The pursuit of happiness: a new ambition for our mental health

THE PURSUIT OF HAPPINESS:
A NEW AMBITION FOR OUR
MENTAL HEALTH

July 2014

A **CENTREFORUM** COMMISSION

About the Commission

CentreForum launched an independent, evidence-based Commission in May 2013 under the chairmanship of Rt Hon Paul Burstow MP.

The Commission members are:

- Chairman Rt Hon Paul Burstow MP,
  Former Liberal Democrat Minister of State for Care and Support (2010-12);
- Lord Victor Adebowale CBE,
  Chief Executive, Turning Point;
- Professor Dame Sue Bailey DBE,
  Chair, Children and Young People's Coalition;
- Paul Farmer,
  Chief Executive, Mind;
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  Chair, Tavistock and Portman NHS Foundation Trust;
- Paul Jenkins OBE,
  Chief Executive, Tavistock and Portman NHS Foundation Trust;
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  Chair, Independent Mental Health Services Alliance.

Secretariat

- Holly Taggart,
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Acknowledgements

The Commission would like to thank everyone who contributed, in writing or in person, to the call for evidence, the Commission's meetings and round table events, and to all of the organisations and individuals who hosted a site visit. The Commission would also like to thank all of the peer reviewers who commented on the interim report. A complete list of acknowledgements can be found in Appendix 2.

Dedication

For Harriet Rowlands: whose generous gift of friendship and warmth of understanding brought comfort and happiness to many.

Her spirit in battling a brief and cruel depression were witness to her courage, and a reminder of the fragile places in all of us.

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About this report

Reading and using the evidence contained within the Commission's report

All the documents associated with the deliberations of the Commission are available for public view and download at www.centreforum.org

Where third parties wish to make use of information contained in these documents or intend to quote from them, please make sure that appropriate acknowledgment is made.

The published documents of the Commission are:

- This document, 'The Pursuit of Happiness: A New Ambition for our Mental Health', the main report of the CentreForum Mental Health Commission;
- 'Mental Health Commission Call For Evidence: Research Findings';
- 'The CentreForum Atlas of Variation in Mental Health';
- 'Perceptions of Wellbeing and Mental Health in English Secondary Schools: A Cross-sectional Study';
- 'Investing in children's mental health: a review of evidence on the costs and benefits of increased service provision' written by Centre for Mental Health for the Mental Health Commission. To be published Autumn 2014.

The content of the report comprises of:

- An executive summary containing the key messages and principle recommendations emanating from the work of the Commission;
- A core report narrative structured into nine chapters;
- Quotations that are illustrative of key messages within the report taken from responses to our call for evidence and from experts participating in Commission events;
- Case studies and illustrations of good practice developed from field visits undertaken by Commissioners and positioned in the core narrative adjacent to the point that they are deemed to support;
- A list of recommendations at the end of each chapter that are developed in response to the specific issues addressed in that chapter.

Publication of this report represents a major milestone in the work of the Commission, but it does not represent the completion of that work.

Over the course of the next twelve months the Commissioners, working in concert with CentreForum, will continue to press for implementation of the recommendations contained in this report and CentreForum will publish additional research designed to support this process.

Acronyms

BME	Black and Minority Ethnic
CAMH	Child and Adolescent Mental Health
CCGs	Clinical Commissioning Groups
HEE	Higher Education England
HWB	Health and Wellbeing Board
HWS	Health and Work Service
IAPT	Improving Access to Psychological Therapies
IPS	Individual Placement Support
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
MHC	Mental Health Commission
NHS	National Health Service
NICE	National Institute for Clinical Excellence
OFSTED	Office for Standards in Education, Children's Services and Skills
PIMH	Perinatal and Infant Mental Health
QALY	Quality Adjusted Life Year
SMI	Serious Mental Illness
TTC	Time To Change
YLD	Years of Life Lived with Disability
YLL	Years of Life Lost

Glossary of Terms

Clinical commissioning group	Clinical Commissioning Groups (CCGs) are statutory bodies clinically led that include all of the GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to take commissioning decisions for their patients. CCGs are overseen by NHS England (including its Regional Offices and Area Teams). Each CCG has a constitution and is run by its governing body.
Health and Wellbeing Board	Health and Wellbeing Boards are statutory bodies based on upper-tier and unitary authorities in England drawing together members of CCGs, local HealthWatch and the local authority. They are charged with assessing the needs of their local population producing Joint Strategic Needs Assessments and agreeing a Joint Health and Wellbeing Strategy. The board also has responsibility for promoting integration of health and care services.
Mental capital	Mental capital relates to 'a person's cognitive and emotional resources'. It includes their cognitive ability, how flexible and efficient they are at learning, and their "emotional intelligence", such as their social skills and resilience in the face of stresses. Mental capital therefore conditions how well an individual is able to contribute effectively to society, and also to experience a high [personal] quality of life.
Social capital	Social capital is networks together with shared norms, values and understandings that facilitate co-operation within or among groups'. Essentially this mean citizenship, 'neighbourliness', social networks and civic participation.
Social prescribing	Social prescribing is a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. Social prescribing is usually delivered via primary care – for example, through 'exercise on prescription' or 'prescription for learning', although there is a range of different models and referral options.'
Subjective wellbeing	Subjective or personal wellbeing can be described as (i) transient feelings of enjoyment: these feelings are measurable both in terms of personal report and brain activity; (ii) evaluative judgements about the balance of our feelings over time: these are used to measure an individual's overall life satisfaction; (iii) and the experience of a state of flourishing and fulfilment of one's potential, sometimes known as 'flow' or engagement.
Wellbeing	Wellbeing refers to a 'dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community'. Positive wellbeing means that people have confidence in themselves and others, are able to connect with others and their community and can cooperate.

Preface

In February 2011, I published the Coalition Government's mental health strategy, No Health Without Mental Health.[1] It was widely welcomed for its emphasis on parity of esteem between physical and mental health and the promotion of wellbeing.

Three years on, the strategy still sets the right direction. But translating it into practice has been painfully slow. Despite the evidence base, the NHS remains doggedly stuck in a model of care that separates the physical from the psychological and the social. Yet it is only by bringing them together that we can hope to make the best use of the resources available and improve the wellbeing of the nation.

This institutional bias against mental health was brought into sharp focus recently by the decision of NHS England to raid the budgets of Mental Health Trusts to help Acute Trusts deliver the recommendations of the Francis Report, as if the same issues did not arise in mental health. Some good may come from this sorry episode, if statements by NHS England translate into deeds, but the bias runs deep.

Over the past twelve months, the Mental Health Commission has taken stock of where we are today and what we need to do to realise the ambition of the mental health strategy. Our goal has been to identify the key changes that will reduce the number of people experiencing lifelong mental health problems over the next 5 to 10 years and help those who suffer mental health problems to recover.

The Commission has identified five big shifts in policy and practice for England.

First, make the mental wellbeing of the nation or the 'pursuit of happiness' a clear and measurable goal of government. The tools are available to evaluate policy and measure its impact with wellbeing in mind. This needs leadership from the top of government and sustained action to tackle stigma.

Second, roll out a National Wellbeing Programme led by Public Health England to foster mutual support, self-care and recovery. They would be locally tailored by Health and Wellbeing Boards to make the best of the skills and talents in communities up and down the country, building up community capacity where necessary.

Third, prioritise investment in the mental health of children and young people right from conception. By scaling up what works, we can transform the life chances of hundreds of thousands of children and reduce the costs to society of low educational attainment, negative behaviour, worklessness, crime, and antisocial behaviour.

Fourth, make our places of work mental health friendly. The cost to business in terms of sickness absence and lost productivity runs to £23.5 billion. There is good practice, it should become the norm, and it would save money. Government must take the lead in its own employment practice and set the standard in its procurement.

Fifth, close the treatment gap that leaves almost one in ten of the adult population needlessly suffering from depression and anxiety and 1-2 per cent of the adult population experiencing a severe mental illnesses such as schizophrenia. These people do not receive the parity of care and outcomes which you would expect if you had a physical illness such as cancer. Equip primary care to identify and support the mental and behavioural health needs of its patients. Integrating mental health and social work expertise into the primary health care teams to ensure a holistic approach.

The Commission believes that NHS England should be set the clear goal of achieving parity of funding for mental health over the next decade. We are under no illusions about the difficulties of making these changes over the next five years against a backdrop of financial constraint. However, we believe that the case for spending to be rebalanced towards mental health is overwhelming. For

1 Department of Health, No Health Without Mental Health: A Cross- Government Mental Health Outcomes Strategy for People of All Ages, February 2011. Department of Health, 'Analysis of the Impact on Equality (AIE), Annex B—Evidence Base', February 2011.

example, poorly-managed long-term mental and physical health problems cost the NHS £13 billion a year.

The cost of doing nothing, or simply settling for gradual change, runs to billions of pounds, but the real cost is measured in human misery, misery for want of a determination to act on the evidence.

Rt Hon Paul Burstow MP
Former Minister of State for Care and Support (2010 – 2012)
Chair of the CentreForum Mental Health Commission

Executive Summary

- **We must prioritise the promotion and protection of the wellbeing and mental and social capital of the nation. The pursuit of happiness should be a goal of government.**
- **The promotion of wellbeing requires a co-ordinated approach with both universal services and targeted interventions. A well-designed and delivered wellbeing programme can over time reduce the burden of mental health problems.**
- **Primary care organisations must be equipped to recognise and meet the mental health needs of their patients.**
- **Investment in the wellbeing and mental health of our children and young people should be a priority and would reduce the lifetime cost of mental health problems. Timely identification and access to the right treatment requires effective collaboration between schools and child and adolescent mental health services.**

Spending between physical and mental health should be rebalanced to reflect the level of unmet need in mental health and better use the £13 billion currently spent on dealing with the physical health consequences of poorly managed mental health. Our wellbeing and mental and social capital make a huge difference throughout our lives. They are shaped by our early experiences in childhood as well as our later experiences in life and are essential to a healthy society, healthy communities and healthy families. They matter because, taken together, they affect our behaviour, our ability to benefit and feel part of the world around us, and our prosperity.[1]

Mental health problems are the biggest contributor to poor wellbeing. Therefore, in attempting to increase the proportion of the population who are feeling good and functioning well, and reducing the prevalence of misery, more needs to be done to help people recover from mental health problems.

