personalisation can open up more choices for people, and look at their life more holistically. Valuable groups and organisations must not be put at risk, though, due to complicated and unpredictable funding mechanisms. Personalisation may work well for individuals, but groups and organisations should have alternative sources of funding support too.”

Information

A common theme was the need for more information and awareness of personalisation, especially given the low take-up of direct payments by people with mental health problems. This is partly about hearing the success stories of how lives have been transformed (In Control) and partly about understanding personalisation mechanisms and choices and how to navigate the system. However, the responses show that wider information needs are also an issue – information about mental health and the services and therapies available to enable choice.

Staffing and training

There were many comments about staffing levels, quality and training. Some concerned person-centred ways of working, others the specifics of personalisation mechanisms. Mind outlined barriers to the take-up of personal budgets in mental health, and the work of Putting Us First (a joint project with the Norah Fry Research Centre) to overcome these barriers, for example through

providing information for care coordinators.

There were examples of staff-service user interactions that are far from person-centred – for example, the person who described the “massive ‘we know best’ attitude” that needs to disappear and the person whose suicidal friend was badly treated.

Others said there needed to be more staff in order to achieve staff: service user ratios that allow for a personalised service. Examples of training needs that were cited include training for mental health staff in self-directed support and for personal assistants to work more effectively with older people with mental health needs. The Association for Family Therapy advocated “a pyramid structure of training” that has been successfully implemented in Oxleas and Somerset and that can support the new vision.

Risk

A number of respondents discussed the issue of risk. One individual reports having her requests for direct payments turned down and says that a “big enemy of personalisation is an obsession with risk that I hear constantly in conversations with the Council and PCT etc” Her wish for mental health service users to be “treated like adults” was mirrored in a trust’s response, “The concept of positive risk and service user rights to take risks need to be explicit within the New Horizons strategy to support the personalised approach.” (Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust)

Other comments questioned the viability of personal budgets for some people or concerned the need

for Protection of Vulnerable Adults safeguards.

The London Borough of Haringey said that local service users wanted information about “the interplay with the Mental Health Act and Mental Capacity Act, in particular about personal budget and risk management during periods of mental ill health”.

Access and equality

A number of responses identified different aspects of access and equality, from out of hours availability for people who are in work to ensuring that the most vulnerable are not disadvantaged in their access to help by personalisation.

The National BME Committee of the Ambulance Service Network supported the delivery of personalised care, but believed this can only be achieved if its workforce reflects the diversity of the population it serves and cultural competence training is provided to the full range of staff. They provided examples of work underway on these issues.

Pan Birmingham Mental Health Commissioning cited the development of a direct payments leaflet aimed at the Somalian community as a good example of engaging communities to raise awareness of the agenda.

Age Concern and Help the Aged pointed up the need and opportunity in personalisation to remove age discrimination in the distribution of resources, and recommended that local authorities move towards a single Resource Allocation Scheme (RAS) across all age groups.

Availability and choice

The Fitness Industry Association “regards the power of choice as central to mental well-being as in contrast, depression thrives upon a sense of powerlessness”.

Respondents called for more choices, in some cases talking about ‘informed’ and ‘real’ choices. Several focused on the need for a range of services, supports, providers and therapies from which to choose. There were references to the need for safe spaces, core services, social housing, spiritual support, a range of psychological therapies, mentoring and implementation of NICE guidelines. A community mental health team said that it could work in a person-centred way but then could not access services; for example, waiting times for therapy were too long, or there was a limited range of supported housing.

Specific choices called for included time and place of treatment and choice of mental health professional. For example, the British Association for Counselling and Psychotherapy (BACP) said that it could be “beneficial for the therapeutic relationship to offer clients a choice of practitioner/therapist (for example based on gender or spoken language)”. However, the British Medical Association disagreed with offering a blanket choice of the gender of health professional, on the basis that this could lead to discrimination.

One of Rethink’s top three recommendations was to “address the disparity between mental and physical health in terms of ‘choice’”. An individual making a similar point said, “only then will services improve, as nobody will choose to

access bad services". Depression Alliance called for Choose and Book to be extended to those with depression and anxiety.

There was a suggestion to develop care pathways to provide choice and support recovery, and another to support people to exercise choice through advance statements (in primary as well as secondary care), personal support planning and brokerage.

User involvement

Respondents saw user involvement as essential to personalisation. All levels of involvement were mentioned, in addition to choice and control over one's own recovery, treatment and care. One individual described the lack of involvement in a self-directed support pilot. Respondents wanted to see 'genuine' and 'more effective' service user involvement in consultations about services, commissioning, design, redesign, delivery and evaluation. The NGO Forum suggested that community learning such as Skills for Health can support this, and LINKs emphasise their own role in a structural engagement process.

Families and carers

A lot of respondents wished to see closer working with families and carers and more support for them. For example, they wanted family involvement in the Care Programme Approach, 24/7 carer support, formalised national support for carers and the right to have their voice heard. The Triangle of Care was commended, as was the Think Family approach, and self-directed support options for carers.

System changes

Many responses called for greater alignment of services, integration of health and social care, and moving ahead with releasing money for individual health budgets. In line with other respondents' concern for the whole person, Mind said that "personalised approaches can only work if personalisation does not stop at the current boundary between social care and the NHS", but meets an individual's support needs in all areas.

Some respondents mentioned Payment by Results and wanted to see this joined up with personalisation, or for there to be guidance on how to match them up or manage the tensions between them.

There were recommendations to base commissioning on person-centred outcomes defined by service users and carers, for example by translating tools such as Recovery Star and Wellness Recovery Action Plan (WRAP) into quality outcomes, or requiring services to use Patient Reported Outcome Measures (PROMs) and have service user feedback and evaluation mechanisms in place.

Eligibility criteria, specifically Fair Access to Care Services, were identified as a barrier to effective personalisation, because people who are recovering or who need preventive help may be excluded. Mind stated that many local authorities operate a threshold for service provision based on mental distress that is severe enough to justify CPA-based care, and service users can as a result be unlawfully denied an initial social

care assessment that might have identified a need for services.

There was also criticism of the CPA for being bureaucratic, and one respondent said that the “future is self-directed support but trusts won't have capacity to run both”.

Public mental health/ prevention

Some responses drew out the relevance of personalisation to public mental health and prevention as well as to mental health services. The New Economics Foundation applied personalisation to their 'Five Ways to Well-being', while West Mercia Probation Trust advocated personalised services for those offenders in custody and their families, who need mental health support. Specifically, “Early interventions could meet the emotional and psychological needs of children who have parents in prison” and “help prevent long-term mental health issues/promote mental well-being for this at-risk group”. In relation to the wider population, the Faculty of Public Health said, “Freedom to use personalised budgets to support families and build mental health resilience would be forward thinking.”

The Chief Fire Officers' Association offered input to personalised approaches that could reduce the very particular risk to some individuals of fire (or involvement in fire-setting).

“There needs to be a move towards integration of the health and social care provision with regard to self-directed support. Service users are struggling to understand why, for example, they can have control over their budget to meet some needs defined as social care but not others defined as health care. The reality is that there are many grey areas – music therapy is health care, membership of a music studio is social care. The recovery model needs to be understood and embedded into community mental health practice so that CPA is far more service user-led. What has worked for us is using direct payments, as often things which improve people's lives can be small – joining a fishing club or a gym. Direct payments for carers can also promote more effective support for individuals to make life easier.”
(Joint response from NHS Westminster and Westminster City Council)

Government response

Through New Horizons, the Government is continuing to look at ways to extend choice and improve personalisation in mental health. See Actions 28–34 and 78–79 on personalisation, Action 12 on the third-sector contribution to developing personalised early intervention and preventive tools, and Actions 80–81 on improving the quality of mental health services.

Access and eligibility

The Green Paper *Shaping the Future of Care Together* sets out the Government's vision for a National Care Service for all adults in England – a service that is fair, simple and affordable for everyone, underpinned by national rights and entitlements and personalised to individual needs.

As part of the reformed care and support system, everyone would get help to stay independent and well for as long as possible, and would be able to access information and advice about care and support. Everyone who qualified for further support would get some help meeting the cost of care needs.

The public consultation on *Shaping the Future of Care Together* ran from 14 July to 13 November 2009 and set out to be the largest ever consultation on care and support – reaching out to people across the whole of England through a public roadshow, stakeholder events and virtual media. Many thousands of people said how they want the new National Care Service to be organised and funded, and these responses will feed into a White Paper to be published this year.

Following consultation (July–October 2009) specifically on *Fair Access to Care Services* (FACS) guidance, revised guidance was published in February 2010 to replace that published in 2003. This aims to support fair and transparent implementation of eligibility criteria, within the new policy context of personalisation and prevention, and will act as a bridge towards wider reform. Alongside that, the Social Care Institute for Excellence (SCIE) is in the process of developing an online training resource for social care staff to ensure that the criteria are applied more consistently across the country.

The guidance *Refocusing the Care Programme Approach* (2008) makes it clear that CPA should not be used as a 'gateway' to social services. It states that as CPA is "not a measure of eligibility, services that currently equate CPA levels with Fair Access to Care Services (FACS) eligibility levels should review their policies accordingly", and that needing CPA should not affect a person's entitlement to take advantage of new and emerging models of service delivery such as individual budgets.

Integrating health and social care

The Government hopes to present as seamless a provision of services as possible for people receiving social care direct payments and personal health budgets. There are a number of issues to be worked through. Some of the personal health budget pilot sites are specifically investigating joint care/support planning and pooling of the two budgets. However, the fundamental differences between health and social care – a needs-based service, free at the point of use versus a means-tested co-payment based system – means that making this work will not be straightforward and a range of approaches may have to be considered.

Question 5: Value for money

“In your view, which are the most important areas in mental health services where value for money could be improved? And how should that be done? If possible, please indicate examples of the current costs of services and areas where the potential savings might exist.”

A range of services and therapies were cited as providing value for money, particularly in prevention and the third sector, and there were many recommendations for adjusting the balance of the workforce and streamlining organisations.

Over half of the respondents (54 per cent) answered this question.

“Self-management groups – giving service users greater opportunities to live a healthy life.”

“Investment in staff retention is a priority. Many senior, experienced staff are being lost due to poor working conditions, lack of appreciation and low wages.”
(Individual)

“Provision of more and varied social housing and related support would reduce the cost of people being in residential care (both financial and human costs).”
(Essex County Council)

Many of the comments related to where money should be spent (whether new investment, redistributed resources or savings). In some cases the link was made

with savings, in others the point was that the intervention, service or sector provides value for money. Some were concerned about overall levels of funding and the risk that any savings may not be reinvested in mental health.

Services and sectors

There was support for spending more upstream, with a particular focus on children and families. There were several examples of preventive work, including perinatal mental health services and work in schools. There was also a strong message about not reducing expenditure on services for people with mental health problems (in some cases specifying secondary services). Many respondents emphasised the importance of collaboration and streamlining organisations, and there were many examples of the kinds of service that respondents

considered did or did not provide value for money.

The Recovery Research Network made a value-for-money case for recovery orientation and peer support. There were various suggestions for 'step down' services and reducing the need for in-patient care or reducing length of stay. These include self-referral to peer-supported respite centres and similar. Psychiatric Intensive Care Unit (PICU) staff were considered best placed to link with the criminal justice system, which would assist with step down. The South West Yorkshire model for care pathways was recommended. Easier access and re-access to services was advocated by both service users and providers as a way of increasing value for money.

Voluntary sector services were cited as value for money, particularly small organisations serving specific communities, and user-led organisations. The BME Housing Consortium described their 'step down' service to Asian men. The Women's Resource Centre made the case (value for money and gender equality) for 'spending to save' on the women's community sector, particularly in relation to violence against women.

The value of investing in families, carers and informal networks also came out strongly.

Treatments

Better access to psychological therapies was a recurrent theme and there were calls for more social prescribing; a wide range of supports and interventions were suggested. Different therapeutic approaches and settings were advocated.

Respondents variously wanted less use of drugs, support for better medication adherence, better drugs, consideration of less expensive drugs, better assessment and case management in primary care which would result in more appropriate/effective prescribing, and implementation of NICE guidance. The Recovery Research Network made a detailed case for spending less on drug prescribing. Another respondent recommended a campaign to reduce the desire for, and prescribing of, antidepressants in mild depression (along the lines of the one relating to antibiotics for viral upper respiratory tract infections).