The CentreForum Mental Health Commission was established to address some of these issues. The aims were to:

- Examine the current state of mental health in England;
- Set out values, principles and approaches to mental health;
- Evaluate the effectiveness and progress made in delivering the implementation framework for the government's mental health strategy, No Health Without Mental Health; and
- Identify, and provide effective solutions based upon key policy issues in this area, looking towards 2020.

Following a year-long evidence-based commission, this report sets out the responses to the challenges faced in mental health over the next five years. The Commission believes that it is vital in the next Parliament that mental health policy includes a more ambitious objective for investing in the wellbeing and mental and social capital of the nation. In achieving this, there should be a focused agenda that recognises and enhances the strengths and assets of our communities.

1 Foresight Mental Capital and Wellbeing Project, Mental Capital and Wellbeing: Making the Most of Ourselves in the 21st Century, 'Final Project Report', The Government Office for Science, London, 2008.

Recommendations

Communities

- A focus on mental health and wellbeing should be embedded across the work of government, including in the formulation of policies affecting housing, education, employment, planning, welfare and policing.
- Progress that has been made in reducing mental health stigma must be maintained with continued funding.
- The annual report that Directors of Public Health are required to produce should include a statutory obligation to include a public record of local progress towards parity of esteem for physical and mental health.
- Public Health England's scrutiny role should be strengthened to allow them to hold local public health teams to account for their performance against the Public Health Outcomes Framework, for which one key indicator is self-reported wellbeing.
- The way the National Institute for Clinical Excellence (NICE) evaluates treatments and interventions discriminates against mental health. The Commission believe that subjective wellbeing should be adopted as a better way of evaluating and allocating health resources.

Families

- Perinatal and Infant Mental Health (PIMH) services should be expanded.
- The families of children considered to be at high risk, or showing signs of severe behavioural problems, should be offered cost-effective, evidence-based parenting programmes.
- All children should receive child development assessments at key stages such as during the antenatal period, at about 6 and 12 months, the 30-month health check, start of primary school, and years 6 and 8.

Schools

- The national curriculum should include the requirement to teach children and young people how to look after their mental health and build emotional resilience through approaches such as mindfulness.
- Teachers and other educational staff should receive training in child development, mental health and psychological resilience to enable them to identify children who are vulnerable.
- For children experiencing mild to moderate mental health problems, there should be increased access to psychological and other therapies in schools or in the community.

Workplace

- All organisations with more than 500 employees should work to become mental health friendly employers.
- Government must take the lead by ensuring that all public sector enterprises meet this standard of a mental health friendly employer.
- Government should use its procurement power to set explicit contractual targets and incentives for the number of people with mental health problems helped into work and this should form part of contract monitoring procedures.
- The re-procurement of the Work Programme to provide an effective and more integrated system of support for people with mental health problems returning to work.
- The proportion of mental health spending in the Access to Work initiative should be increased.
- The Health and Work Service (HWS) should offer tailored occupational health support services to employers by training line managers to recognise mental health problems and intervene before the employee takes sick leave.

Health and Social Care

- Primary care mental health must be transformed so that services are more joined up and are closer to individuals.
- The Secretary of State's mandate to NHS England should make clear that a full range of evidence-based psychological therapies should be available to everyone who needs them, including children and young people.
- GP social prescribing should be available in every primary care practice.
- Everyone should have guaranteed access to crisis care in England.
- There is a need to produce a psychologically minded workforce by reforming medical and professional related training.

Making it Happen

- A dedicated mental health minister in the Department of Health should be created with responsibility for mental health services and a Cabinet level Minister for Wellbeing reporting to the Prime Minister should be appointed.
- The Secretary of State for Health should report annually to Parliament on progress towards the goal of parity of esteem between mental and physical health.
- Every Health and Wellbeing Board (HWB) should appoint a Wellbeing Champion to advocate parity of esteem between mental and physical health and promote wellbeing.

- **The Department of Health should take steps to enable NHS England to pilot the delegation of primary care commissioning to HWBs as part of a further wave of pioneers, building on the arrangements for agreeing local plans for delivering the Better Care Fund.**

- **The Commission recommend that there is a clear commitment by the Secretary of State for Health in the mandate to NHS England to achieve parity of funding for mental health over a ten-year period.**

Last year I had a three-month long psychosis—very powerful—which blew my life apart, I was eventually hospitalised. My life was in complete tatters, no job, isolated from friends and family, really bad situation. I then entered a six- month depression, which left me feeling utterly helpless—I wanted to end my life. I had researched my situation and concluded that I was probably bi polar. So I went to the NHS for help. Care provision provided by [removed] for me has almost solely relied on medication—which I declined. After a number of interviews with the Consultant psychiatrist, nurses, care team . . . not once did anyone ask me about the quality of my diet, question my alcohol consumption (around 40 pints of beer a week) or suggest I do some exercise. I was not once advised to go and hang out with my friends. They just wanted to know if I was suicidal, and could only offer medication—lithium—to help me. The impression I got was that these professionals were actually afraid of my illness, and did not really have enough understanding of it to offer me any real help.

Service user
MHC Call for Evidence Survey

Chapter 1: Introduction

I do not feel 'ill'. I feel different. One cannot recover from being oneself.

Service user
MHC Call for Evidence Survey

This chapter of the report introduces the concepts of wellbeing, mental and social capital and recovery before setting out the Commission's proposed ambition.

Mental wellbeing refers to a 'dynamic state in which an individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community'.[2] In protecting mental wellbeing, it is necessary to promote mental and social capital. Mental capital relates to 'a person's cognitive and emotional resources'. It includes their cognitive ability, how flexible and efficient they are at learning, and their 'emotional intelligence', such as their social skills and resilience in the face of stresses. Mental capital therefore conditions how well an individual is able to contribute effectively to society, and also to experience a high [personal] quality of life.[3] Social capital can be defined as 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups'. Essentially this means citizenship, 'neighbourliness', social networks and civic participation.[4]

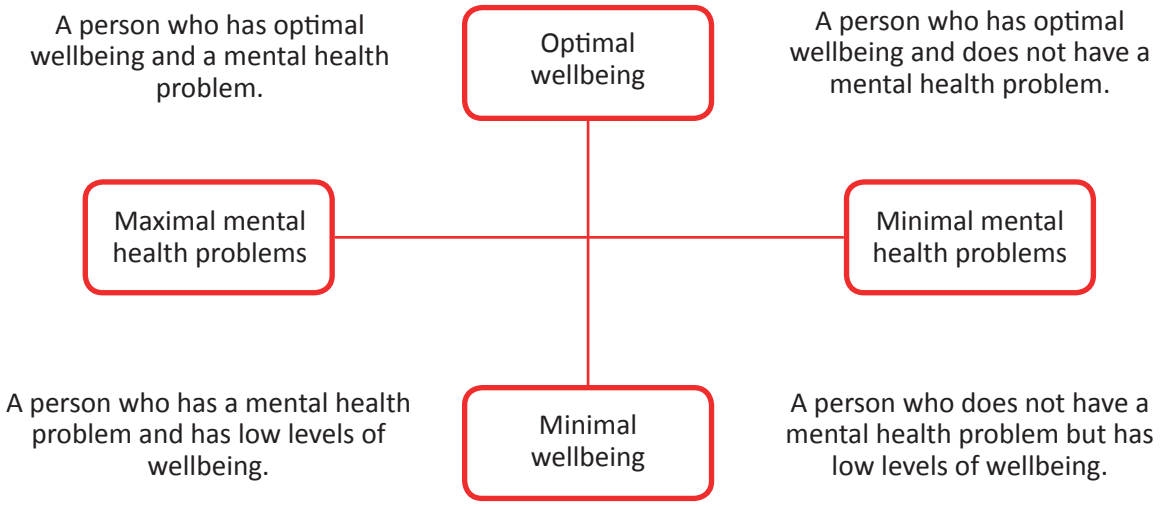
Our wellbeing and mental and social capital make a huge difference throughout our lives. They are shaped by our early experiences in childhood as well as our later experiences in life and are essential to a healthy society, healthy communities, and healthy families. They matter because taken together, they affect our behaviour, our ability to benefit and feel part of the world around us, and our prosperity.[5] Since 1970, the UK's GDP has doubled but people's satisfaction with their life has hardly changed. In fact, 81 per cent of Britons believe that the government should prioritise creating the greatest happiness, not the greatest wealth. [6]

In addressing these issues, public policy can focus on increasing the proportion of the population with optimal wellbeing or reducing the proportion of the population with low levels of wellbeing, thus reducing misery. However when proposing recommendations for this, it is necessary to consider the predictive factors of differing levels of wellbeing. For instance, the factors that distinguish people with the very lowest levels of wellbeing are issues relating to basic needs, such as lack of employment, partner, poor health and serious debt. On the other hand, the factors that distinguish those with the very highest levels of wellbeing tend to be more related to factors associated with the wider environment, such as neighbours and their community.[7] This is not surprising: communities that have higher levels of social capital are associated with better health, higher educational achievement, better employment outcomes, and lower crime rates.[8] So, social policy measures prioritising neighbourhood renewal and social capital are key to supporting higher wellbeing but, at the same time, without addressing the basic needs of individuals, there is a risk of exacerbating inequalities further as those with moderate wellbeing will benefit, while those who are struggling the most may not be in a position to do so until their basic needs have been met.[9]

2 Foresight Mental Capital and Wellbeing Project, Mental Capital and Wellbeing: Making the Most of Ourselves in the 21st Century, 'Final Project Report', The Government Office for Science, London, 2008.
3 Ibid.
4 Office for National Statistics, Guide to Social Capital, 2014, available from: http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html.
5 Foresight Mental Capital and Wellbeing Project, Mental Capital and Wellbeing: Making the Most of Ourselves in the 21st Century, 'Final Project Report', The Government Office for Science, London, 2008.
6 New Economics Foundation, Five Ways to Well-being, 2008, available from: www.neweconomics.org/projects/fivewaystowell-being.
7 J Chanfreau and S McManus, Wellbeing in Wales, NatCen, April 2014.
8 Office for National Statistics, Guide to Social Capital, 2014, available from: http://www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html.
9 J Chanfreau and S McManus, Wellbeing in Wales, NatCen, April 2014.