Social inclusion

Many aspects of inclusion were suggested, based largely around housing, education, work, recreation and money. One person described 'the pivotal moment' in their improving health being getting a nice flat with a secure tenancy.

Staffing

Many respondents advocated shifting the workforce balance towards frontline workers, and within that group from doctors to other mental health workers. At the same time there were calls for more administrative support (and/or use of IT) to enable mental health workers to focus on contact with service users. Others stressed the importance of employing more mental health service users or ex-users within mental health services. Staff recruitment and retention, training, support and screening are all mentioned as important, and there are numerous comments about negative staff attitudes or poor-quality service. There was a

suggestion to realign pay scales and HR in the NHS (rather than running separate medical and non-medical systems). One respondent also proposed that doctors should no longer be paid separate fees for assessing patients under Section 12 of the Mental Health Act, as other professionals carry out statutory duties as part of their primary jobs.

Commissioning and systems

Many suggestions were made about collaboration, integration and streamlining, with some respondents identifying conflicting quality assurance systems as wasteful. Some called for joint working, collaborative commissioning and common assessments; others for full integration of health, social care and other inclusion support. Various aspects of IT were considered wasteful and one respondent said the national IT programme should be scrapped. There were strong advocates of the Lean model and a range of views on Payment by Results.

There were some concerns about the 'NSF teams' and fragmented systems, some service user dissatisfaction with crisis teams, access, pathways, and to what extent they have been evaluated as providing value for money.

Out-of-area treatment was highlighted in some responses as wasteful, and various ways of tackling it were suggested.

Value-for-money services

Respondents provided details of numerous services as examples of value for money. Some of these are described below:

Early years

The Place2Be reported that its work with young children showed a return in excess of 600 per cent. It reported the average cost as roughly £90 per annum for each child, with positive improvement as measured by Dr Goodman's strengths and difficulties questionnaire in over 65 per cent of cases and a 'did not answer' rate of below 10 per cent.

Benefits of green space

The Woodland Trust said that the 'Walking the Way to Health Scheme' offered a saving of £7.18 in health care costs for every £1 invested. It reported Natural England as estimating that if the population of England was afforded equitable access to quality green space, the saving to the health service would be £2.1 billion per year; a figure equivalent to 2.3 per cent of the annual NHS expenditure.

Recovery orientation

Recovery Research Network cited a service called The Village in Los Angeles which reduced spending on residential and in-patient treatment facilities and reinvested the savings in work support. Randomised controlled trial evidence showed better outcomes for less cost. The service is still prospering, despite the current financial crisis in California (for further information see www.mhavillage.org). It reported that the Center for Psychiatric Rehabilitation, which provides clinical services through an educational lens, shows similar success in moving people on in their lives into socially valued roles and increased ability to self-manage (for further information see www.bu.edu/cpr).

Reducing bed base

Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust said that through reducing their in-patient bed base from 169 beds to fewer than 40, community services were excellent and savings significant (ie a surplus 14 years in a row, now of about £1 million a year), while quality and outcomes had improved significantly.

Other examples were:

- Coventry and Warwickshire Partnership Trust on abolishing routine out-patient appointments for some of those with long-term needs in favour of direct access by service users when needed;
- Sheffield Mind on voluntary sector contracting, specifically their psychotherapy provision;
- Race on the Agenda on the work of black and Asian minority ethnic community organisations; and
- The Women's Resource Centre on the preventive work of women's community organisations, especially with women affected by violence and abuse.

Government response

New Horizons: a shared vision for mental health affirms that value for money is not about cutting resources but about making efficient use of the resources available. It sets out promising areas for value for money interventions where further analysis is being carried out:

Improving acute care pathways and quality.

Improving access to early intervention across all areas and user groups.

Improving access to psychological treatment for people with long-term physical conditions.

Improving identification and treatment of depression among all age groups.

Prevention of mental ill health and improving mental well-being through early years interventions, school-based programmes, alcohol reduction programmes, early intervention for conduct disorder, physical exercise for older people with dementia or depression, and work-based support for employment.

The Department of Health is developing an online cost calculator to provide a ready tool to support value for money in effective local approaches to population well-being in both urban and rural areas (Action 7).

NICE implementation: the Care Quality Commission's commitment to include the availability of NICE-recommended interventions as a key indicator is a critical lever to improving local services (Action 81).

Mental health services: where the NSF established new services, *New Horizons* starts from the expectation that these are now in place and, in line with the Quality and Productivity challenge, are now being used as a key lever in the redesign of pathways and systems. Please see the final strategy document (Section 4: How we will get there) for the range of levers to deliver change.

Service user employment in mental health services: the Government is actively pursuing improved employment rates of people with mental health problems and people with learning disabilities, including within the NHS (Actions 45–50).

Workforce: a range of initiatives are in place or planned that will identify workforce issues and training needs, and provide training for staff working in health and social care and the criminal justice system (Actions 107–120).

Stigma in mental health services: the shift programme will continue to address stigma and discrimination in the workplace, which includes the NHS and mental health services (Actions 23 and 50).

Question 6: Innovative technology

“Which areas can you identify where innovative technology can help people with mental health problems, and their families? It would be particularly helpful to hear about examples of what works well in your local area and what could be done in the future.”

People suggested a range of uses for technology in mental health promotion, support and therapy, care planning and management, and improving quality of life.

Just under half of the respondents (49 per cent) answered this question.

“Computer literacy, especially the ability to find congenial company on some website. I know of one website which is devoted to philosophy and where personal problems are addressed rationally although with empathy and where the site owner and the moderators are efficient managers. One man whom I know from the website is a returned soldier from Afghanistan and he affirms that he is very much helped by discussions of his problems.” (Individual)

“The internet has helped me a lot, mainly because I have found so many other people who see the world in similar eyes.” (Individual)

Respondents identified the use of technology and its potential to support many aspects of mental health promotion and service improvement.

Mental health promotion

There were suggestions for using technology to contact people through the media they use, and to reach more people. Ideas included using the media for promoting mental health, computer-based learning for children (eg games with mentors), e-learning to promote self-help, and the use of creative media to support parenting.

Information, education and support

“The Living Life to the Full website is a relatively new resource and is growing each day. It clearly indicates that self-help and peer support is working more effectively than repeat prescriptions. In my area it is being promoted at the GP appointment. It obviously can't be used by those lacking computer skills and certain groups such as [those with a] learning disability

and people with sight and reading problems will find it inaccessible."
(Individual)

The web and other media were also put forward as ways of enabling people to access information, exercise choice, find peers, overcome barriers of social and geographical isolation, address language difference and literacy issues, and facilitate support and self-help.

The websites Second Life and Living Life to the Full were mentioned positively, and blogs, forums, Facebook, and online information and support in general were all cited as useful. Web access is an issue in institutional settings – in-patients, including those who are detained, and those in residential care were mentioned. Technology could help widen access, for example through alternatives to reading materials such as DVDs, as part of information and training for service users and carers, and through audio materials made for and by Travellers and translation computer software. Options for support included distance befriending, and telephone/teleconferencing.

Care planning, records, system access and management

Responses identified the potential for better communication, service user involvement, timely recording, and booking/buying/allocating treatment and care. Suggestions included the use of communications technology for care planning for use by both service users and care coordinators, web-based resource allocation systems, and smart cards for patient-held budgets. The use of laptops and PDAs by community staff allowed them to co-record notes/plans with service users on systems such as the Outcomes Star.

Diagnosis, assessment, therapy and care

"As part of our peer support networks for people with a diagnosis of dementia and their families we are looking into the use of social networking sites to allow both service users and their carers to share experiential learning and to develop coping strategies. The use of assistive technology would also be beneficial such as Telecare and Telehealth."
(Southend Borough Council)

A range of uses were recommended, for assessment, reminders and alternatives to face-to-face consultations.

Telecare for people with dementia was suggested, and one assertive outreach team referred to using telecare for a young man with alcohol problems to call for help. Some respondents proposed using text requests for contact/support as well as text appointment and medication reminders for the service user.

Respondents said that technology could assist directly with therapy through email counselling, online CBT, virtual hospital appointments via Skype for those who would prefer them and video-conferencing with international experts or across multiple NHS sites and/or the service user's home.

Several other therapeutic technologies were mentioned, including interactive computer games for depression, fitness technology (particularly for older people), biofeedback technology, and promotion of sound, colour and music healing.

Other aspects of treatment where respondents said technology could play a part were in assessment (examples were provided by West Midlands Access and Gay and Lesbian Youth in Calderdale), and medication – whether to reduce errors or monitor its collection.

Some respondents provided examples of using technology, including touch screens and a vox pop station, to gather service user feedback.

Safety and/or security

Other respondents mentioned using technology for safety or security in residential homes (eg sensors in care home bedrooms) and secure units (eg CCTV, de-escalation rooms, electrical fittings and thermal imaging being considered).

Social inclusion and recreation

A range of uses of technology were suggested to support recovery, improve quality of life, reduce digital inequality/exclusion, and promote social inclusion more broadly. It was stated that access to the internet is a social necessity for daily living and social contact, and that grants could provide laptops or mobiles. Examples ranged from Wii games and brain training to personal safety alarms. An MP3 player might help someone who hears voices to travel and GPS could help service users who are travelling on foot. Video links in prisons could be used to maintain contact between the prisoners and their children. The Chief Fire Officers' Association suggested installing sprinklers in accommodation for those vulnerable to fire.

Environmental sustainability

One response was from a team that uses electric bikes for home visits, thus reducing their carbon footprint and transport costs.

Non-ICT or 'hardware' technologies

A number of responses concerned technologies in the wider sense and included social prescribing, books on prescription, arts, better drugs, therapeutic use of nature and animals, NLP, meditation, energy therapies, skills centres and innovative day centres. The Recovery Research Network made a case for decision support systems such as Common Ground and for peer involvement.

Problems, disagreements and reservations

"I scrimped and saved to buy a computer; unfortunately my printer packed in and I can't afford to replace it at the moment. Are you getting the picture?" (Individual)

Problems with IT use that were identified were the failure to use it (such as trusts not using email), the amount of clinician time it can take up and the different strategic approaches to IT infrastructure development. There was also reference to the use of 08 numbers in the NHS and the cost for mobile users.

Numerous respondents said that technology was not needed. They believed that it could not replace listening and that the main issue was to ensure personal contact. Others supported the innovative use of technology as long as it was not at the expense of personal contact and/or that it was supported where relevant by appropriately trained/knowledgeable practitioners.

There was also a strong message that greater use of technology could reinforce digital exclusion unless steps were taken to prevent this.

Examples

BME Housing Consortium used multimedia and IT to raise awareness of mental health issues among Asian communities. In partnership with Asian male service users they produced DVDs and developed a website for Asian men with mental health problems. They are now working with young people of school age on producing a photographic comic.

Gay and Lesbian Youth in Calderdale (www.galyic.org.uk) have developed the GALYIC Needs Assessment Tool: "we use this to identify the holistic needs of young LGBT people who access our service. We have worked with a local firm, ReSurv, to put the NAT online and are hoping to roll it out to other LGBT youth groups in October. CAMHS and other services could also utilise the tool. It could also be adapted for use with BME and disabled youth."

"What works in this area is the 'Choose Your Own Home' website where prospective tenants of social housing are able to select where they want to live within the local area. They feel they are taking part in remedying their situation, and are supported through this by informed and trained professionals through a variety of access points." (Social Work Group working in Mental Health in Telford and Wrekin, Shropshire)

Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust are piloting 'Virtual Therapy' in their e-clinic facility within North Lincolnshire. 'Animate' is a partnership between the Trust, BT and the Digital Inclusion Unit. Residents in North Lincolnshire can access mental health workers and psychological therapies in live synchronous chat as well as by telephone, email and a virtual drop-in.

Government response

The Department of Health is leading a short series of focused workshops on the innovation landscape and will also explore any other ways in which innovation in mental health can be encouraged (Action 36). The Office of the Third Sector is supporting the brokerage initiatives Innovation Exchange and Health Launchpad, which aim to speed up the creation and development of social enterprises relating to long-term conditions (Action 37).

Concerns about loss of human contact: technology-based tools and aids which support people and promote their mental well-being are important resources for people who can benefit from them. Often these tools can help people to manage and improve their mental well-being in the community. However, the Government recognises that for many people, technological supports cannot be an alternative to human contact and to working with an appropriately skilled counsellor, psychological well-being practitioner (PWP) or psychological therapist. Indeed, for people with diagnosable problems such as depression and anxiety, it is imperative that technology-based supports like computerised cognitive behavioural therapy (cCBT) are used as part of the individual's care package, working under the guidance and support of a qualified practitioner.

Question 7:

Gaps in research evidence

“In your view, where are the current gaps in research evidence supporting the development of New Horizons?”

Respondents identified a range of gaps in mental health research, and wanted to see more investment in it and a wider range of methodologies explored.

Nearly half the respondents (47 per cent) answered this question.

Overarching comments received were about the need for more investment in mental health research and the need for service users to be involved. Responses provided a diverse range of suggested topics for research, and also suggested methods of research that are needed, or are underfunded or overlooked.

Investment in research

There were numerous comments about the need to invest more in mental health research (one person said that “dinosaurs get more”). Mental Health Research UK said that the New Horizons consultation document was “disappointingly quiet on the subject of research into mental illness”. They pointed out that “Whereas 25% of all UK research funding is spent on cancer only 6.5% is spent on mental illness and the burden of mental illness to

the UK economy is actually greater than that for cancer” (Kingdon D (2006) *BMJ*, 332, 1510). They were concerned that mental health should get its fair share of government research funding – “without it how will NICE have available to it the evidence that it needs to produce the guidelines of the future?”

Service user involvement

There were numerous comments about the need for research that is done with or led by service users. The Care Quality Commission said this should be an essential component of all large-scale/national evaluation of services.

Topics for research

A very wide range of topics for research were suggested, from tackling causes of mental health problems to evaluating different treatments and the impact of anti-stigma work.

Public mental health

People wanted to see research into mental health promotion and prevention, including environmental impacts on mental health. Well-being research should be applied to mental health and lessons learned from countries with better well-being rates. Specific topics for research included improving relationships, physical and genetic causes (including the developing brain) of mental health problems, vascular cognitive impairment in the over 50s, childhood abuse and conduct disorders, sexual abuse, media influences, debt, and drugs and alcohol. One response proposed Fetal Alcohol Spectrum Disorder as a priority as the biggest cause of preventable disability. The importance of good housing was also identified as a gap in New Horizons research.

Therapies

Various aspects of psychological therapies were proposed for research. In particular, there were concerns about the evidence gap around psychological therapies other than CBT, and the research methodologies recognised for evaluating them. Other issues included the cultural relevance of IAPT and alternatives to them. One person recounted their experience of using therapy to enable reduction of their medication dosage (a depot antipsychotic) and called for the CBT sessions recommended by NICE to be extended.

Other therapeutic areas included an overarching question 'What is effective for whom?', meditation, diet, holistic health coaching and creative therapies.

Social interventions and a focus on recovery were very important

to some respondents and they wanted to see, for example, more 'social perspective' interventions, research into what aspects of social interaction and community are important in recovery, return-to-work programmes, and decent living standards for long-term service users.

Some respondents considered therapies and services for people with particular conditions, for example personality disorder, dual diagnosis or self-harm, and "innovative support for the person living at home with dementia that is not based on a medical model".

Pharmacology

Suggestions for research topics in pharmacology included reducing drug side effects, the better use of drugs, gene research and natural alternatives to drugs.

Service and organisational areas/models

Numerous aspects of primary and secondary health care and social care were suggested as areas for research including models of primary care mental health care delivery, evaluation of the secondary services' specialist teams and their value for older people, mental health liaison, perinatal mental health, how the NHS and social services can best link, and access to higher-level social care.

Some suggestions were to do with service user outcomes and involvement, making services recovery-oriented, finding out what has worked for service users, and what 'really works' in personalisation. One respondent suggested looking at the relationship between patient choice and outcomes.

Other aspects of research into services included the impact of the changes to the Mental Health Act, restraint, day care for people with forensic history, physical checks and the criminal justice system's approach to people with mental health problems and learning disabilities.

Different groups, populations, communities

Different groups and communities were mentioned, including homeless people, older people and BME communities. The BME Housing Consortium said that research was needed into "the changing patterns and trends in mental health problems among BME and refugee and asylum seeker communities and among vulnerable groups within these communities. What works well for one group may not work for another." Their priority recommendation overall was to address the number of third sector organisations providing services for the most disadvantaged, marginalised and vulnerable groups who are hidden from mainstream services.

Other groups or areas mentioned were gender and mental health – including different experiences of stigma – children and young people, and those with autism.

Stigma, discrimination and rights

Some respondents addressed stigma and discrimination, including media impact and how to use the media more effectively to combat stigma, doubts about effectiveness of anti-stigma work, the impact of early education on attitudes and stigma, and human rights.

Approaches to research

These are forms of research that respondents said were needed, or were underfunded or overlooked:

- research with and/or led by service users and carers, including the most vulnerable young people (eg LGBT, disabled, BME), qualitative studies of lived experience and individuals' stories (eg journals);
- local evaluative studies, ethnographic and qualitative studies; and
- interdisciplinary research including applied sociology to address family/network/community aspects.

There was concern expressed about research evidence hierarchies, especially as they impact on psychological and social research.

Nottingham Institute of Mental Health referred to the need to attract high-quality research staff into the field, and to their own work in this area.

Government response

The Department of Health will, in discussion with research funders, take steps to achieve a greater range and level of research funding that better addresses identified gaps in knowledge and increases the level of research on prevention. The Department of Health will formally respond to the Medical Research Council consultation on the Strategy for Research in Mental Health (Action 35).

Question 8: Local leadership

“How can we support local leadership in building mental well-being and mental health care services? Please explain your view giving examples, if possible.”

Almost half of the respondents (48 per cent) answered this question.

People said that local leadership could be supported by a cross-government approach to mental well-being, community involvement in local strategies, joint training and joint working, support for clinician leadership, support for service user leadership, and opening up leadership programmes to the third sector.

National leadership

“An explicit cross-government approach to mental well-being would aid and support local leadership (similar to the cross-government approach to obesity). This can be supported on an SHA-wide basis to enhance consistency across local markets.”
(Public health professional)

One theme in the responses was national leadership as a support or precursor to local leadership. For example, one individual pointed out that the lack of investment in public mental health means that it is starting from a lower baseline and would particularly benefit from national and regional leadership. It was felt that within the Department of Health there needed to be shared leadership between Mental Health and the Health Improvement Directorate, while the Chief Medical

Officer needed to show leadership to regional directors of public health. Similarly, visible national leadership was needed in social care. There needed to be lines of responsibility and accountability, not just a vague “everybody’s business”.

Equality was another focus for national leadership, with the Men’s Health Forum calling for central leadership to ensure that providers meet the requirements of the Gender Equality Duty, and others referring to the Disability Equality Duty. One person was very critical of Monitor’s record on implementing equality and diversity legislation and so questioned their ability to monitor and support foundation trusts’ leadership on this. For this person, strong regional strategy and enabling compliance with equality and human rights legislation were the priorities.

Joint working and community engagement

“Free joint training across statutory and non-statutory sectors. Monitor the employment rates of people with mental health problems.”
(Community Links)

Joint or multi-agency working was a common theme, particularly work across statutory and third sectors and with the wider community and its leaders. Suggested ways to do this

included funds for local innovation and rewarding cross-working, public sector equality impact assessments that include social inclusion, removal of stigma, and mental well-being for the community, and involving community organisations more assertively in local strategies. There were calls for local implementation teams to be strengthened, although Sound Minds recommended they be abandoned in favour of specific mental health consultation. Communication and direct consultation with service users was emphasised by others too, and for local consultation to be targeted via the third sector towards marginalised groups, including those seeking asylum, and LGBT and BME communities. Beacon Counselling recommended training for mental health commissioners, whom they see as being “too reliant on a strict interpretation of NICE guidelines and unwilling to really innovate”, and greater investment in trialling new methods.

Leadership by service users

“Involve a larger number of service users in planning at all stages. Giving them more power in the voting process. This does not happen locally. Requiring they work with people who disagree with them on an equal basis.” (Individual)

The responses gave a very strong message about supporting the leadership role of people with experience of mental health problems and of having used mental health services.

There were general calls for a greater voice and more involvement for service users, and specific suggestions such as recovery

champions, employment of people with direct personal experience within mental health services, for example in crisis counselling, and their appointment to key policy panels. A number of user-led initiatives were mentioned as examples of projects that should be supported, for example Brainstorm (a music and arts group), Cooltan Arts, or the James Naylor Foundation’s Emotional Support Centres. One suggestion was for charities to be required to state how many service users they employ before they are given grants.

Suggestions of how to build service user and carer involvement into the structures of policy- and decision-making included making it compulsory that service user involvement is demonstrated in all aspects of service commissioning, and setting up an independent, national service user and carer organisation to participate in national forums alongside other stakeholders such as the NHS Confederation.

One example of involvement was provided by Patient Opinion. In addition to hosting patient ratings and comments on services across the NHS, the organisation said they were supporting NHS North West’s Strategic Health Authority’s Standing Conference for Mental Health Service Users, an informal body of service users who help develop policy. All participants can contribute opinions and comment on policy issues either directly or online to the Standing Conference.

Staff groups and professional development

“We should ensure that Mental Health is included in the existing NHS leadership initiatives and that those have a mental health focus. Too often, leadership initiatives are aimed at acute services and use only acute examples. Mental Health needs not to be excluded by the rest of the NHS!”

(NHS Information Centre)

A social work group working in mental health in Shropshire drew attention to confusion surrounding local leadership, and in particular the conflicts that arise for workers from lack of clarity between the PCT and the local authority as to their respective roles. They were concerned that too much worker time was diverted away from “‘real’ social work (the complex and fundamental business of supporting and enabling people to manage or recover from mental illness)” to data collection instead.

Numerous responses called for more clinical leaders, including nurse consultants, or leadership by other groups involved in direct care. Ways to support this included training, investing in leadership rather than promoting people beyond their abilities, recognising and valuing trained professionals (for example social workers, psychologists), involving frontline workers in the teams that advise commissioners, clearer staff roles with shared goals and more time to dedicate to priorities, formal posts for clinical leads with ring-fenced time and supervision/support, and facilitation of networking between leaders locally across disciplines and nationally among clinical leaders.

“Networks that work!” was one person’s response, signposting www.jan-net.co.uk.

One foundation trust said that what does not work is when managers impose change from an ideological stance, and what does work is when clinicians lead and present solutions to managers who can then manage the change.

Other suggestions were for support and development for mental health commissioners, support for the leadership role of the chief pharmacist in medicines management and holding them accountable for governance of the use of pharmacological treatments in mental health, more say for careworkers, empowerment through career development and raising the status of the field so that people want to work in it.

A health improvement adviser was concerned about the invisibility of their “skilled and specialised field that sees no real national discussion” and was “desperate” for backing.

Leadership development

Numerous responses referred to education and training, and some to coaching and mentoring as well. These included education and coaching in leadership skills, but also education of leaders, such as MPs, in mental health issues and awareness-raising. One organisation delivering low-level therapeutic approaches wanted leaders to understand that these approaches can be safe and effective and do not need to be delivered by therapists. Several respondents mentioned funding, for example in a trust where preventive mental health was

low on the agenda. People wanted to see leaders that were accountable, kept in direct contact with service users, carers, staff and communities, and had a focus on delivery and outcomes. One suggestion was for a tsar or other independent person in every area, another was for the use of specific, measurable, achievable, realistic and time-bound (SMART) objectives. There were calls for more support for third sector organisations and for their inclusion in leadership programmes.

Government response

New Horizons addresses national leadership through the Ministerial board, support to local government through the Total Place initiative, recognition of the importance of clinical leadership in the Next Stage Review, the role of Royal Colleges, professional and third sector organisations in leadership, and the role of the National Quality Board (see the strategy document, Section 4: How we will get there).

Actions 51 and 52 describe steps to support volunteering and community-building, including leadership issues.

Service user involvement: service users will be involved in developing the different strands of work in the New Horizons programme. The Government agrees with strengthening service user involvement and expects trusts to be able to say how they have involved service users in their work. Equality impact assessments should help ensure this takes place.

Question 9: Joint working

“How can we promote joint working between local authorities, the NHS and others to make New Horizons effective in your local area?”

Half the respondents answered this question.

Many respondents described joint working that was already happening, but in general indicated that much more action or support was needed in this area. Recommendations included better communication and coordination, mental health targets, more accountability and more collaboration between the statutory and third sectors. People did not want to see any additional bureaucracy.