This matters in the context of the prevalence of mental health problems, and attention should also be given to the interrelationships that exist. This can be considered on two axes (see the figure below).[10]

The interrelationship between wellbeing and mental health



This relationship demonstrates that optimal wellbeing can be achieved despite mental health problems and, likewise, individuals with low levels of wellbeing do not necessarily have a mental health problem. We are in a permanent state of flux, moving from different levels of wellbeing and vulnerability to mental health problems. The Mental Health Foundation argue that reducing the number of people across the UK developing a mental health problem is the only way that mental health services will be able to cope with demand in 20–30 years' time.[11]

Mental health problems are the biggest contributor to poor wellbeing.[12] Therefore, in attempting to increase the proportion of the population who have optimal wellbeing and reducing the proportion of the population who have low levels of wellbeing, more needs to be done to help people recover from mental health problems.

In England, one in six adults and one in ten children experience a mental health problem at any one time.[13] The human costs of mental ill health are huge in terms of the personal and emotional impact that it can have on individuals and their families.[14] Mental and behavioural health problems also contribute significantly to the global burden of disease, accounting for 23 per cent of the total years of life lived with disabilities (YLDs) and 5.1 per cent of the total years of life lost (YLL) in the UK.[15] People experiencing a mental health problem also have higher rates of morbidity, caused by poorer physical health. As a consequence, a premature mortality rate of fifteen to twenty years exists for people experiencing a serious mental illness (SMI).[16]

10 The Scottish Government, Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-11 October 2007, available from: http://www.scotland.gov.uk/Publications/2007/10/26112853/1
11 Mental Health Foundation, Starting Today: The Future of Mental Health Services, September 2013.
12 R Layard, D Chisholm, V Patel et al., Mental Illness and Unhappiness, Centre for Economic Performance, LSE, September 2013.
13 Health and Social Care Information Centre, Adult Psychiatric Morbidity in England – Results of a Household Survey, January 2009, available from: http://www.hscic.gov.uk/pubs/psychiatricmorbidity07.
14 Centre for Mental Health, The Economic and Social Costs of Mental Health Problems in 2009/10, 2010.
15 Christopher J L Murray, UK Health Performance: Findings of the Global Burden of Disease Study, 2010.
16 G Thornicroft, 'Physical Health Disparities and Mental Illness: The Scandal of Premature Mortality' The British Journal of Psychiatry, 2011, 199: p. 441-442.

However, a clear tension exists between wellbeing, resilience and recovery. They are linked but distinct concepts. Increasing resilience can help to safeguard wellbeing in difficult circumstances and supporting recovery can help people living with mental health problems to increase their wellbeing. But, both universal and targeted wellbeing promotion initiatives are also needed in order to increase levels of wellbeing across the population. The Young Foundation particularly warns against an approach that conflates wellbeing and resilience, which risks failing to support people with low resilience but high wellbeing (who are particularly at risk from external circumstances such as the economic downturn) or people with low wellbeing but high resilience, who would see no improvement in their wellbeing through a focus solely on resilience.[17]

This report addresses these issues by setting a new ambition for mental health.

ILLUSTRATION **Building Resilience**

Local Minds Resilience Program is a community based project that aims to help vulnerable groups look after their mental wellbeing during challenging periods in their lives. Through the creation of nine local pilots, they aimed to work with individuals who fell into one of two categories: those who were not currently experiencing mental health problems and those who were not accessing any mental health services.

The pilots combined wellbeing activities, psychological coping strategies, and building social capital to improve beneficiaries' emotional resilience and wellbeing. Working with identified 'at risk' groups—women in the perinatal period and unemployed men aged 45 and over—the nine local Minds provide psycho-educational groups, wellbeing and social activities, both in groups and in one to one befriending. The findings demonstrate that:

- All of the perinatal projects were over-subscribed and exceeded the project targets;
- Almost all beneficiaries had never accessed Mind's services previously;
- The model is flexible enough to meet the needs of potential beneficiaries. For example, those initially not comfortable with accessing groups straight away can build up gradually through other activities or befriending.

Source: http://www.mind.org.uk/news-campaigns/news/mind-given-grant-to-help-new-mums-and-unemployed-men-look-after-their-mental-health/#.U6Qn3vldXA8.

17 N Mguni, N Bacon and J Brown, The Wellbeing and Resilience Paradox, Young Foundation, September 2012.

Chapter 2: A New Ambition

> **The support in our communities is becoming more and more diminished, the work place is becoming a more stressful environment for all and the services that exist are only accessible in crisis. We need to identify, acknowledge and value the assets we have, as individuals and communities.**
>
> *Sarah Yiannoulou*
> *National Survivor User Network*

The Commission believe that government should set a new ambition for our society's mental health where the wellbeing and mental and social capital of the nation is promoted, there is a reduction in the misery experienced, and there is delivery of effective interventions for people with existing mental health problems. This ambition should be underpinned by the following core principles.[18]

Core Principles

- **Investment in the prevention of mental health problems, and the promotion of mental wellbeing, in proportion to need.**
- **Respect and dignity for those with mental health problems across all areas of health and social care.**
- **Equal access to health and social care, including: comparable waiting times; equitable treatment for all, according to their need; the provision of equivalent levels of choice and quality, regardless of condition and age.**
- **Equal access should apply to people of all ages, and to all groups in the population who may be placed at increased risk of developing mental health problems.**
- **Particular focus also needs to be given to black and minority ethnic communities, who are over-represented in secondary mental health services and under-represented in primary care.**
- **Planning for integration – this requires movement away from mental health, physical health and social care 'silos'. The consideration of mental health should be integral to all health and social care, at any point where someone with a mental or physical health problem comes into contact with a service.**
- **Aspirational outcomes and an expectation that mental healthcare should continuously improve (as is the case for other areas of healthcare), including closing the premature mortality gap for people with serious mental illness compared with the general population.**
- **Investment in mental health research in proportion to need.**
- **Investment of both funding and clinical/managerial time and attention should be proportionate to the prevalence of mental health problems and scale of mental health need.**

18 Royal College of Psychiatrists, Whole Person Care: From Rhetoric to Reality, March 2013.

At the forefront of this agenda, the Commission propose a National Wellbeing Programme, led by Public Health England, to expand the range and access of local wellbeing services and support by 2020. Within this programme, mental health problems are a component rather than a core focus, with a wider remit for public mental health prevention and health promotion.

The aim is to help people stay well and feel well at a local level but in order for this to be realised, parity of esteem must be achieved. This includes parity between mental and physical health, parity between the mental wellbeing and health of the general population compared to black and minority ethnic groups (BME), and parity between people with common mental health problems .

The Commission believe that in achieving this, policy and practice changes need to centre on five key places:

- Communities;
- Families;
- Schools;
- Workplace;
- Health and social care.

The Commission have developed a series of place-based proposals and have sought to operationalise these through existing commissioning structures. The remainder of this report discusses these proposals in detail.

Chapter 3: Communities

> **The markers of a society where there is no mental health stigma . . . would be community mental wellbeing services in every neighbourhood, run by charities and Community Interest Companies and staffed by people with lived experience who would act as 'peer navigators' for people to get help and support for recovery and 'getting a life'.**
>
> *Sue Forber*
> *Time To Change*

In establishing a National Wellbeing Programme, an asset and strength based approach should be adopted as this values the capacity, skills, knowledge, connections and the potential of communities.[19] This is not just about direct provision of services but also about promoting resilience and help in strengthening and improving the quality of social relationships within families and communities and building social support, social networks and social capital.[20]

In doing this, there needs to be consideration for vulnerable and excluded groups. People who are lonely report lower life satisfaction[21] and an increased risk of developing a mental health problem.[22] More than 50 per cent of people with a mental health problem are likely to have poor social contact, compared with 6 per cent in the general population. Two thirds of people who experience a mental health problem also live alone, which is a fourfold increase compared to the general population.[23] Lonliness is a health prioirty in itself due to its far-reaching adverse effects.[24] Mental health and wellbeing and their associated inequalities are also just one aspect of the wider issues affecting BME communities.

Furthermore, in the promotion of wellbeing and mental capital, it is necessary to recognise and challenge the stigma of mental health, within government, public services and in wider society. Some progress has been made through Time To Change (TTC)[25] and other initiatives in tackling stigma and in raising the political profile of mental health. However, much more is needed to ensure that political intent is reflected in concrete action on the ground to improve the population's mental health and improve the life outcomes of those affected by mental health problems.

Our call for evidence found that:[26]

- 58 per cent of mental health service users feel isolated rather than part of society;
- 75 per cent of service users indicate that having a mental health problem has stopped them from having a close personal relationship;
- Only 28 per cent of service users say that their professional team involve their significant others and other sources of natural support, if this is their preference;
- 76 per cent of carers do not get to spend as much time doing the activities they value and enjoy.