“Start off with the philosophy that we want the same result. Better lives for people who suffer from mental ill health. Not be too precious about who does what as long as the input is helping the individual. Move toward a single pot of money.” (Individual)

Strategic partnerships, commissioning and targets

“Our measures are your measures.” (East Riding Partnership Board)

Numerous responses called for more joint commissioning, integration of health and social care and more pooling of budgets. Others did not want to see structural change so much as shared vision, agendas, targets and review processes. Some wanted both. The Sandwell Mental Health Economy recommended

the creation of a new joint New Horizons/Well-being commissioning group. Some respondents saw a role for coordination and liaison posts to facilitate joint working and access to different parts of the system. Single points of delivery also featured among the suggestions. The tendering process was seen as a barrier, or alternatively a means to encourage cooperation and collaboration across artificial boundaries.

There were references to the importance of local strategic partnerships and there were positive comments about PSA 16 targets encouraging joint working. Several suggestions were made to support or add value to joint working at this level:⁷

Public Service Agreements (PSAs)

- Introduce a new mental health/well-being PSA.
- Identify the many existing National Indicators (NIs) that have a mental health benefit with a recognised mental health ‘badge’ or otherwise make them explicit (as has been done for food and health).
- Include community and population level indicators of well-being in NI sets and/or indicators that are more specific than the current one, such as workplace health and well-being programmes (eg Mental Health First Aid Training).

- Replace the Autumn Assessment, which measures inputs, with more effort to map outcomes and service quality.

Support for commissioning and implementation

- Provide more support to help local strategic partnerships understand the mental health needs of their populations and the relationship of mental health to the breadth of local policies such as housing and transport.
- Use the innovative practice of the Mental Well-being Impact Assessment, which recent evaluation has shown to promote joint working between a wide range of local partners.
- Incorporate and build on learning from Supporting People commissioning.
- Produce NICE public health guidance targeted to different audiences.
- Provide a national mechanism for sharing good practice.

Other measures

- Set targets from different government departments that genuinely match (for example changes to adult education funding and targets do not support the modernising mental health day services agenda).
- Incorporate improving mental health and well-being as a key deliverable in the work held by deputy regional directors for social care and partnerships in government offices.
- Join up the national work on Payment by Results and personalisation by piloting a series of local “integrated approaches” to inform subsequent guidance.

Another comment was that client-centred programmes bring agencies together. The *Journal of Public Mental Health* cited specific parenting programmes and self-harm programmes as examples of services that demonstrated “the willingness of agencies to cooperate around clearly defined needs”. NHS Suffolk recommended focusing on specific areas or groups, such as people with dementia, for implementing joint working.

Local champions had helped make joint working successful, and senior level mental health champions were recommended.

Numerous responses called for some kind of enforcement or sanctions around joint working or lack of it. There was a recommendation that local strategic partnership boards be mandated to monitor joint working and calls to embed New Horizons in Care Quality Commission and Audit Commission reviews. My Time CIC made recommendations as to how to empower citizens – a mental health ombudsman, citizens committees in professional bodies such as the HPC, and local surgeries whereby commissioners maintain contact with the public. Progress said that New Horizons should dispel the idea that dual diagnosis is a specialist area and advocated sanctions against insularity.

IT and the lack of connectivity between information systems was identified as a barrier to joint working that needed tackling. Other barriers were geographical boundaries and differences in work culture.

Sefton Council and NHS Sefton suggested developing joint cluster working along common NHS boundaries, where a trust works with different local authorities.

The Depression Alliance pointed out how lack of understanding across work cultures prevented service users getting the full range of treatment options. They wanted to see people with depression leading on training for staff on depression and effective routes to recovery. Other responses included numerous suggestions of how to increase contact and hence understanding between different sectors, agencies and staff groups, for example through joint workshops and awaydays, secondments, sharing the same physical space, and developing a shared language.

Numerous responses looked at the range of sectors and agencies that should be working jointly. There were comments saying there was an imbalance between statutory and third sectors in the *New Horizons* document and in practice. These respondents wanted to see the third sector as a more equal partner and not just the recipient of funds. Other services and sectors mentioned included substance misuse teams, housing associations, the police, probation service, the pharmaceutical industry, unions and medicines management.

There were calls for service user involvement, which one person identified as a way of addressing the lack of mental health awareness and understanding that may be a barrier to joint working:

“Local authorities need more mental health knowledge. I am currently assisting my local council with a scoping and scrutiny review they are doing of local mental health services. This is good for me to share knowledge and also have a lot of input – as well as being valued. As service users we can describe the effects of mental health and what works us in living our lives and trying to mitigate the disruption and distress. We also know a great deal about the system and are keen to pass this onto community leaders and the NHS managers.” (Individual)

Examples of joint working

“The STAR project in Nottingham is an excellent example of partnership between health, housing and advocacy working together to rehabilitate people suffering from severe mental illness.” (Individual)

“In Coventry there are good examples of agencies coming together to tackle shared problems/ issues (eg with regards to the use of the Mental Health Act, mentally disordered offenders, housing and homelessness, adult safeguarding, employment, etc).”
(Coventry City Council)

The appointment of a Specialist Mental Health Officer in the Greater Manchester Fire and Rescue Service is an example of collaborative prevention to help to reduce fire deaths in the Manchester area, by helping fire service personnel more fully understand the needs of people with mental health issues and, through Home Fire Risk Assessments, to reduce the likelihood of a fire. The initiative is jointly funded by the Greater Manchester Fire and Rescue Service and the Manchester Mental Health and Social Care Trust.

The East Midlands Perinatal Mental Health Network – “an example of specialist services developing a comprehensive and integrated model of care across all tiers of service delivery, driven by standard setting and clinical need”.
(Royal College of Psychiatrists)

“The West Midlands Health and Well-being Strategy which brings together the broader issues which affect people’s health such as access to transport, good housing and economic issues. Extensive work has been carried out with various organisations and partners from different agencies on how these areas affect peoples overall health, including mental health, and the Regional Health Partnership champion work in areas such as skills and equality. This takes the work well beyond the traditional boundaries of the NHS.”
(West Midlands Regional Assembly)

“Within Sunderland the Delivering Race Equality (DRE) Team has upheld a partnership approach to delivering awareness-raising and training of local interpreters about mental health. The DRE approach has been used as a model of good practice within the region.”
(Sunderland Mental Health LIT)

Examples using the Innovation Fund associated with PSA 16:

- In Hampshire, Supported Housing Panels at district level, involving a range of service providers and stakeholders, review applications for supported accommodation and housing related support and attempt to ease blockages in move-on accommodation provision.
 - In Brighton and Hove, a rehab ward was closed and replaced by a community based service with 12-hour, 7-day floating support, supporting more than five times as many people as the funding would previously have allowed.
 - The Kent Joint Policy and Planning Board (Housing) includes representation from housing authorities, Supporting People, health and social care professionals and probation services, and seeks to ensure partnership arrangements to deliver housing schemes for people suffering from mental health problems and other vulnerable people.
- (RAISE)

“The development of the Wakefield Integrated Substance Misuse Service could be regarded as a good practice model that exemplifies the process where multiple community agencies can collaborate to develop and deliver a cohesive multi dimensional intervention – www.wisms.org.uk/.”
(Family Action)

Government response

New Horizons recognises that only a robust partnership across the public, private and third sector working with local people will deliver the necessary change to improve mental health and well-being for individuals, families, carers and communities of all ages and backgrounds. Section 4: How we will get there, in the strategy document, outlines the levers available at different levels to deliver change.

Measures to support public mental health are set out in Actions 4–11, including work that the Department of Health will undertake with other government departments to identify future priorities and ensure that policies consider the impact on well-being (Action 11).

The Department of Health is working with NHS North West and partners to support local organisations to determine needs and assets within their communities and so enable commissioning for well-being outcomes (Action 106).

Question 10: Inequalities

“What do you think are the most important steps that the Government can take to reduce the inequalities that affect our mental health? And why?”

This question prompted a wide range of responses about different aspects of inequality – unequal access to mental health services, discrimination on mental health grounds, discrimination on all the grounds covered by legislation (age, gender, ethnicity, disability, sexuality, and religion and belief), poverty, income and class inequality, and the inequality between mental and physical health as sectors or services.

For more detail from people’s responses, please see the Equality Impact Assessment published alongside the strategy document and available at www.dh.gov.uk/newhorizons

“Reduce poverty, raise awareness, teach friendship and collaboration, root out abuse, concentrate on parenting and Sure Start classes for any parent who may be vulnerable or likely to abuse or neglect, address the overrepresentation of black people in the mental health system, destigmatise and even praise those with mental distress for getting through!” (Individual)

Poverty, unequal society, class, social inclusion

Numerous respondents call for a reduction in income inequality in

society, often citing the work of Wilkinson and Pickett (*The Spirit Level*, 2009). One said that failing this, “a greater shared sense of ownership of mental health (as proposed by New Horizons and before that the SEU report of 2004) really is the right way forward” (RJA Consultancy).

The Royal College of Psychiatrists’ Old Age Faculty highlighted pensioner poverty and their recommendations for improvement included financial support for carers of older people, redistribution of wealth, and government policy that looks beyond economic productivity. They, and others, commented on social values, for example questioning the view that occupational success or accumulation of wealth are the basis for happiness.

Respondents suggested a number of ways to address poverty and inequality including the use of mental health and/or well-being impact assessments, for example in social housing allocations.⁸ Other housing measures included tenancy support programmes such as rent deposit schemes and Mortgage Rescue, renewing ring-fencing of Supporting People, and more mental health training for staff of homelessness and supported housing services. There were calls to improve the quality of decision-making for Employment and Support Allowance, provide greater support for income maximisation through the care programme, simplify the benefits and tax credit systems, and address the unintended consequences of benefit changes for people with fluctuating mental health. St Mungo's argued for a focus on rough sleepers and the chronically homeless as being among the most excluded of the excluded.

Recommendations on social inclusion more generally and employment were to tackle stigma and discrimination in the mainstream services especially among staff who are the first point of contact, renew PSA 16 targets, provide support and advice to employers and publicise Access to Work.

Discrimination on mental health grounds

The inequalities resulting from mental health discrimination featured strongly in responses to this question. Areas of discrimination included employment (particularly confidentiality of records and the use of pre-employment questionnaires, insurance, access to physical health

care (see *Health inequalities* below), access to social care, and discrimination within mental health services).

Proposals included:

- legislation against discrimination on the grounds of mental health with wider powers than those given in the Disability Discrimination Act;
- more service user and carer employment in mental health services;
- a regional tsar to hear complaints;
- attention to mental health staff training, selection and retention;
- a national service user reference panel "with teeth"; and
- steps to ensure equal access to social care services for people with mental health problems.

Black and minority ethnic communities

"The magnitude of ethnic disproportionality, particularly on medium/high secure wards, also in terms of access to primary mental care and psychological treatment, demands more than an in-principle aim to tackle such issues."
(National Black and Minority Mental Health Network)

"Addressing the health inequalities experienced by black and minority ethnic groups and newly arrived communities has to be prioritised as the current ethnic discrimination experienced in services is unacceptable."
(College of Occupational Therapists)

Numerous respondents emphasised the need to tackle the inequalities experienced by BME communities and to continue Delivering Race Equality or indicate how this work would be taken forward. Key points were to:

- engage with BME communities;
- make services accessible to BME communities;
- raise awareness of mental health within BME communities;
- train staff in cultural competence and race equality;
- ensure that diversity is central to public mental health;
- tackle the complex stigma and discrimination faced by BME communities;
- value, support and work with the BME voluntary sector; and
- ensure that the workforce reflects the diversity of communities served.

Specific suggestions included assessing the appropriateness of IAPT provision for BME communities, a big increase in mother tongue counselling and interpreter services, and providing mentoring and befriending particularly for refugees and asylum seekers. There were calls for the full RECC (Race Equality and Cultural Capability) training to be provided. One community development worker (CDW) identified a “clear gap” in counselling and mentoring provision for young children (from age 6). The union Unite said that children and young people who were refugees or asylum seekers should be assumed to have mental health problems and be assessed.

Practice examples included:

- work in Tower Hamlets to ensure that the Bengali population is properly served;
- Sheffield City Council’s “Transcultural Team” that recruits and supports people from BME communities into social work careers;
- the model used by community development workers (CDWs) in Kent and Medway whereby they operate short-term placements in areas of need, pump-priming race equality; and
- cultural awareness training for mental health staff by Friends, Families and Travellers.

Sexual orientation

There were comments about a lack of attention to LGBTQ (lesbian, gay, bisexual, transgender and questioning) people in New Horizons, and the high prevalence of mental health problems in this group. Homophobia and bullying in schools was identified as a particular problem. The Lesbian and Gay Foundation called for more specialised services (such as LGBT counselling services) to work alongside mainstream services, particularly in areas outside cities and large towns. They pointed to isolation in the LGBT community, especially for older people whose needs are often overlooked or assumed to be identical to those of heterosexual older people. Other needs were for more preventive work to tackle homophobia throughout school years, role models at a senior level, early intervention, and staff training to create services where lesbian, gay and bisexual people feel comfortable, safe and accepted.

Age

Child poverty was raised by respondents including the disproportionate poverty of Black, Asian and Minority Ethnic (BAME) children and young people, and there were calls for an adequate income for families with young children. The needs of looked after children were also highlighted. The Darzi regional leads said that prioritising young people would help reduce future inequalities. Youth Access wanted young people's issues to be understood and addressed holistically, with alignment and pooling of youth funding and access to counselling services through targeted youth support teams.

Age discrimination and the social isolation and poverty of older people were raised by respondents including Age Concern, Help the Aged and the Royal College of Psychiatrists. In addition to implementing age discrimination law, recommended measures were scrapping the default retirement age, reforming the benefits system to provide automatic payment of entitlements, and building all new homes to Lifetime Home standards. Prevention activity should be resourced in all services (for example podiatry, optician, utilities, lifelong learning) and the "well elderly" be encouraged to plan ahead.

There were also calls for a level playing field in terms of funding for services for older people with investment in specialist services (please see Section 11 for more detail). Some respondents wanted to see more effort and/or campaigns to meet the needs of older people

with undiagnosed depression and for older people to have access to psychological therapies through the IAPT programme.

The Foyer Federation supplied an example of intergenerational activity in which young people provided information technology training for pensioners and pensioners assisted the young people with gardening skills to establish an allotment, resulting in "a dramatic shift in attitudes" in both groups.

Gender

Organisations including the Women's Resource Centre, Race on the Agenda and Newham Asian Women's Project asserted the importance of a gender specific strategy and/or services. They focused particularly on the impact of violence against women, providing extensive evidence of the links with mental health and highlighting the role of the specialist community sector in meeting women's needs, including those of BAME women.

Mind highlighted the way in which men experience and manifest mental distress differently to women and the differences in how men seek help. They called for a men's mental health strategy to match the women's mental health strategy.

The Gender Equality & Women's Mental Health Network said that more directives and assertiveness were required from the Government to reinforce Public Sector Duties.

Disability

“There needs to be much greater use of the DDA [Disability Discrimination Act] – and a greater emphasis on reasonable adjustments in all mental health support services to meet the needs of all. In particular, the mental health needs of people with a learning disability – all aspects need to be accessible – from diagnosis, information, treatment, person centred approaches, etc.” (Challenging Behaviour Foundation)

Respondents raised access issues relating to people with specific impairments or characteristics including deaf people, those with visual impairment, people with learning disabilities, and people with facial disfigurement.

For example RNID said that the mental health workforce should include people who are deaf and that some services be delivered using British Sign Language (BSL). They gave as an example staff of SignHealth Counselling who are deaf themselves and training as counsellors using BSL. They also recommended extending training beyond traditional professional boundaries so as to move towards more inclusive services and person centred approaches. An example is the Certificate in Mental Health & Deafness. Part-funded by RNID, and in association with Birmingham University, by a collaborative of hearing and deaf people and organisations, its first intake of participants is in March 2010.

Religion and belief

Most comments about religion concerned respect for religion and belief, provision of spiritual care, the role of faith leaders and communities in mental health promotion, and concerns about community relations. There were some comments about the mental health benefits of faith generally or particular faiths (“Legitimise Christianity as a useful system for building a happy persona”) and also criticism of religion and/or religious organisations as oppressive (“Christianity (and other religions) have been used to oppress women, black people, disabled people, LGBT people.... for centuries”).

Unequal access of different groups to mental health services

“Recognise Adult Attention Deficit Disorder and give funding as people like me, and their families, are really suffering and the UK NHS is way behind in this field and I think it is discrimination. It's not bad enough that I find my life is ruined at 35 but also there is no help, be it medical or financial or support, it's absolutely terrible.” (Individual)

In addition to the groups covered by antidiscrimination legislation, a number of groups were identified who had unequal access to mental health services. These included people made unequal by circumstances, or whose condition was less well served by mental health services – homeless people, those with substance misuse issues, people in the Armed Forces and veterans, adults with attention deficit disorder, and prisoners.

The King's Fund said that, "Given the higher prevalence of substance misuse problems among people with mental health problems, those in the criminal justice system, and people from lower socioeconomic groups, a strategy to reduce mental health inequalities needs to give prominent attention to this issue." Developing Partners recommended taking a human rights approach targeting the most excluded and vulnerable, saying that if it worked for them it would work for all. The British Medical Association were concerned about younger patients with cognitive impairments from alcohol and drug related brain damage and saw the lack of specialised services as a form of age discrimination.

(Homelessness and substance misuse are discussed in more detail under Question 1.)

Inequality of mental health as service/sector in relation to physical health services

There was a strong message throughout the consultation that respondents wanted to see mental health problems being given the same priority as physical health problems (as well as being treated together holistically), with equitable funding and provision.

Health inequalities

"When it comes to physical health, it is my experience that if you have a mental health problem, your GP doesn't take [your] physical health seriously. They think you are making things up." (Individual)

Responses covered issues of access to physical health care for people with a mental health problem and access to healthy living advice and opportunities. Personal experiences illustrated some dismissive attitudes on the part of health professionals towards physical symptoms experienced by people with a mental health problem, including medication side effects, and lack of support to optimise physical health, for example by eating well and exercising.

The Future Vision Coalition, among others, recommended that proactive physical health checks and healthy lifestyle support should be provided by GPs to people with severe and enduring mental health problems. Coventry City Council specified the affordability of opportunities for healthy living and exercise. Another respondent specified free exercise for anyone on mood stabilisers and antipsychotics. The Mental Health Foundation said it should be standard that anyone receiving mental health support should also receive information about how to maintain good physical health.

Some respondents focused on smoking. Fresh, Smoke Free North East said that smoking was the number one cause of health inequalities, a point also made by the Faculty of Public Health. They pointed out the links between smoking and both deprivation and mental health, and the greater difficulties that people in marginalised groups have in quitting despite being as keen as others to quit. They therefore called on the Government to continue to take action on smoking and prioritise marginalised groups in the design and targeting of all stop

smoking services, campaigns and interventions. Delegates at a Royal College of Psychiatrists' summit on smoking echoed these points and said that health inequalities would increase unless greater smoking cessation provision were made for people with mental illness than for the general population. Their suggestions included using Commissioning for Quality and Innovation (CQUIN) contracts and Quality and Outcomes Framework (QOF) indicators to this end, and involving service users and carers in clinical guidance. However one or two respondents criticised the smoking ban in hospitals and Bright recommended that the ban be reviewed, and only enforced if compensatory measures were in place. This should include support for those who want to cut down rather than quit.

Cross-cutting issues

The NHS Next Stage Review regional leads commented on a need for accessible information on local prevalence, needs assessments and inequalities so that the information is available and the problems can be owned by local commissioners as well as government, as in the London dementia needs assessment.

The Social Perspectives Network called on the Government to publicise further the successes of social work, particularly with the media: "A more confident and better respected profession would be more effective at tackling inequalities."

Homeless Link considered it imperative to expand access to psychological therapies to all client groups, for example those with complex needs, personality disorder, drug or alcohol problems, and to older people.

Government response

Please see the Equality Impact Assessment for New Horizons. The evidence in this report will be used to inform the work being undertaken to revise and progress the existing Equality Impact Assessment, and this assessment work will be completed by the end of April 2010.

A continuing equalities programme is being developed in the light of New Horizons and consultation responses. A New Horizons Ministerial Advisory Group for inequalities and mental health, involving external stakeholders and chaired by the Minister of State for Care Services, will help monitor progress and advise on strategy (Action 3).

The Equality Bill, subject to parliamentary approval, will provide strengthened protection against discrimination (Action 22).

The public mental health framework for well-being will be providing a structure to address the wider determinants of mental health and well-being and deliver interventions targeting areas of most need (Actions 4–11).

Further specific actions are as follows:

Age

The Department of Health is working with partner organisations on initiatives to promote better mental health and well-being and non-discriminatory care for older people (Actions 103–105 and *Annex A: Characteristics or descriptors of non-discriminatory services for older people*).

BME communities

Delivering Race Equality (DRE) in Mental Health Care – A Review (summary report, December 2009) sets out what has been learned from this five-year action plan and how activity should be focused in future (Action 102).

Gender

Actions 67–70 set out actions against violence and abuse, including strands focusing on girls and women.

Physical health

Actions 71–77 set out a range of measures to address physical health inequalities, including improving the psychological assessment and management of long-term conditions (including medically unexplained symptoms), supporting liaison mental health services, health promotion, workforce development and training, and research.

Employment

With respect to people of working-age, the cross-government framework *Working our way to better mental health* is designed to improve well-being at work for everyone, and deliver significantly better employment results for people with mental health conditions. *Work, Recovery and Inclusion*, is a cross-government delivery plan for England to support people in contact with secondary mental health services into work. (See Actions 45–50 for a summary.)

A new package of measures will improve support for people who have mental health conditions, including:

Mental health and well-being messaging in the current phase of the *Find Your Way Back to Work* campaign for all jobseekers.

A mental health coordinator in every Jobcentre Plus District – a new role designed to build practical links between health and employment services at local level (eg with IAPT), and provide information, advice, and guidance to Jobcentre Plus advisers.

Improvements to the management of transitions between ESA and JSA for people who may have mental health conditions, by ensuring advisers have appropriate skills, and are knowledgeable of local provision, to support customers where appropriate.

A research project to identify the incidence and prevalence of psychological distress among new claimants of Jobseeker's Allowance to inform policy development.

Question 11: Age transitions and interfaces

“How best can we improve a) the transition from child and adolescent mental health services to adult services, and b) the interface between services for younger and older adults? What works well in your local area? And what does not?”

There was strong support for addressing young people’s transitions and providing non-discriminatory treatment and care across the whole age spectrum. Overall respondents wanted flexibility so that people could access the services best suited to their needs, and appropriately skilled staff.

Approaching half of the respondents (46 per cent) answered this question.

Young people’s transitions

Most, though not all, of those answering this question addressed the issue of transitions for young people and gave strong support for tackling it. Some personal accounts highlighted the need for age-appropriate services for young adults.

One young woman gave a detailed account of her traumatic experiences of adult services and A&E after moving from Scotland to England aged 17 to go to university. There was no sharing of information by CAMHS in Scotland, no support for her as a young person on an adult ward, and no psychiatric liaison at A&E following self-harm.

“I present this to you in the hope that something may change as a result of this horrible and traumatic time in my life. I think, perhaps, I hope that it will stand out amongst the dry statistics and make you angry and hungry for change.”

Another respondent wrote about the impact on a young man of entering adult services: “he felt traumatised, scared, and this tainted his opinion of mental health services.”

Respondents’ concerns were not only about the transition between services, but also about the transition to adulthood. According to the Foyer Federation, “research in the USA⁹ has shown that early interventions are not sustainable unless more attention is given to support young people (aged 16–25) in their transition to adulthood”.

The Transition Information Network urged learning from *Aiming High for Disabled Children* (May 2007).

Service structure and age thresholds

There was support for the proposed youth service although a concern was expressed that reorganisation could increase complexities: "The 14/24 service would be terrific."

Respondents suggested various upper ages for young people's services ranging from 18 to 30, but the main message reflected that of the young people who Young Minds consulted with – that services should be flexible and based on need not arbitrary age cut-offs. One suggestion for avoiding hard cut-offs was to have overlapping services, for example CAMHS resourced to see people up to the age of 25 and adult services starting at 16, so that people could choose appropriately for their needs. But critically, no-one should be left without a service, and if a young person could not access Adult Mental Health they should stay in CAMHS.

There was also a view that with a more person-centred approach there would be less need for separate services, and some people disagreed completely with age-based services.

There were variations on the themes of joint working and service unification, with views that teams or the whole service should be unified or work jointly. There were calls for improved joint commissioning, clear pathways, co-location of services, and work across the age interface. Early intervention teams were cited as a good model, although a concern was expressed that they did not have CAMHS training.