19 F Huppert, 'A New Approach to Reducing Disorder and Improving Well-being', Perspectives on Psychological Science, January 2009, 4: p.108-111.
20 L Friedli, Mental Health, Resilience and Inequalities, World Health Organisation, 2009.
21 Office for National Statistics, Measuring National Well-being – Older People and Loneliness, April 2013.
22 J Cacioppo, M Hughes, L Waite, et al., 'Loneliness as a Specific Risk Factor for Depressive Symptoms: Cross-Sectional and Longitudinal Analyses', Psychol Aging, 2006; 21(1): p.140-51.
23 Scottish Association Mental Health, A World to Belong to: Social Networks of People with Mental Health Problems, Glasgow: SAMH, 2006.
24 J Kempton and S Tomlin, Ageing Alone: Loneliness in the Oldest Old, CentreForum, 2014.
25 Time To Change, 'Time To Change is Having a Positive Effect on Reducing Mental Health Stigma And Discrimination', 2013, available from: http://www.time-to-change.org.uk/news/time-change-having-positive-effect-reducing-mental-health-stigma-and-discrimination.
26 H Taggart, I Keable-Elliot, L McDonald and T Rathborn, 'Mental Health Commission: Call for Evidence Detailed Analysis and Findings', CentreForum, July 2014.

However, there are many good examples of programmes and interventions that are already happening that promote wellbeing, mental and social capital and recovery. For instance, the New Economics Foundation suggests that national levels of wellbeing can be improved if individuals engage with the following 'five ways':

- Connect with the people around you;
- Be active;
- Keep moving;
- Take notice—environmental and emotional awareness;
- Keep learning—try something new at any age;
- Give—help others and build reciprocity and trust. [27]

The mental health charity, Mind, also suggests that effective intervention to improve social capital should include:

- Targeted interventions to build social relationships amongst isolated groups;
- Changes to the way existing (non-wellbeing focused) services and support are run to facilitate social connections;
- Interventions that encourage social connections between people with similar experiences to provide peer support.[28]

Much of the work of service user/survivor-led networks and self-help organisations around the country has addressed asset-based community development that helps individuals connect with groups very successfully.

ILLUSTRATION **Community Promoted Recovery**

York House is one of 130 projects funded by Mind through Ecominds: a £7.5m Big Lottery Fund grants scheme that uses nature and green activities to improve physical and mental health. York House Community Gardens is a social and therapeutic horticulture project that has transformed an area of overgrown and unused land in a community centre in Stony Stratford, Milton Keynes into allotments for community groups. A partnership between Mind in Milton Keynes and York House Centre led to a weekly Mind gardening group for people with mental health problems, they developed an allotment-style plot and supported other community groups in managing their plots. All participants with mental health problems have shown reductions in anxiety and depression and 33 per cent have gone on to employment, education or volunteering.

27 Ibid.
28 Mind, Building Resilient Communities. Making Every Contact Count for Public Mental Health, August 2013.

Five ways to wellbeing according to participants

Five ways to wellbeing	What York House participants say happens for them
Connect with others	Make friends and meet people regularly
	Become part of a community—reduces stigma
	Gain support from other mental health service users
Be more active	Enjoy regular physical activity
Take notice of the world	Enjoy being in a natural environment
	Plan seasonal and weather-related work on the garden
	Plan new developments with other groups
Keep Learning	Develop a new interest and skill
	Some have gone on to education or training
Give to others	Take part in enhancing a community venue
	Take part in meetings and decisions about the garden
	Help other 'allotmenteers' and community groups in the garden
	Join community events like work parties and barbecues

Source: http://www.mind.org.uk/media/336359/Feel-better-outside-feel-better-inside-report.pdf?ctaId=/about-us/policies-issues/ecotherapy/slices/read-the-report/.

However a wider remit for public health is required in order to co-ordinate services and transform communities. The Commission believe that Health and Wellbeing Boards (HWBs) have the potential to lead work on wellbeing and mental and social capital at a local level. They have the task of mapping population needs and devising a strategy to meet them. However, while HWBs are barely one year old and it is too early to assess their performance, to date mental health has not featured as strongly in their work as it should.[29]

For instance, a report by Centre for Mental Health found that:

- Less than half of HWBs (45 per cent) set mental health as a specific, standalone priority; 46 per cent addressed at least one area of mental health as one element in a broader mix; 9 per cent did not include mental health at all;
- The most commonly addressed single issue was the mental health needs of children and young people but even that, 55 per cent, was barely over half;
- Lower still were the proportions of mental health need-related strategies addressing employment (41 per cent), alcohol and smoking (19 per cent), housing (20 per cent).[30]

A report published by the King's Fund which reviewed Joint Health and Wellbeing Strategies (JHWS) found that the main priorities were related to public health and health inequality issues but commissioners were struggling to address these issues in the context of the health and social care system.[31]

29 J Scrutton, A Place for Parity', Centre for Mental Health, November 2013.
30 Ibid.
31 R Humphries and A Galea, Health and Wellbeing Boards: One Year On, The King's Fund, October 2013.

CASE STUDY **Community Led Commissioning**

Connected Care is Turning Point's model of community led commissioning, a proven methodology that enables communities to make positive changes in their local area. It improves health and wellbeing through building the capacity of local people to design and deliver local health and social care services in partnership with Clinical Commissioning Groups (CCGs) and local authorities. Local people, often with complex family circumstances or needs themselves, are trained to engage with their peers, with other organisations, to challenge preconceptions, to build community resilience and to develop innovative approaches that meet the needs of their particular communities.

Positive results have been demonstrated across 19 areas in England, namely: improved health outcomes through service redesign; sharper focus on early intervention/prevention; lower costs through less delivery duplication and through development of low cost community-led services. Strong mutual accountability and trust have grown between commissioners and communities.

In 2012, a cost-benefit analysis of a prospective re-design in Basildon was conducted in partnership with the London School of Economics. Findings indicated £4.44 could be saved for every £1 spent through reduced demand on public services (rising to £14.07 when the value of quality of life improvements are included).

Source: http://www.turning-point.co.uk/community-commissioning/connected-care.aspx.

The Children and Young People's Mental Health Coalition also conducted a review of Joint Strategic Needs Assessments (JSNAs) and JHWSs and found that many were not prioritising children and young people's mental health. The main findings showed that:

- Two thirds of JSNAs did not measure levels of children and young people's mental health locally;
- One third of JHWS do not prioritise children and young people's mental health; and the most commonly used data to estimate prevalence was a decade old;
- There is also an absence of any data relevant to 18–25 year olds although many JSNAs recognised the problems of transition for this group.[32]

As a result of varying levels of priority given to mental health at a commissioning level, disparities in health states relating to wellbeing and mental health are apparent across England. The CentreForum Atlas of Variation demonstrates these findings. This may be explained by commissioning inadequacies of Clinical Commissioning Groups (CCGs) or problems in the translation of mental health needs from the Joint Strategic Needs Assessment (JSNA) into Joint Health and Wellbeing Strategies (JHWS).[33] However, in looking towards 2020, the Commission believe that HWBs have the potential to strengthen their role and become the local system leader and integrator that is needed. Drawing together local government and the NHS by pooling sovereignty and budgets can help to realise the common goal of greater human wellbeing that this report advocates.

32 Children and Young People's Mental Health Coalition, Overlooked and Forgotten, December 2013.
33 H Taggart, 'The CentreForum Atlas of Variation: identifying unwarrented variation in mental health in England', CentreForum, July 2014.

Recommendations

- **That mental health and wellbeing should feature across the work of government, including in the formulation of policies affecting housing, education, employment, planning, welfare and policing. The impact assessment process for new policies in all departments should specifically consider mental health and wellbeing. Just as Directors of Public Health are expected to embed health promotion across the work of local authorities, mental health and wellbeing promotion initiatives will have limited impact if confined to the Department of Health. It is essential to ensure that policy decisions from other departments do not undermine progress being made towards increasing wellbeing.**

- **That the annual report, which Directors of Public Health are required to produce, should include a statutory obligation to include a record of local progress towards parity of esteem for physical and mental health within public health. A national commitment has been made to 'close the gap' between physical and mental health in terms of investment, outcomes, waiting times, quality, research and aspirations, amongst other things.[34] The prevention agenda is one in which a particular disparity exists and if this is to be effectively addressed, it will need to be the job of every local Director of Public Health and progress should be monitored at a national level.**

- **That Public Health England's scrutiny role should be strengthened, allowing them to hold local public health teams to account for their performance against the Public Health Outcomes Framework,[35] for which one key indicator is self-reported wellbeing. Public Health England has great potential to support wellbeing promotion. However, there is a gap between these good intentions at a national level and the delivery of wellbeing initiatives locally. The publication of data on self-reported wellbeing by the Office for National Statistics (ONS) is an important first step but the Commission believe that Public Health England should have the authority to use this data to challenge local public health teams and hold them to account.**

- **That improving wellbeing should be included as a core function of local public health teams, along with the delivery of sexual health services and the NHS Health Check Assessment. A failure to address wellbeing not only misses a key opportunity to reduce the prevalence of mental health problems, but also undermines the wider work of public health teams. Improved wellbeing and reduced prevalence of mental health problems are associated with better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life.[36] Despite this, many public health teams currently do not see the promotion of wellbeing as an important part of their role, or as part of an integrated approach to reducing the effect of substance misuse, obesity or smoking where mental health is often also prevalent.**

- **That the progress that has been made in reducing mental health stigma is maintained with the funding of the Time To Change (TTC) programme being included in the 2015 spending review with at least £4 million a year. The priorities for a further phase of TTC should include tackling the stigma and discrimination faced by children and**

34 Social Care, Local Government and Care Partnership Directorate, Closing the Gap: Priorities for Essential Change in Mental Health, Department of Health, February 2014.
35 The Commission propose that the Public Health Outcomes Framework should become part of a new Wellbeing Outcome Framework, which would cover health, social care and public health.
36 Joint Commissioning Panel for Mental Health, Guidance for Commissioning Public Mental Health Services, July 2013.

young people and extending work with employers in the public and private sectors to become TTC accredited organisations.[37] The public stigma attached to mental health problems will be remain long-term unless we do more to change public attitudes.[38]

* That a national wellbeing social marketing campaign should be rolled out should findings from Public Health England's regional pilot conclude that such a campaign could have a positive impact on wellbeing. The pilot campaign focuses on the 'five ways to wellbeing', which includes five evidence-based steps that people can take to improve their own wellbeing.[39] An effective national marketing campaign of this type could increase wellbeing, help to tackle stigma around mental health and support local Directors of Public Health by increasing the uptake of local initiatives and services to promote wellbeing.

* That further work should be done to improve the wellbeing of excluded and vulnerable communities. This should include: addressing the diversity of identities and experiences within communities while delivering services; developing systems to enable excluded communities to influence policy making at the top level; supporting community-led social marketing campaigns to challenge inequalities and raise awareness; using the new Wellbeing Outcomes framework to set measurable outcomes for CCGs and other NHS bodies in meeting their statutory obligations to reduce health equality; monitoring the commissioning process for effectiveness in meeting community need; ensuring service user and carer leadership are part of evaluating services; recognising and respecting the cultural heritage, identity, and belief systems of communities; looking at the impact of discrimination and racism against BME staff in the workforce at senior management and board level where there is a correlation with the experiences of service users and delivery of services.

* That the goal of promoting wellbeing and mental capital should be measured through a basket of new and existing metrics. These should be included in a new Wellbeing Outcomes Framework which draws together the Department of Health's three outcome frameworks: NHS Outcomes Framework; Public Health Outcomes Framework; and Adult Social Care Outcomes Framework.

* These measures should include a common measure of wellbeing that will allow policy makers to shape and compare the effects of different policies on the population, in ways which are useful to public agencies, civil society organisations and private organisations.

* Additionally, there should be a new set of multiple measures of wellbeing that are more sensitive than the current ONS measures (life satisfaction, happiness, worthwhile and anxiety), to include communities, groups, and neighbourhoods alongside ethnic, gender, and geographic patterns.

  The methods that NICE currently use to evaluate treatments and therapies discriminates against mental health. NICE currently use the EQ-5D to describe health states and the metric of Quality Adjusted Life Years (QALYs) to apply a weighting. In doing this, the cost effectiveness of various health treatments is assessed by asking people how many life years they would be willing to give up in order to not have

37 M Smith, 'Anti-Stigma Campaigns: Time To Change', BJPsych, 2013.
38 Mental Health Foundation, Starting Today: The Future of Mental Health Services, September 2013.
39 New Economics Foundation, Five Ways to Well-Being, 2008.

a certain health condition. However, the EQ-5D only asks one question in relation to mental health (mood) and the QALY measure is vulnerable to over-estimation of perceived health states. In these cases, physical health is typically shown as, or more important, than mental health.

The Commission believes that Subjective Wellbeing (SWB) should be adopted by NICE as part of its evaluation methodology. SWB provides a global assessment of life satisfaction but keeps the QALY weighting system. This metric is more appropriate for measuring wellbeing and mental capital. It overwhelmingly shows that mental health problems have a greater impact on SWB than physical ill health, and are around five times worse for depression and anxiety compared to the worst physical health condition.[40]

Currently, recommendations by NICE relating to therapeutic interventions, such as talking therapies, are not binding on Clinical Commissioning Groups and NHS England in the way that those for drugs are. The Department of Health should revise the NHS Constitution to ensure that NICE recommendations in respect of mental health cannot be ignored.

Other tools that can be used include the Warwick-Edinburgh Mental Wellbeing Score and the wellbeing and resilience measurement,[41] which is being tested in several European cities as a way of achieving a more realistic picture of the state of social capacity in neighbourhoods. Similarly, the Good Childhood Index, which can be used with children from eight years of age, can be valuable.[42]

- **The last collection of prevalence data for children and young people was in 2004. The Commission agrees with the Chief Medical Officer's recommendation[43] that a regular survey to identify the current prevalence of mental health problems among children and young people should be commissioned. The results of the survey would fill gaps in local JSNAs and JHWS.**

- **There should be increased investment in epidemiological and evaluative research in mental health. In 2007/8, the total budget of all major research funding organisations was approximately £1.9 billion, of which 119.7 million was spent on mental health research (6.3 per cent).[44] We should aim to increase annual mental health research investment by 6 per cent (£114 million) by 2020.**

40 D Fujiwara and P Dolan, Valuing Mental Health: How a Subjective Wellbeing Approach can Show Just how Much it Matters, UK Council for Psychotherapy, January 2014.
41 N Bacon and N Mguni, Taking the Temperature of Local Communities: the Wellbeing and Resilience Measure (WARM), Young Foundation, 2010.
42 The Children's Society, The Good Childhood Index, 2014, available from: http://www.childrenssociety.org.uk/what-we-do/research/well-being/background-programme/good-childhood-index.
43 Annual Report of the Chief Medical Officer, Our Children Deserve Better: Prevention Pays, Annex 1, 2012, Department of Health, available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252664/33571_2901304_CMO_Chapter_Anx_1.pdf.
44 Medical Research Council, Review of Mental Health Research: Report of the Strategic Review Group, 2010, p.49.

Chapter 4: Families

In my experience the hardest thing to deal with is the isolation that caring for someone when they become unwell brings.

Carer
MHC Call for Evidence Survey

From pregnancy through to the first two years of life is the most crucial period for healthy child development. Babies are going through a rapid stage of development, both physically and mentally, and the period offers an ideal opportunity to ensure that healthy brain circuitry is established so that they get off to the best start in life.[45]

The first 1001 days of a child's life are critical, and this is the best time to offer support. It is essential that all babies are securely attached to the main parent/carer(s) and to enable this to happen, the parent/carer(s) needs to be consistently and sensitively responsive to the baby. This first relationship between the infant and his/her parents or carers forms the basis for healthy development throughout childhood and beyond. Being securely attached helps children to be more resilient, better able to form and maintain relationships, and helps reduce the chances of a child developing a mental health problem. [46]

However, sometimes it is difficult for parents/carers to form a secure attachment with their child. This may be due to trauma associated with the birth, the baby having a learning disability or an autistic spectrum disorder, or the parent/carer having their own mental health problem that means they find it difficult to form attachments.[47] Therefore, professionals working with new parents/carers, such as midwives, health visitors, GPs, should be trained to identify potential problems and be able to provide support or refer them on for a suitable intervention.

The evidence suggests that there needs to be a range of services available to help support parents/carers. These include: universal services which are available to everyone and are provided by midwives and health visitors; targeted services for those who have been identified as having additional needs; specialist provision provided within Child and Adolescent Mental Health Services (CAMHS); and highly specialist services such as perinatal mental health services, and inpatient mother and baby units.[48]

Currently, part of the problem is that infant mental health is nobody's sole responsibility. There is a whole spectrum of services that make up infant mental health services and as a result there are many different agencies commissioning services. There is little or no integrated commissioning for this age group. There is also a lack of UK-based prevalence data on the mental health of under five-year-olds and we do not have any current data on infant mental health services. However, a mapping exercise conducted some time ago found that there was a lot of local variation in provision and that infant mental health services are only provided by around one in two child and adolescent mental health services.[49] Only 23 per cent of mental health trusts in England report having comprehensive PIMH services, which include both inpatient and community arms.[50] This position is likely to have deteriorated since these studies were published because many infant mental health services are delivered through Tier 2 or targeted CAMH services. It is these services that have been particularly vulnerable to cuts in the last four years.

45 S Moullin, J Waldfogel and E Washbrook, Baby Bonds: Parenting, Attachment and a Secure Base for Children, The Sutton Trust, March 2014.
46 J Barlow and P Svanberg, Keeping the Baby in Mind, London and New York: Routledge, 2009.
47 Ibid.
48 NSPCC, All Babies Count: Spotlight on Perinatal Mental Health, 2013, available from: http://www.nspcc.org.uk/Inform/resources-forprofessionals/underones/spotlight-mental-health-landing_wda96578.html
49 P Lavis, Perinatal and Infant Mental Health Survey, Care Services Improvement Partnership, 2007.
50 O Oluwatayo and T Friedman, 'A Survey of Specialist Perinatal Mental Health Services in England', Psychiatric Bulletin, May 2005 29:177-179.

CASE STUDY Mental Health Services: Conception to three years

North East London Foundation Trust Perinatal Parent Infant Mental Health Service provides integrated antenatal and postnatal care through comprehensive, specialist clinical and/or therapeutic intervention to mothers with mental health problems up until the child is one year old for psychiatric patients, and 36 months old for psychotherapy patients. The Service is unique in that it is able to work with both the baby and the parent(s) by offering both psychiatric assessment and treatment and a psychotherapeutic treatment plan for parents and babies.

The multidisciplinary team consists of two consultant perinatal psychiatrists, one perinatal Speciality Psychiatrist, one core psychiatry trainee, community mental health practitioners, perinatal psychotherapists one senior social worker practitioner, administrators and management.

The service aims to identify mothers in the antenatal period who:

- Are at risk of a recurrence of a psychotic illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, psychotic depression or puerperal psychosis);
- Present with a complex non-psychotic condition such as non–psychotic severe depression, severe anxiety, OCD, complex eating disorder anxiety;
- Are considered at risk of emotionally neglecting or harming their baby;
- May be psychiatrically well but describe having no bond with their baby (expressed either during pregnancy or post-natally).

The service aims to identify parents in the postnatal period who:

- Have been admitted to a Mother Baby Psychiatric Unit;
- Present with an inability to bond with their baby or feel love for their baby;
- Present with the onset of an acute perinatal emotional illness;
- Have a premature baby in the Neonatal Intensive Care Unit at Queens Hospital.

Mothers and fathers under 18 can be referred if a perinatal psychiatric or emotional illness dominates the clinical picture. A CAMHS psychiatrist will work alongside the Adult Consultant Perinatal Psychiatrist and Perinatal Psychotherapist. Clinical responsibility is retained by the CAMHS psychiatrist.