Respondents mentioned a range of specific needs of different young people, for example those who are homeless, have experienced sexual trauma, are in or leaving care, those with autism, ADHD or an eating disorder, those with any emerging condition not covered by early intervention teams, single mothers, and those entering forensic services.

Making the transition

Respondents wanted to see clarity about responsibility for young people's transition between services. There were variations in the transition processes proposed or described, which included transition planning groups, teams and key workers, but they were all geared to ensure that there was planning for transition and a good process implemented.

As regards the content of transition, people wanted to see person-centredness and multi-agency care planning – to ask young people and families what they want and give it to them, to use personalisation tools, and to be flexible about the timing (both transition itself and appointments). One person, speaking from their own experience, said to explain to the young person that they can make choices as an adult.

The editor of the *Journal of Public Health* referred to the role of health facilitators working in primary care with school leavers with learning disabilities, but pointed out that they could only have limited impact if GPs were not interested in providing continuity of care.

A strong theme in the responses was the difference in approach and quality of CAMHS and AMH: "In a

way my son was lucky that he was under 16 when he became psychotic as he avoided being sectioned and had very good treatment." One respondent said that the transition process should set expectations of how services differ. Others focused on making adult services more like CAMHS. For example, one said that the trauma and developmental perspectives get lost in adult mental health.

"...because of my mental health difficulties, I was unable to function as an adult at the age of 17 when I was transferred to adult services, and was denied therapy because I 'wasn't trying hard enough' whereas in CAMHS it had been understood that therapy was hard for me, and I was gradually supported to engage more and more in it." (Individual)

There were comments about staff skills and mix, and about ways of joint- and cross-working to optimise the use of skills in working with young people at transitional points. Suggestions included co-location of services, community day services for all, adult therapists in the children's team and vice versa, work placements in each others' services, rotation posts and more joint posts. Other suggestions were that counsellors working with young people in adult services should be trained to work with children and that youth support workers should continue working with young people after transition to adult services.

Children and young people's services

Numerous responses concerned the content and quality of children and young people's services generally, rather than transition as such.

Key messages were to listen to children and young people, take them seriously and provide explanations, to treat young people as young people and not children or adults, and to meet the whole range of their needs and include/support the family. Young Minds stressed that involving young people in the development of services should be seen as standard.

Various aspects of service content, quality and staffing were mentioned. The Foyer Federation said that the service users they surveyed most valued one-to-one personal support. Other recommendations were for good relational therapists, more school counsellors and other school- and college-based work, involvement of young people in delivering mental health awareness training, better in-patient environments, support for young carers, and a mental health direct line for parents.

Wider policy and systems issues

Some respondents had concerns about eligibility. Children of people with mental health problems may not be seen as children in need, supported young people may not be eligible for social care, and the broader approach of early intervention is only available to those with emerging psychosis not other conditions.

There was concern that the *Aiming High for Disabled Children* (May 2007) recommendations should apply to children with mental health problems as with other disabled children and/or provide learning for mental health services, and the SCIE toolkit for Mental Health services – *Think child, think parent, think family* – should be adopted.

Older people

“In real communities, age groups mix so reduce the segregated nature of services and promote inter-generational support and mutual self-help.” (Individual)

Respondents wanted an end to age discrimination and to see equality of service either side of age 65 with public mental health interventions and service developments that target, or are inclusive of, older people.

Respondents said that older people’s mental health was neglected and the disparity between funding of older and younger adult services was discriminatory. They commented on poverty and isolation in old age, discrimination in benefits and housing, ageist notions that mental health problems are a natural and inevitable part of ageing, and

unrecognised depression among older people. Prevention and promotion was needed to address poverty, housing, isolation, physical health issues, and bereavement.

They wanted equitable access to psychological therapies, in line with NICE guidance, and full inclusion of older people’s needs and perspectives in all the elements of New Horizons – for example Gateshead’s Older People’s Mental Health Services called for preventive services such as memory clinics; information and options to provide genuine choice; simple pathways (for dementia services, for example); and paying attention to older people’s dual diagnosis needs.

There was support for services being based on individual need not age and there were a number of general comments about not separating or segregating people by age.

There were also strong statements about maintaining and investing in specialist older adult mental health services as having the skills to support age-appropriateness in the rest of the system. The Older Adult Network of Lancashire Care Foundation Trust said, “Current older adult services, though evidentially under-resourced (PSSRU, 2008), have the skills and expertise and a workforce who have chosen to support older people with mental health problems. If New Horizons is truly committed to non-discriminatory care then it would be sensible to invest in specialist older adult services first, who could then offer practical support and advice and guidance to younger adult services in re-shaping their ageless services so that they become flexible and age-appropriate.”

Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust argued for separate services, saying that older adults needed “equitable services, not the same services”. However, this did not imply inflexibility on when or whether service users move from one service to another: “We have a needs based service, not age based service, for this. If needs continue to be met within working age services, they stay in that team. If they develop problems that are better met in older adults’ services, they graduate to there.”

On the issue of integrated or separate services, the Mental Health Foundation (who made a range of other recommendations as well) focused on skills, saying that “the expertise of staff working in specialist older people’s mental health services must be maintained, regardless of any integration or reconfiguration of services”.

Age Concern and Help the Aged called for a single Resource Allocation Scheme across all age groups to ensure equitable funding. The Mental Health Foundation recommended that the Care Quality Commission should establish appropriate Quality of Life outcome measures against which older people’s mental health services could be judged, and ensure that older people receive an equitable level of care to younger adults, particularly in the light of forthcoming Equality legislation.

There was also a proposal to have a single data set and not perpetuate age divisions in data collection.

Government response

Work to support effective transitions and good practice in services for adolescents and young adults is set out in Actions 41–44.

The Standard NHS Contract for Mental Health and Learning Disability Services, to be used from 2010, includes the need for locally audited transition protocols as part of care planning, and requires reporting of any age-inappropriate admissions to adult wards.

Many services have taken action to improve access to services by reducing the time children, young people and families have to wait for support. The Department of Health and Department for Children, Schools and Families' guide, *Improving Access to Child and Adolescent Mental Health Services*, aims to help services deliver this by showing how to achieve a low-wait CAMHS.

Information on programmes to support children, young people and their families are at Actions 16 and 38–40, and *Keeping children and young people in mind: the Government's full response to the independent review of CAMHS* sets out in more detail the Government's plans for the future of children and young people's mental health.

The Equality Bill, subject to parliamentary approval, will strengthen protection against discrimination including on the basis of age (Action 22).

The Department of Health is working with the Royal College of Psychiatrists on a toolkit to assist in the development of age-appropriate non-discriminatory services (Action 103 and *Annex A: Characteristics or descriptors of non-discriminatory services for older people*), and reviewing staff training needs (Action 109). The Department of Health is also working with Royal Colleges and the British Psychological Society on training initiatives to improve the rate of identification and treatment of depression in older people (Action 104).

The Department of Health will work with the NHS Information Centre and regulatory bodies to ensure that monitoring is inclusive of the full age range (Action 105).

Question 12: Stigma

“In your view, what more should the Government be doing to combat stigma?”

Over half of respondents (57 per cent) answered this question.

Most respondents supported public education and campaigns, including in schools, and many referred to the role of the media and the importance of people ‘coming out’. Some focused more on mental health promotion and others on improving services and/or making mental health services less stigmatising. There was a strong strand about strengthening rights against discrimination. A few people said stigma is not a problem, or that it is not the Government’s role to tackle it.

“Welcome people like me who are willing to share their experience, want to give back their whole experience and have lots of ideas based on experience.” (Individual)

“Encourage the Police to take action against those who intimidate and bully us because of our condition.” (Individual)

“To make New Horizons a real contribution to changing and transforming attitudes towards issues of mental health. Whether short-term or long-term, having a mental health problem is as human and as ordinary as having a physical problem. To encourage NHS to be Champions of employing people with long-term mental health issues.” (Cornwall Partnership NHS Trust)

“There should be Government funding for the voluntary sector led Time to Change second phase. Support work around mental health hate crime prevention and awareness. Fund more Mental Health First Aid.” (Mental Health Providers Forum)

Campaigns

Many responses supported campaigns to combat stigma and discrimination, and some specified maintaining, developing, learning from or working with existing campaigns, in particular Time to Change. The College of Occupational Therapists called for a government-funded ten-year anti-stigma campaign as part of the implementation of New Horizons, while an individual said to “continue publicity via organisations who have a track record in reaching out”. The Afiya Trust was critical of Shift and Time to Change in tackling mental health stigma and discrimination when it is combined with racist, islamophobic and culturally ignorant stereotypes. They called for a clear focus in the strategy to address the multiple stigma and discrimination faced by BME communities.

Respondents wanted to see national campaigns that involved people locally, used engaging messages and media, and met commercial standards. Some respondents prioritised methods

other than campaigning (see below). A smaller number explicitly disagreed, saying for example that the public were not the problem, or that it was better to inform the public by demystifying developments in brain research, not bash them.

One suggested campaign was to tackle hate crime by encouraging mental health hate crime reporting.

Media

There were numerous comments about the media – some about the need to challenge negative media or regulate or legislate against it, and some about using the media positively to educate the public or convey anti-stigma messages. One proposal was that Ofcom’s audits on how disability is presented in the media should include mental health problems.

“The honest and vivid portrayal of Stacey’s life, living with bi-polar disorder in Eastenders, can do more to increase public awareness than thousands of leaflets.”
(North Yorkshire County Council)

Education

Many responses concerned the need for education – of the public, healthcare professionals, employers, the workforce generally, faith communities, police, and a range of other sectors and audiences. Some specified Mental Health First Aid training; particular recommendations included a shorter version for all workers and the public, national targets for population coverage as in Australia, and making it mandatory to have at least one trained person in every workplace. The Prison Reform Trust recommended Mental

Health First Aid training for prison staff. They outlined the costs to defendants and prisoners of disclosing mental health problems in terms of various forms of discrimination, while not disclosing closes off access to help. Some responses highlighted the power of mental health awareness training grounded in personal experience and called for funding for service user led or involved services and groups to undergo training.

In particular, respondents wanted to see education on mental health in schools – several called for inclusion in the national curriculum – and in Early Years education, including parents.

Shared responsibility

Some responses emphasised shared responsibility for challenging stigma, across society or across government. Schools, colleges and workplaces featured in these comments, with a call from the Darzi regional leads for organisations to take responsibility for psychological well-being. This response also welcomed the continued alignment of PSA targets as a way of aligning responsibility across different agencies and government departments. A group from the statutory sector in Leicestershire said, “Challenge to stigma must come from all quarters. No one agency has overall responsibility here. We should highlight and celebrate all small scale successes.” The demand for a Cabinet Minister for mental health and well-being, or a Ministerial champion of mental health, featured in responses to this question.

Employment

Many responses focused on the workplace and called on the Government to “lead by example”. Responses covered mental health promotion in the workplace, in education and in training, and strengthened rights against discrimination.

Recommendations included:

- mental health specific antidiscrimination legislation;
- outlawing pre-employment health/disability questions;
- making combatting stigma in the workplace a key performance indicator for all state-funded services, and a marker of good management for all good employers; and
- promote the Mindful Employer initiative.

Coming out

A lot of respondents saw the involvement of public figures in campaigns and their openness about their own experiences as very positive. They said to build on what Stephen Fry and Alastair Campbell have done, and encourage others in public life to “come out”. Perhaps as the question was about the Government’s role, there were calls for politicians and senior civil servants to do this as well as senior business people. There were also comments that “ordinary people” would be more effective and that the Government should support a culture of “coming out”.

“It should actively support respected people in declaring that they have/continue to suffer from a mental health problem. One way of doing this would be to strengthen further protection for NHS staff’s jobs who declare a mental illness, and to celebrate those who are open about their difficulties. This might well include politicians!” (Individual)

Legal/civil rights

Some responses focused on legal protection and/or talking in terms of discrimination, not stigma.

“Stop calling it stigma and name it discrimination and legislate to make it illegal.” (In Control)

Recommendations included specific mental illness antidiscrimination law, having a mental health ombudsman and local charters based on human rights and cultural inclusion, changing the law as regards MPs who are sectioned under the Mental Health Act, or repealing this Act altogether. One person who disagreed with social marketing as being ineffective in changing behaviour, said that the emphasis should be on discrimination and exclusion.

Language

Other comments on language were that there should be a move away from mental health terminology.