There have been three positive outcomes:

- Women suffering from a psychotic illness are less likely to relapse in the two post-natal years if they are managed well during the perinatal period;
- Women who were previously under the care of a Community Recovery Team are less likely to require ongoing secondary mental health services and are often discharged to primary care;
- There is a high rate of service user satisfaction for parents who receive a psychotherapy intervention and compelling evidence of improved attachment security in many of the babies at 12 months.

Source: http://www.nelft.nhs.uk/our_services/mental_health/camhs/camhs_services/perinatal_parent_infant_mhs

As children grow older, it is possible that mental and neurodevelopment disorders may develop. In England, anxiety affects approximately 3 per cent of children and young people; depression affects 1 per cent of children and young people, and hyperkinetic disorder affects approximately 1.6 per cent of children and young people. Mental health problems among children also tend to increase as they reach adolescence, with disorders in general affecting 10.4 per cent of boys aged 5–10, rising to 12.8 per cent of boys aged 11–15, and 5.9 per cent of girls aged 5–10, rising to 9.65 per cent of girls aged 11–15. Depression and anxiety rates among teenagers in England have also increased by 70 per cent in the past 25 years.[51]

ILLUSTRATION **Engaging Children's Mental Health Problems**

The Early Years Collaborative is a coalition of Community Planning Partners in Scotland. The framework was established in 2009, with additional funding attached through partnerships (local authority, health, police, education and third sector professionals) to implement GIRFEC (Getting It Right For Every Child) and committed to ensuring that every baby, child, mother, father and family in Scotland has access to the best support available.

Jointly chaired by the Scottish government, Health and local government, members are elected politicians, practitioners, and experts from the statutory and voluntary sectors. Arguably, it is the world's first national multi-agency quality improvement programme. The Early Years Taskforce sets the strategic direction for the early years change programme and co-ordinates policy across government and the wider public sector to ensure that early years spending is prioritised by the whole public sector. In this way, thinking through the needs of each child at engagement with any service has permeated through all agencies including health.

Early intervention has relevance to a wide range of social policy but, now supported by a wide range of research evidence from education, health, justice and economic experts, is regarded in Scotland as particularly relevant for early years, which is often the best opportunity to intervene. For the purposes of the framework, early years are defined as pre-birth to eight years old. This broad definition of early years recognises the importance of pregnancy in influencing outcomes and of transition into primary school as a critical period.

Since January 2013, teams from across all 32 Partnerships have embarked on improvement interventions to address issues identified on the agreed key changes to meet local need:

- Early support for pregnancy and beyond;
- Attachment and child development;
- Continuity of care in transitions;
- 27–30 month review;
- Developing parents' skills;
- Family engagement to support learning;
- Addressing child poverty.

Source: http://www.scotland.gov.uk/Topics/People/Young-People/early-years/early-years-collaborative

51 National Statistics Online, 'Mental Health: Mental Disorder More Common In Boys', at http//:www.statistics.gov.uk, (2004).

The most prevalent mental health problem in children and young people is conduct disorder, which affects 5 per cent of children in England, and a further 15–20 per cent of children display serious behavioural problems. Children diagnosed with conduct disorders are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs, six times more likely to die before the age of 30, eight times more likely to end up on the child protection register, and 20 times more likely to end up in prison.[52]

CASE STUDY **Triple P — Positive Parenting Programme**

The model, developed by the University of Queensland, Australia, is one of the most effective evidence-based parenting programmes in the world, backed up by more than 30 years of continuing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's (or their own) emotional behaviours, so preventing problems developing and enabling stronger, healthy relationships. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups and in all kinds of family structures.

The Triple P system aims to:

- Put evidence-based parenting into the hands of parents;
- Normalise the concept of parenting programmes so parents feel comfortable asking for help;
- Deliver only the amount of support needed;
- Dive parents the confidence and skills to be self-sufficient; and
- Provide population-level early intervention to communities to prevent child abuse, mental health problems and anti-social behaviour.

Self-regulation is one main tenet. It encourages parents to set their own goals and choose the types of strategies that will work within their family homes. This relieves the pressure on agencies and practitioners, who are not required to continue providing clinical support to the parents who have completed Triple P.

It is accepted that quality, evidence-based parenting programmes can impact on services and budgets dealing with crime and antisocial behaviour, health care, mental health, housing, education, and drugs. In the US, a population trial found that when Triple P was made available to all parents in a county (not just those parents at risk), it led to:

- 17 per cent fewer hospitalisations from child abuse injuries;
- 16 per cent fewer out-of-home placements;
- 22 per cent slowed growth of confirmed child abuse cases.

Source: http://www.triplep.net/glo-en/home/

52 M Parsonage, L Khan and A Saunders, Building a Better Future. The Lifetime Costs of Childhood Behavioural Problems and the Benefits of Early Interventions, Centre for Mental Health, January 2014.

As part of its work, the Commission asked the Centre for Mental Health to evaluate the best available evidence for cost effective interventions in a range of childhood and adolescent mental health problems. The full results from this analysis will be published in the autumn of 2014. However, its findings provide a compelling case for investment in children's mental health.

Recommendations

- **That Perinatal and Infant Mental Health (PIMH) services should be comprehensive in nature and be provided by multidisciplinary teams with psychiatrists, parent–infant psychotherapists, health visitors, mental health workers and voluntary sector organisations offering a range of psychological and psychosocial interventions. There should be a range of universal and specialist services aimed at promoting maternal/paternal and infant mental health and treating maternal and paternal mental health problems and parent-infant relationship difficulties.**

  Given the incomplete coverage offered by current services, investment is needed. A comprehensive parent-infant mental health service covering a mixed urban/suburban area of almost 1 million head of population would cost approximately £1.2m. In order to develop comprehensive PIMH services across England an investment of £50m would be needed.[53]

- **That families of children considered to be at high risk, or showing signs of severe behavioural problems, should be offered cost-effective, evidence-based parenting programmes. This can include short courses, long-term contact or group interventions. A parenting programme costs around £1,300 per child but the scale of benefits are huge. A child with a severe behavioural problem costs education £3,000 extra a year and the overall lifetime costs to society amount to at least £260,000. This means parenting programmes only need to make marginal improvements to justify their cost.[54]**

- **That investment is required to deliver at scale. Currently, these programmes tend to be funded through the budget for Children's Services in councils. The Commission recommend a pooled budget arrangement due to the multi-sector budgets that stand to benefit. Furthermore, current commissioning of these programmes is either through local authorities or individual schools. Therefore, HWBs should take the lead in ensuring the co-ordination of services between families, education services, children's services and primary care is managed successfully. This is essential as programmes which are commissioned poorly and not delivered faithfully do not work. Cutting corners (as is so often the case) creates false economies.**

- **That all children should receive child development assessments at key stages, such as during the antenatal period, at about 6 and 12 months, at the 30-month health check, at the start of primary school and at years 6 and 8. In the early years, tools such as the Ages and Stages Questionnaires (ASQ), the Antenatal Promotional Interview, and the Postnatal Promotional Interview could be used by midwives or health visitors as appropriate to screen for potential problems. When the child is older, simple tools such as the Strengths and Difficulties Questionnaire (SDQ) can be used by nursery staff, teachers and other practitioners to identify children falling outside the normal**

53 This figure is based on the costings for the Perinatal-Infant Mental Health Service in North East London FT and then prorated per capita nationally.

54 E Rosa Brown, L Khan and M Parsonage, A Chance to Change: Delivering Effective Parenting Programmes to Transform Lives, London: Centre for Mental Health, 2012.

range of healthy development. This will help to identify those whose families may need support and allow schools and health and wellbeing boards to assess the overall levels of wellbeing in the local population. This data should be shared with schools as well as other local agencies such as public health departments. HWBs, CCGs, and local authority/public health commissioners should use this data to plan and commission relevant services, which may be schools based as well as clinic based.

Chapter 5: Schools

We strongly believe that our pupils' wellbeing and mental health matters, and that by intervening early and providing accessible support for our pupils we are giving them the best chance to overcome problems and issues which are currently affecting their young lives.

Head teacher
Place2Be

The primary focus of schools is to cultivate a personal disposition to learn, work and relate, with the skills to live in society. It is vital that schools provide an environment that offers the opportunity for all children to learn and develop, including those children who are experiencing low levels of wellbeing or a mental health problem.

At any one time, as many as 10 per cent of children and young people have low levels of wellbeing. Compared to children with average to high wellbeing, these individuals are:

- Eight times as likely to feel there is conflict in their family;
- Five times as likely to have been recently bullied;
- Three times as likely to feel they do not have enough friends;
- Three times as likely to feel they have a lot less money than their friends.

Between 1994 and 2008, children's self-reported wellbeing increased. However, from 2009 onwards there is evidence that children's life satisfaction has stopped improving and may have begun to decline.[55] YoungMinds argue that the pressure to have access to money and the perfect body and lifestyle, and to achieve in school and university are all negative factors that our society places on children and young people.[56]

In England, approximately 10 per cent of children and young people have a diagnosed mental health problem at any one time, which is equivalent to three children in every classroom.[57] As well as misery and suffering, having a mental health problem has implications for physical health as young people with a mental health problem also have high rates of risk-taking behaviours:

- 41 per cent smoke regularly;
- 24 per cent drink alcohol at least once a week;
- 49 per cent using cannabis at least once a month;
- Between one in every 12 and one in 15 young people deliberately self-harm;[58]
- Children and young people who develop mental health problems are less likely to do well at school and the negative outcomes continue into adulthood.[59] [60] [61]

We need to teach children to be resilient: the potential benefits could be lifelong. In order to achieve this, there should be a whole school approach, which means that the promotion of emotional wellbeing is integrated into the ethos, culture, routine life and core business of the school setting.

55 G Rees, H Goswami, L Pople, J Bradshaw, A Keung and G Main, The Good Childhood Report 2013, The Children's Society, 2013.
56 YoungMinds, What's the Problem? 2014, available from: http://www.youngminds.org.uk/about/whats_the_problem
57 Mental Health Foundation, Childhood and Adolescent Mental Health: Understanding The Lifetime Impacts, 2005, p4.
58 Mental Health Foundation, Truth Hurts: Report of the National Inquiry into Self-Harm Among Young People, London: Mental Health Foundation, 2006.
59 H Green, A McGinnity, H Meltzer, et al., Mental Health of Children and Young People in Great Britain 2004, London: Palgrave, 2004.
60 S Gibb, 'Burden of Psychiatric Disorder in Young Adulthood and Life Outcomes at Age 30', British Journal of Psychiatry', 2010, V. 197, pp. 122-127.
61 M Richards, et al., Childhood Mental Health and Life Chances in Post-War Britain, London: Centre for Mental Health, 2009.

ILLUSTRATION **Service Partnerships in Schools**

The London Borough of Islington launched a programme for mental health awareness, Healthy Minds, in secondary schools in October 2013. The programme responds to some 29,000 people in the borough who are affected by depression or anxiety. The borough's incidence of psychotic illnesses is double the national average and the suicide rate is the second highest in London. In schools, it is estimated that 3,000 children have a mental health problem, 36 per cent higher than the national average, amounting to four pupils in every classroom in Islington. The common problems are anxiety, depression, conduct disorders, attention deficit hyperactivity disorder.

The programme, led by public health and developed through collaboration between the Healthy Schools Team, CAMHS, Educational Psychology, school nursing and voluntary sector parties, is premised on the idea that children with good mental health enjoy and contribute to a better wellbeing, that early mental health problems lead to adult mental illness, that treatment is available and effective, and that silence and prejudice add enormously to the stigma and burden of mental illness.

The comprehensive package has three components:

- A new scheme of work for pupils in key stage 3: a four-lesson package with necessary materials, a suggested plan, resources and teacher background notes. The scheme addresses stigma, explains common mental health problems, and points to help and ways to support a friend;
- Mental health awareness training for staff, delivered jointly by the Healthy Schools team, CAMHS, and Rethink. This is funded by Public Health;
- Increasing awareness of support available to schools and pupils: a new booklet and online resource, with CAMHS involvement in refreshers for schools on services available.

The scheme does not seek to make mental health experts of school staff but to debunk myths about mental health, to build resilience and to ensure easy accessibility in all schools (including funding for staff day releases).

The Programme's second stage now proceeds, aiming to develop mental health resilience in primary schools.

Source: http://www.ndcs.org.uk/family_support/positive_parenting_families/emotional_health_and_wellbeing/healthy_minds.html

There is a lot that schools can do themselves to help support the emotional wellbeing of their students. Schools should have an ethos that promotes the emotional wellbeing of the entire school community, including staff, and helps children to develop character and resilience.[62] This is particularly important as educational staff have very high rates of work related stress: 40 per cent have been to the doctor and 25 per cent have taken sick leave from work within the current academic year because of the pressure of their job.[63]

The whole school approach needs to be led from the top but the school should also actively consider the views of the student body. The school can promote emotional wellbeing through the curriculum or find out how their students are feeling, or measure levels of wellbeing to help them plan what

62 C Paterson, C Tyler and J Lexmond, Character and Resilience Manifesto, CentreForum and Character Counts, January 2014.
63 ATL, 'Four in Ten Education Staff have Visited the Doctor and a Quarter taken Sick Leave of Pressure', April 2013, available from: http://www.atl.org.uk/media-office/media-archive/sickness-work-pressure-survey.asp.

they need to do. However, schools cannot be expected to do everything. Therefore, they should work in partnership with local or national agencies who can help provide specialist support such as counselling services in the school, or CAMHS workers based in the school.

The recently published report, *Wellbeing and Policy*, by the former Cabinet Secretary, Gus O'Donnell demonstrates that much can achieved in schools to promote wellbeing through the systematic and structured teaching of life-skills and values throughout school life. Providing effective training to all teachers in mental health and the management of child behaviour will be critical to success.[64]

However, the recent cuts to CAMHS are cause for concern. A freedom of information request by YoungMinds found that two-thirds of local authorities have cut their CAMHS budgets, and the largest cuts have been to early intervention services (Tier 1 and Tier 2).[65] [66] This has resulted in stricter thresholds for children and young people in low level services so that they are unable to get help when a problem is emerging and only enter mental health services at Tier 3 or 4, by which time the problem has increased in severity and complexity. So, despite the innovative and evidence-based treatments available for child and adolescent mental health, there is poor treatment coverage. This would not be acceptable in childhood cancer or diabetes services.[67]

CASE STUDY Child and Adolescent Outreach Work, Lille, France

Covering a larger population, the children's mental health (12–18 years) service has developed a mobile team model of care that operates 24 hours a day Monday to Friday and Saturday mornings. This service operates on the principle that 'if they won't come to us then we will go to them'. Non-engagement by the young person is not sufficient justification for the service to disengage from the young person. Just one per cent of teenagers refuse the service on follow-up.

The service operates a 'no decision about me without me' approach and runs on an open access basis. It has four mobile teams that focus on people who have made suicide attempts and people who have behavioural disorders. One of the teams concentrates on children's homes.

The model leads to earlier intervention so that, when compared to the natural evolution of the illness it is possible to prevent a crisis and promote recovery.

In 2013, they made 808 interventions, with 200 emergency department admissions to paediatric MH service. There were 582 non-emergency interventions at the mental health centres, 1 at a GP office and 34 at home. Overall there were 27 teenage hospitalisations in 2013 for 891 days with a mean length of stay of 6 days.

Over ten years, the mobile team model has delivered intensive ambulatory care. Ten years ago bed occupancy was at 100 per cent and length of stay was two years. Now less than 7 per cent of interventions result in hospitalisation.

Hospital is now seen as an alternative to ambulatory care, rather than the other way round.

When the teams attend at a teenager's home, the GP attends too and provides an introduction.

64 Legatum Institute, Wellbeing and Policy, March 2014.
65 YoungMinds, 'Stop cutting CAMHS Services', 2013, available from: http://www.youngminds.org.uk/about/our_campaigns/cuts_to_camhs_services
66 Tier 1: healthy school environment (relationships); Tier 2: awareness raising for children and school staff on mental health and emotional wellbeing; T3: support for children with less severe or emerging mental health problems; T4: support for severe problems (i.e. CAMHS).
67 S Bailey, 'Achieving Parity Because "Our Children Deserve Better"' (editorial), Child and Adolescent Mental Health 19(2), 2014 p. 81-82.

They have tested a mobile team approach to schools but, having engaged with teachers in its design, they found no one took up the service. They are commissioning following up research to understand why. Five per cent of the teenage population is in care with them. There have been no suicides amongst those using their service.

Source: http://www.imhclille2015.com/index.php?seccion=committees&subSeccion=detailCommittees&id=a9frooOCvtnVfu61q7UQ5AsUwa_UuNO01Zm6WPnImX0&idC=cXJXQ5d6KOgpHjBTZISMhU0GHpUPwvm5mSpH6zZ_tpA

This evidence has been further supported by new research commissioned by the mental health commission. This research provides a comprehensive analysis of head teacher perceptions of pupil mental health provision in mainstream and maintained schools, independent schools, pupil referral units, and schools with children with special educational needs across England.

Key findings from this research indicate that:

- Head teachers underestimated the incidence of mental health problems as evidenced by behavioural and emotional behaviour in children and young people;
- Only around half of schools currently use a screening tool to identify difficulties in pupils;
- Head teacher perceptions of their school's effectiveness, confidence, and the ability to differentiate between levels of need were low;
- Current provision specifically designed to address the mental health needs of pupils in schools is inadequate to meet the perceived incidence of mental health problems;
- Only half of schools implemented universal interventions to promote wellbeing and maintained on-site mental health provision available regularly;
- The majority of respondents reported that the external referral pathway to CAMHS was considered to be inadequate.[68]

There is a growing body of empirical research evidence suggesting that more could be done to protect and promote the wellbeing and mental health of children and young people within schools. The relationship between schools and CAMHS needs to be strengthened in order to provide the best wellbeing, health and educational services to future generations.

68 H Taggart S Lee and L McDonald, Perceptions of Wellbeing and Mental Health in English Secondary Schools: A Cross-sectional Study, CentreForum, July 2014.

Recommendations

- **That the national curriculum should include the requirement to teach children and young people how to look after their mental health and build emotional resilience through approaches such as mindfulness. They should also provide relationship skills education as standard, given the links between relationship distress and poor mental health.[69] The exact nature of the wellbeing programme being offered should be at the discretion of individual schools but every school in England must be able to demonstrate they are providing something of benefit to their students. OFSTED would be charged with monitoring progress towards the goal of at least 80 per cent of primary and secondary schools incorporating wellbeing programmes into school curriculum by 2020.**

- **That teachers and other educational staff should receive training in child development, mental health and psychological resilience to enable them to identify children who are vulnerable. The Commission recognise that teachers are not substitutes for mental health professionals but they should have the understanding and skills to recognise problems and know how to refer them on for further help. The Commission propose that mental health related training should be included on the Initial Teacher Training course by 2020. It is also essential that teachers have the opportunity to learn more about children and young people's mental health, and how to promote wellbeing in a school context through continuous professional development. The position and role of school nurses should also be fully utilised in moving towards expert guides in mental health.**

- **That for children experiencing a less severe or emerging mental health problem, there should be greater accessibility to psychological therapies in schools or in the community. This service should be provided by a practitioner with a background in child and adolescent mental health. This should be delivered through different evidence-based modalities such as face-to-face participation and mobile technologies. This could be provided by the voluntary or independent sector or statutory services. For children with moderate to severe mental health problems, all secondary schools should have routine access to a named CAMHS worker, either on site or through an effective referral pathway to CAMHS tier 3 or 4.**

69 The Tavistock Centre for Couple Relations, 'Couple relationships and mental health: a policy briefing from the Relationships Alliance', 2014, available from: http://tccr.ac.uk/policy/policy-briefings/484-couple-relationships-and-mental-health-a-policy-briefing-from-the-relationships-alliance.