“Revise terminology – no one likes to admit to ‘mental health’ problems but everyone can relate to the terms well-being, emotional well-being, aliveness and so on.” (Friends, Families and Travellers)

Equalities

The Men's Health Forum raised the need for research into any gender differences in how stigmatisation is experienced, and in how the public perceive men and women with mental health problems. The Campaign Against Living Miserably (CALM) was concerned that campaign messages should be communicated effectively to young men and not be undermined by inappropriate branding.

Several responses drew parallels with other equality or emancipation campaigns or commented on issues facing people subjected to multiple oppression.

Involvement

A lot of responses called for inclusion of people with experience of mental health problems in anti-stigma work, for example as champions and trainers, and some focused on the importance of involving the whole community and of having locally based education, campaigning and mental health promotion. One recommendation was to reward inclusive organisations that involve mental health service users.

"The Government should provide opportunities for mental health service users to become mental health promotion champions. The Government can work with the voluntary sector to find ways to promote better messages in the media about mental health issues. Ordinary people have the skills and the knowledge to become powerful role models. There needs to be support for work done at local level, within and between communities to understand mental health issues." (National NGO Forum)

Service improvements

A number of respondents took the view that improving services – assuring choice and demonstrating the high value placed on services and their staff – was the best way to address stigma. There were also calls for mainstreaming and/or co-location of mental health services with(in) general health and community provision.

"If the general public were less scared about what would happen if they got mentally ill and witnessed anyone they knew getting good, caring, timely, appropriate, professional care, there would be less stigma." (Individual)

While supporting initiatives to combat stigma, the UK Council for Psychotherapy, Child Psychotherapy and Psychotherapy with Children Committee said that, "We particularly see children and young people's fear of stigma as a consequence of the failure of various arms of provision to work together. It is imperative that the statutory, voluntary and private sectors collaborate in sharing their skills and knowledge, and valuing the diversity of options they can offer each other and their clients."

Tackling stigma within the mental health services

Some people identified the mental health services as the main source of stigma, or the place to prioritise combating it. Others said to stop stigmatising people on benefits, and models of mental illness were also raised. A mental health 'SWOT' analysis (strengths, weaknesses, opportunities and threats) of all government policies was recommended.

“Stop putting people into stigmatised services.” (Individual)

“Resist categorical models of mental disorders. Emphasise the mental health strengths and weaknesses everybody has.” (Individual)

“Not deride people for needing welfare support would be a start...” (Individual)

Government response

Actions on stigma and discrimination include an inter-Ministerial summit, new initiatives in the Shift programme focusing on the media and the workplace, a Hate Crime Action Plan, and mental health awareness training in schools (Actions 19–27).

The Equality Bill, subject to parliamentary approval, will strengthen protections against discrimination including discrimination against disabled people. Many people with mental health conditions meet the legal definition of a disabled person and have the protection of legislation (Action 22). The Government does not consider that there would be additional benefit from a mental health specific antidiscrimination law.

The Equality Bill, subject to parliamentary approval, will also be used to tackle inappropriate use of pre-recruitment health enquiries, and will encourage all organisations to follow the best practice that many companies have already introduced.

Other measures connected with employment are set out in Actions 45–50, and there is more detail in the Government’s national mental health and employment strategy, *Working our way to better mental health: a framework for action*, and in the cross-government delivery plan to help people in contact with secondary mental health services, *Work, Recovery and Inclusion*.

The Government’s delivery plan *Improving Health, Supporting Justice* includes continued investment in mental health awareness training for frontline criminal justice staff (Action 94).

Government departments engaged with the New Horizons agenda will establish a Ministerial board to ensure high-level oversight of progress (Action 1), addressing the need for a Cabinet Minister for mental health or Ministerial champion.

Annex: List of organisations that responded and engagement events

List of organisations that responded

The current names of these organisations have been given as far as possible and where organisations jointly responded, we have listed as such.

2gether NHS Foundation Trust

5 Boroughs Partnership NHS Trust

Aberdeen Life Coaching Voluntary

Access to Mental Health in Primary Care (AMP) – research and development programme funded by the National Institute for Health Research

Acocks Green Neighbourhood Forum (Birmingham)

Action for Carers Surrey

Adult Attention Deficit Disorder – UK (AADD-UK)

Adults, Wellbeing and Health – Durham County Council (DCC) and Stonham housing

The Afiya Trust

Age Concern and Help the Aged

Age Concern North East

Age Concern Yorkshire and Humber Region and Yorkshire and Humber Improvement Partnership, Joint Partnership Project

Ambulance Service Network

Anxiety UK

Arts and Minds Network – Leeds Partnerships NHS Foundation Trust

Association for Better Care of Children Prevention of Premature Births

Association for Family Therapy

Asteens

Avon & Wiltshire Mental Health Partnership NHS Trust

Barking & Dagenham Community Health Services NHS Trust

Barnet Voice for Mental Health

Barrow Cadbury Trust

Bath and North East Somerset Mental Health Commissioning Strategy Group

Beacon Counselling
Beat
Bedford Borough Council
Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust
Belong
Big White Wall
Birmingham LINK
Birmingham LINK Mental Health working group
Black and Minority Ethnic Committee of the Ambulance Service Network
BME Alliance for the East Midlands
BME Housing Consortium
Booktrust
BPD Supporters UK
Bracknell Forest Health and Social Care
Bradford District Care Trust
Bradford Metropolitan District Council, Adult & Community Services
Brent Mental Health User Group
Bright, and Star Wards
Bristol Primary Care Trust
British Association for Counselling and Psychotherapy
British Association of Social Workers
British Psychological Society
College of Occupational Therapists
Royal College of Nursing
Royal College of Psychiatrists
British Geriatrics Society
British Medical Association
British Psychological Society
Bromley Mental Health Forum
BTCV
Buckinghamshire County Council
Business Boosters Network Community Interest Company (CIC)
Cambridgeshire and Peterborough NHS Foundation Trust
Cambridgeshire County Council
Camden and Islington Foundation NHS Trust

Camden and Islington Providers Forum
The Camden Crusader
Campaign Against Living Miserably (CALM)
Campaign for the Return of Dynamic Psychotherapy North West
Canterbury & Coastal Rethink – Carers' Support Group
The Capital Project Trust – mental health service user group
Care Quality Commission, mental health policy
Carers FIRST
Carers in Partnership
Carerwatch
Caring about Caring
Centre for Economic Performance, London School of Economics
The Challenging Behaviour Foundation
Changing Faces
Cheshire & Wirral Partnership NHS Foundation Trust
Chief Fire Officers Association
Child and Adolescent Psychiatrists, Sheffield Children's NHS Foundation Trust
Chill4usCarers
Christian Science Committee on Publication
Citizens Advice
Citizens Commission on Human Rights (UK)
Client Alliance
College of Occupational Therapists
Combined Healthcare, Mental Health and Vascular Wellbeing Service and
British Association of Behavioural and Cognitive Therapists
Commission for Architecture and the Built Environment (CABE)
Commissioning Support for London
Communication Workers Union North West Safety Forum
Community Links
Community Service Volunteers
Cornwall Partnership NHS Trust
Council of Ethnic Minority Voluntary Sector Organisations
Coventry and Warwickshire Partnership Trust
Coventry Carers Centre

Coventry City Council
Coventry Mental Health Partnership Board, and NHS Coventry
Creative Support (Redcar Floating Support)
Crisis
Crisis Resolution and Home Treatment, Walsall
Croydon New Horizons Workshop
CSC
Cumbria Children's Services Directorate
Cumbria County Council
Darlington Citizens Advice Bureau
Darzi/NHS Next Stage Review regional leads
Defence Clinical Psychology Service
Depression Alliance
Derby Depression Club
Developing Partners
Devon Partnership NHS Trust
The Digbeth Trust
Dorset HealthCare NHS Foundation Trust
Dorset Mental Health Local Implementation Team
DrugScope
Dudley and Walsall Mental Health Partnership NHS Trust
Dudley Mental Health Board
East Leeds Carers Support Group
East London NHS Foundation Trust, Older Person's Directorate
East of England Public Health & Social Care Directorate
East Riding Mental Health Partnership Board
Employment Law, Diversity & Discrimination Service
Equilibrium and Enablement Ltd
Essex County Council
Experts by Experience, East of England
Faculty of Public Health
Family Action
Financial Services Authority
Fitness Industry Association

Foundation for People with Learning Disabilities
The Foyer Federation
Framework Housing Association/Rethink/Nottingham Counselling Service
Fresh, Smoke Free North East
Friends, Families and Travellers
Future Health & Social Care Association CIC
The Future Vision Coalition
GamCare
Gateshead Mental Health Local Implementation Team
Gateshead Older People's Mental Health Service
Gay and Lesbian Youth in Calderdale
Gender Equality and Women's Mental Health Network
Greater Manchester Mental Health Network
Greater Manchester West Mental Health NHS Foundation Trust
Greenwich Council
The Grove Centre (now Birkbeck College and School of Oriental and African Studies)
Halton and St Helens Primary Care Trust
Hambleton and Richmondshire Carers Centre
Hampshire County Council
Hampshire Partnership NHS Foundation Trust
Harmless
Harrogate Rethink Mental Health Support Group
Hartlepool Borough Council Child and Adult Services
Hertfordshire Partnership NHS Foundation Trust and Hertfordshire County Council (Adult Care Services)
Hillside Clubhouse
Homeless Link
Home-Start UK
HYPe (Healthy Young People)
In Control
Inclusion South West
Institute of Psychiatry, King's College London
Intapsych

InterAct Chelmsford Ltd
Involve Project, Doncaster
Janssen-Cilag UK Ltd
Jobcentre Plus, South Tyne & Wear, Valley District
Journal of Public Mental Health
Kent Adult Social Services, Kent County Council
Kent and Medway Rethink
Kent County Council
KEO Films
Kids Company
The King's Fund
Kirklees Council and Kirklees NHS Mental Health Partnership Board
Kirklees Social Care Council (Adult Mental Health)
Lancashire Care NHS Foundation Trust
Lancashire County Council
Leeds City Council, Adult Social Care
Leeds Involvement Project, Mental Health Services User and Carer Reference Group
Leeds Irish Health and Homes
Leeds Local Implementation Team, Leeds Mental Health Service User and Carer Reference Group, Volition and the BME Advisory Group
Leicester, Leicestershire and Rutland Mental Health Promotion Network and East Midlands Regional Mental Health Promotion Network and Leicester Mental Health Strategic Group
Leicestershire and Leicester Local Safeguarding Children's Board Sub Group
The Lesbian and Gay Foundation
Lewis Governance
The Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and the Improvement and Development Agency (IDeA) for local government
Lifeworks Staffordshire
LINK in Cornwall
Liverpool Mental Health Consortium
Liverpool PCT Mental Health Commissioning
London Borough of Barking & Dagenham, mental health champions in the community and NHS partners

London Borough of Haringey
London Borough of Wandsworth (Service Users, Carers), NHS Wandsworth
Mental Health Trust and Stakeholders
London Health Commission
London Health Forum
London (Mental Health) Carers Advisory Group
London Regional Public Health Group – Tobacco Policy Team
Loud and Clear
Lundbeck UK
MAGIC (Mental Awareness Group Input Committee)
Making Waves, Nottingham
Manchester Gestalt Centre
Manchester Mental Health and Social Care Trust
Mandela House Museum
Memphasis
Mencap
Men's Health Forum
Mental Health and Substance Misuse Group (part of the Essex and
Southend LINK)
Mental Health Commissioning Managers
Mental Health First Aid England
Mental Health Foundation
Mental Health Helplines Partnership (mhhp)
Mental Health Network
Mental health promotion leads for NHS County Durham
and NHS Darlington
Mental Health Providers Forum
Mental Health Research UK
Mental Health Users Action Group
Mentoring and Befriending Foundation
The Meriden Family Programme
The Metro Centre, South East London
Middlesbrough Local Implementation Team
Mind
Mind Maze Mentoring Project

My Time CIC
Nacro
National Advisory Council
National Association of Psychiatric Intensive Care and Low Secure Units
National Black and Minority Ethnic Mental Health Network
National CAMHS Support Service
National Care Advisory Service
National Forum for Assertive Outreach
National Housing Federation
National Institute of Adult Continuing Education (NIACE)
National Mental Health Development Unit (NMHDU)
National Mental Well-being Impact Assessment Collaborative
National NGO Forum
National Patient Safety Agency
The National Spirituality and Mental Health Forum
National Treatment Agency for Substance Misuse
New Economics Foundation (nef) – Centre for Well-being
Newcastle Adult & Culture Services Directorate
Newcastle Upon Tyne Mental Health Services Partnership Board
Newham Asian Women's Project
NHS Bradford and Airedale
NHS Brighton and Hove and Adult Social Care
NHS Cambridgeshire
NHS Camden/London Borough of Camden Joint Strategic Planning
and Commissioning Team
NHS Commissioning Support for London
NHS Confederation PCT Network
NHS Doncaster
NHS Ealing
NHS East Midlands
NHS Greenwich, Public Health and Wellbeing Directorate
NHS Greenwich Mental Health Promotion Social Marketing
NHS Information Centre for Health and Social Care
NHS Lambeth

NHS Leeds (Public Health) and Suicide Prevention Group
NHS Manchester
NHS Medway, NHS Eastern & Coastal Kent, NHS West Kent
NHS Newham
NHS Nottingham City, Nottingham City Council (Adult Support and Health)
and Nottingham City Health and Wellbeing Partnership
NHS Nottinghamshire County
NHS SC MH Pathway
NHS Stockport Local Implementation Team
NHS Suffolk
NHS Walsall Community Health – National Service Framework Standard One
(MH Promotion) Leads Peer Group
NHS Westminster and NHS Kensington and Chelsea
NHS Westminster and Westminster City Council
NHS Wirral
Norfolk and Waveney Mental Health NHS Foundation Trust
North East London Foundation Trust and London Borough of Barking
& Dagenham and Mental Health Champions
North East Mental Health Development Unit
North East Consultation Focus Group – Group 1 (am)
North East Consultation Focus Group – Group 2 (am)
North East Consultation Focus Group – Group 1 (pm)
North East Public Health Observatory
North East Regional Employment Team on Mental Health
North Essex Partnership NHS Foundation Trust
North Staffs Users Group
North Tyneside Day Services
North Tyneside Mental Health Partnership Board
North West Mental Health Improvement Programme
North Yorkshire and York Mental Health Local Implementation Team
North Yorkshire County Council
North, Central and East Lancashire PCTs
Northamptonshire Healthcare
Northants Mental Health Carers Reference Group

Northumberland LINK
Northumberland Mental Health Partnership Board
Northumberland Mental Health Promotion Steering Group, Northumberland
Care NHS Trust & Northumberland, Tyne and Wear NHS Trust
Northumberland, Tyne and Wear Mental Health NHS Trust Chaplaincy Team
Northumberland, Tyne and Wear NHS Trust
Nottingham African Women Empowerment Forum
Nottingham City Council
Nottinghamshire County Council Adult Social Care and Health
Nottinghamshire Healthcare NHS Trust
Nottinghamshire Healthcare NHS Trust and NHS East Midlands Specialised
Commissioning Group
Office for Disability Issues
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust
Oxfordshire PCT (Mental Health Service Redesign and Public Health)
Oxleas NHS Foundation Trust
Pan Birmingham Mental Health Commissioning Team
PAPYRUS Prevention of Young Suicide
Pennine Care Footprint
The Place2Be
Play England
Plymouth Local Implementation Team
Poole Mental Health Forum
Preston Adult Learning Disability Community Mental Health Team
The Princess Royal Trust for Carers
The Princess Royal Trust for Carers, Sunderland Carers' Centre, Mental
Health Carers group
Prison Reform Trust
Progress – National Consortium of Consultant Nurses in Dual Diagnosis and
Substance Use
Psychotherapy and Counselling Service, Broomfield Hospital,
Chelmsford, Essex
Race on the Agenda
Raise
Rape and Sexual Abuse (RASA) Centre

Recovery Research Network
Relate, Chesterfield and North Derbyshire
Relate, Derby and Southern Derbyshire
Relatives Support to Douglas House
Rethink
Rethink, Harrogate Group
Rethink, Sahayak Services
Revolving Doors Agency
Richmond Fellowship
Richmond Upon Thames Joint Commissioning Group
Richmond Youth Partnership
RJA consultancy
Rochdale Local Implementation Team
Rotherham, Doncaster and South Humber Mental Health NHS
Foundation Trust
Rotherham Mental Health Planning Team (multi-agency 'LIT')
Rotherham Women's Counselling Service
Royal College of Nursing
Royal College of Psychiatrists
Royal College of Psychiatrists, Northern & Yorkshire Division
Royal College of Psychiatrists, Section of Perinatal Psychiatry
Royal College of Psychiatrists Smoking Summit
Royal College of Speech and Language Therapists
Royal National Institute for Deaf People (RNID)
Royal National Institute of Blind People (RNIB)
Sainsbury Centre for Mental Health
St Helens Mental Health Carers group
St Johns Housing Trust
St Luke's Hospital Group
St Mungo's
St Mungo's, Crisis, Homeless link, Broadway, Thames Reach,
Salvation Army, Centre Point
Salford Arts and Wellbeing Centre
Samaritans

Sandwell Mental Health and Social Care NHS Foundation Trust
Sandwell Mental Health Economy
SANE
Schizophreniawatch.co.uk
Sefton Council and NHS Sefton
Service Users Resource Centre (SURE)
Sharp Campaigns
Sharp Team Response
Sheffield City Council
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Mental Health Partnership Board
Sheffield Mind
Shropshire Mental Health Local Implementation Team
SIFA Fireside
Slough Borough Council, Slough Learning Disability Partnership Board
Social Perspectives Network for Modern Mental Health (SPN)
Sound Minds
South East Coast Ambulance Service
South East Coast Strategic Health Authority & Valuing People Regional Lead
– DH South
South East Hampshire Local Implementation Team
South East Regional Implementation Group
South Essex Partnership University NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South London and Maudsley NHS Foundation Trust and King's Health Partners
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South Tyneside Mental Health Partnership
South West Strategic Health Authority
South Wight Housing Association
Southampton Community Healthcare
Southend Borough Council
Southern Derbyshire Voluntary Sector Mental Health Forum
Southwark Primary Care Trust – Mental Health Commissioning
Step Ahead

Stockport Borough Council
Stockton-on-Tees Mental Health Local Implementation Team
Strategic Health Authority for the North West
Suffolk County Council
Suffolk Mental Health Partnership Trust
Suffolk Supporting People
Sunderland City Council: Health, Housing and Adult Services
Sunderland Mental Health Local Implementation Team
Support to Recovery
The Surrey LINK
Surrey Local Implementation Team
Sutton Mental Health Foundation
Tameside, Oldham & Glossop Mind and Topaz Café Ltd
Teacher Support Network
Tees, Esk and Wear Valleys NHS Foundation Trust
Telford and Wrekin, Shropshire – Mental Health Social Work Group
Thames Reach
Touchstone, Leeds
Transition Information Network
Turning Point
The UK Council for Psychotherapy
Umbrella – Working for Positive Mental Health
UNISON
Unite the Union
University Mental Health Advisers Network (UMHAN),
University of Cumbria
University of Warwick
Vielife
Vine Partnership Psychotherapy
visyon ltd
Volition
Waltham Forest LINK
Wargrave House School

Warrington Mental Health Forum
Warrington Mental Health Partnership Board
Warwickshire Mental Health Partnership
Washington Mind
The Well-being Institute, University of Cambridge
West Cheshire Mental Health Forum
West London Mental Health Trust
West Mercia Probation Trust
West Midlands Regional Assembly
West Midlands Research and Development Centre
West Midlands Strategic Health Authority
West Sussex County Council
Wirral LINK
Wolverhampton City PCT
Women's Resource Centre
Women's Sport and Fitness Foundation
Women's Therapy Centre
Woodland Trust
Worthing Homes
www.crazymadbonkers.com
Yorkshire and Humber Improvement Partnership (YHP)
Yorkshire and Humber Improvement Partnership, ELS Reference Group
YoungMinds
Youth Access
Youth Information Service
YouthNet UK

Engagement events

1. New Horizons engagement began with a national stakeholder event on 14 November 2007 and included a round table discussion with stakeholders on race and mental health, chaired by the Minister of State for Care Services. The National Institute for Mental Health in England organised a series of events and focus groups, including a meeting for mental health researchers.

Date	Region/organiser
3 June 2008	West Midlands
23 June 2008	South West
25 September 2008	Mental Health Research UK forum
29 September 2008	North East
27 October 2008	East Midlands
	Eastern, London and South Eastern
20 November 2008	Mental health policy forum held in collaboration with Inside Government, London

2. Listening events with Professor Louis Appleby, National Clinical Director for Mental Health, all held in 2009 and organised by local Trusts.

Date	Area	Location
13 March	North East	Gateshead
2 April	North West	Manchester
22 April	London	Kensington & Chelsea
29 April	Yorkshire and Humber	Wakefield
30 April	South Central	Oxford
13 May	Epsom Downs	Surrey
22 May	East Midlands	Northampton
17 June	West Midlands	Birmingham
8 July	South East Coast	Sussex
15 July	South West	Taunton
19 October	East of England	Cambridge

3. Engagement events for people with personal experience of mental distress and carers organised by Mind and Rethink on behalf of the Department of Health, all held in 2009.

Date	Place
12 June	Exeter
19 June	Cambridge
22 June	Manchester
29 June	Nottingham

4. Consultation events held during the consultation period

Date and place	Theme	Organiser/participants
9 September Leeds	Third Sector	Department of Health Third Sector team for local groups
14 September North West	NHS	North West Mental Health Trust CEOs
16–17 September London	Quality	Health Service Journal conference
17 September London	Health	Westminster Health Forum (parliamentarians)
17 September London	Housing	National Housing Federation for housing providers
23 September London	BME communities	Afiya Trust for BME groups and individuals
28 September London	Learning disabilities	Department of Health Valuing People team for learning disability staff and service users
28 September London	Local government	Department of Health and Local Government Association conference for lead council members and officers
28 September London	Health inequalities	London Health Commission expert round table seminar
28 September London	Well-being	The Reading Agency seminar
29 September London	Learning disabilities	Department of Health Valuing People team for learning disability staff and service users
30 September Liverpool	BME communities	Afiya Trust for BME groups and individuals

Date and place	Theme	Organiser/participants
1 October Birmingham	BME communities	Afiya Trust for BME groups and individuals
5 October Birmingham	Public health	Core Cities Health Improvement Collaborative
6 October Taunton	Public health	NHS Somerset, Healthy Schools, Somerset and Somerset Partnership NHS Foundation Trust
6 October London	Third sector	Department of Health Third Sector team for local groups
8 October Yorkshire & Humber	NHS	Yorkshire and Humber Improvement Partnership for regional NHS
14 October Leicestershire	Regulation	Care Quality Commission conference for former Mental Health Act commissioners
20 October South West	Public health	South West Public Health
22 October Harrogate	Social care	National Children and Adults conference – joint policy session with the Association of Directors of Social Services

5. Online discussion hosted by the Healthy Communities community of practice on the Improvement and Development Agency (IDeA) website, www.communities.idea.gov.uk, with weekly themed discussions running between 7 September and 13 October.

Notes

- 1 Events are listed in the Annex, page 100.
- 2 The Future Vision Coalition comprised mental health providers, charities and professional bodies. Members: ADASS (Association of Directors of Adult Social Services), ADCS (Association of Directors of Children's Services), Local Government Association, Mental Health Foundation, Mental Health Network of the NHS Confederation, Mental Health Providers Forum, Mind, Rethink, Royal College of Psychiatrists, Sainsbury Centre for Mental Health, and Together.
- 3 Alison Cobb, on secondment from Mind.
- 4 Events are listed in the Annex, page 100.
- 5 Consortium of Consultant Nurses in Dual Diagnosis and Substance Use.
- 6 Homeless Link, Drugscope, Mind and Clinks.
- 7 These largely draw on responses from NHS Nottinghamshire County, Coventry City Council, Sefton Council and NHS Sefton, NHS Ealing and Ealing Local Implementation Team, NHS Cambridgeshire, Citizens Advice, National Mental Well-being Impact Assessment Collaborative, West Midlands Regional Assembly, South West Strategic Health Authority, Newcastle Adult & Culture Services Directorate, National Housing Federation and Future Vision Coalition.
- 8 Detail of these proposals is drawn largely from Citizens Advice, RAISE and Leeds Local Implementation Team's responses.
- 9 MacArthur Research Network on Transitions to Adulthood and Forum for Youth Investment and Youth Transitions Funders Group.