Chapter 6: Workplace

I tried to return to work when sick pay ran out, but within 2 weeks was off sick again, and [my] employer began steps towards terminating my contract on [the] grounds of incapacity. 'Incapacity' – that word went on to haunt me as I internalised it and believed it about myself.

Sue Forber
Time to change

There is a two-way relationship between a positive working environment and good wellbeing: those who have high levels of wellbeing have greater productivity levels and job satisfaction; whereas, those experiencing a poor working environment are more likely to develop work-related stress and illness, which affects one worker in six at any one time and is the most common of all work-related illnesses.[70] [71] [72] High levels of work-related stress are particularly evident in the public sector where employers have the highest risk of work-related stress compared to any other sector. Health and social care professionals are almost twice as likely as the average worker to suffer.[73]

Despite known means of support and treatment, mental health problems cost UK employers £26 billion each year, averaging £1,035 per employee. This cost comprises £8.4 billion lost through sickness absence, £15.1 billion through lost productivity and 2.4 billion lost through staff turnover.[74] So, for business reasons, besides moral imperatives, employers should have a keen interest in ensuring that people with such conditions are supported to recover and retain their jobs and, when they are absent, to enable them to return to work as soon as they can. Employers should take steps to ensure their organisation or business promotes and protects the mental wellbeing of their employees.

However, for those with existing mental health problems, employment is a key area where people experience discrimination, which has a significant and negative impact on their recovery. Mental health problems have become the major driver for labour market exclusion within the UK with an average prevalence gap of 62.2 per cent between those with a SMI in work compared to the general working population in England. This is comparable to a much lower prevalence gap of 7.1 per cent for the employment rate of those with long-term conditions and the general working population in England.[75]

Nearly three in five employees in the UK say they would feel uncomfortable talking to their line manager if they had a mental health problem due to fears of losing their job and concern that their colleagues would find out. Furthermore, 92 per cent of the general population believe that disclosing a history of mental health problems to an employer would damage a person's career.[76] [77] One of the leading indicators for success in mental health will be when the employment rate of people with SMI is close to that of people with other disabilities, and as close as possible to the rest of the population. This is what must be achieved if we really want to reduce the cost of mental health problems.

Following a recent reform of welfare services, people who want to claim for employment support

70 C van Stolk, J Hofman, M Hafner et al., Psychological Wellbeing and Work. Improving Service Provision and Outcomes, RAND Europe, January 2014.
71 K Paul and K Moser, 'Unemployment Impairs Mental Health: Meta-Analyses', Journal of Vocational Behavior, 2009, 264–282.
72 G Waddell and K Burton, Is Work Good for Your Health and Wellbeing? London: The Stationery Office, 2006.
73 Office for National Statistics (ONS), Public Sector Employment Q1 2011, (year to March 2011; aged 16 and over; GB, not seasonally adjusted). Note that the latest figures on public sector employment by industry are unavailable for GB so United Kingdom proportions were applied to the GB total (ONS, Labour Market Statistics, September 2011).
74 Centre for Mental Health, Mental Health at Work: Developing the Business Case, Sainsbury's Centre for Mental Health, 2007.
75 Health and Social Care Information Centre, 'Dataset: 2.5 Employment of People with Mental Illness', February 2014, available from: https://indicators.ic.nhs.uk/webview/
76 Rethink, Fear of Stigma Stops Employees with Mental Health Problems from Speaking out. YouGov Poll, London: Rethink, 2010.
77 Time To Change, Stigma of Mental Health Makes Finding Work in Recession More Difficult. YouGov Poll, 2009)

allowance must receive the Work Capability Assessment. For people experiencing a mental health problem, this can result in poor and inaccurate assessments, which have impacted upon the type of benefits they can receive.[78] [79] This is significant, as people with mental health problems accounted for up to 38 per cent of all new claims to disability benefit in 2011, and are strongly represented in other working-age benefits, such as income support and housing benefit. [80] As a result, people with mental health problems are at a high risk of poverty through labour market disadvantages and unfair disability assessments. This has serious implications for suffering and misery.[81]

Our call for evidence support these findings further:

- 75 per cent of service users said that they had stopped themselves applying for work due to a fear of discrimination related to their mental health problem;
- 61 per cent of service users said that they had avoided applying for education or training services due to fear of discrimination related to their mental health problem;
- 63 per cent of service users said that they had been treated unfairly in finding a job;
- 67 per cent of service users said that they had been treated unfairly in keeping a job;
- 61 per cent of service users said that they had been treated unfairly in getting welfare benefits or disabled pension.

It is not all bad news. The OECD recognises that the UK is more innovative in the area of mental health and work than most other OECD countries. Compared with other developed economies, they point to the higher level of awareness that employers and policy makers have of issues of mental health and work in the UK and the desire for integrated health and work services.

This last point is significant. RAND Europe, an independent not-for-profit research institute, found that work based mental health services in the UK are not joined up. Too often the mental health problem and the attendant the employment needs are addressed as discrete issues resulting in delays in the delivery of an effective response. It is clear that we are better at innovation than implementation when it comes to mental health and work.

This is further demonstrated by the fact that the current Work Programme has failed to support people with mental health problems get into work.[82] Of the 126,000 people on the Work Programme, only 5,500 people with mental health problems have managed to find a place in sustainable employment (4.4 per cent). This may be because the ethos is based on conditionality and sanctioning, and the assumption that people need to be forced back to work. The mental health charity, Mind, has found that this attitude is making people more unwell. [83]

As the economy begins to recover, the Commission believe there is a significant opportunity to build a resilient, mentally healthy workforce, with employers recognising the full business benefit of talking openly about mental health. Many large and small organisations, including Business in the Community, the Federation of Small Business and the City Mental Health Alliance, are supporting

78 If you have put in a claim for Employment and Support Allowance (ESA), the Department for Work and Pensions (DWP) use a test called the Work Capability Assessment (WCA) to decide whether you can claim benefits.
79 Mind, Our Work on Benefits, 2014, available from: http://www.mind.org.uk/about-us/policies-issues/benefits/.
80 OECD, Mental Health and Work, 2014.
81 Marmot M, Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010, 2010.
82 Anyone who is found fit for work through the Work Capability Assessment, those put into the Work Readiness Action Group (WRAG) of Employment and Support Allowance and people who have claimed Job Seekers Allowance for three months are usually mandated to the Work Programme. People with additional needs, including people in the Support Group of Employment and Support Allowance are able to voluntarily engage with the Work Programme or Work Choice, the specialist employment programme for disabled people. The Work Programme gives providers wide scope to find their own creative and individualised support options for people with any disability or need which may place them at a disadvantage in the labour market. Employment support is funded through staged payments which the Work Programme provider draws down at engagement, job entry and successive points of job retention.
83 Mind, Our Work on Benefits, 2014, available from: http://www.mind.org.uk/about-us/policies-issues/benefits/.

employers to address mental health in the workplace. Yet a tiny fraction of businesses have the right kind of policies, plans and practices in place. The recession had helped employers to see the importance of mental health in the workplace; the recovery can see it fully embedded as a core part of good business practice.

Recommendations

- **There should be a concerted effort to make the UK a friendlier place for people experiencing mental health problems to work. The Commission recommend that all organisations with more than 500 employees should have the goal of becoming mental health friendly employers, such as through the Mindful Employer framework or Mind's Workplace Wellbeing programme.[84] A mark of a good employer should be one who makes it obvious that people with a mental health problem can disclose and talk about it without prejudice. By 2020, 90 per cent of these organisations should meet these requirements.**

- **In working towards this aspiration, government must take the lead by ensuring that all public sector enterprises meet this standard of a mental health friendly employer. The Commission recommend that this should be supported with a 'Time To Change' accreditation scheme.**

- **Government should use public sector procurement to set explicit contractual targets and incentives for the number of people with mental health problems helped into work, and this should fall into contract monitoring procedures. Contractors should only be awarded public work if and when they demonstrate their 'Time To Change' accreditation. This should also be accompanied by social marketing campaigns and must be driven in both the public and private sectors.**

- **The re-procurement of the Work Programme should be used to provide an effective and more integrated system of support for people with mental health problems returning to work. The most effective interventions in supporting people with a mental health problem into work are those that are specific and delivered locally, such as the Place then Train model of Individual Placement Support (IPS).[85] The Commission recommend that IPS should be offered to all groups disadvantaged by the labour market and commissioned at a local level. So far, the most effective services tend to be health funded within the NHS Trust with support of Local Authority funding.**

- **Similarly, of the 31,230 individuals who have been helped by the Access to Work initiative in the current financial year, only 3.5 per cent have a mental health condition as their primary medical condition.[86] This demonstrates how Access to Work spending allocated for those individuals with mental ill health is unrelated to the disease burden of 23 per cent.[87] The Commission propose that the proportion of mental health spending in the Access to Work initiative is increased to 10 per cent and that more should be done by Access to Work to proactively support people with mental health problems get back into work.**

84 Mindful Employer, Be a Mindful Employer and Be Positive About Mental Health, 2014, available from: http://www.mindfulemployer.net/
85 Centre for Mental Health, Implementing What Works: The Impact of Individual Placement Support, 2012.
86 G Gifford, Access to Work: Official Statistics, DWP, 2014.
87 Institute for Health Metrics and Evaluation, GBD Heat Map, 2010, available from: http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-heatmap.

- **The Commission believe that, as part of a co-ordinated approach to the promotion of mental wellbeing and capital, the Health and Work Service (HWS) should be developed to offer tailored occupational health support services to employers. This should involve training line managers to recognise mental health problems and intervene before the employee takes sick leave. Mental health sickness absence cases often have an element of workplace conflict or relationship breakdown between employee and employer and mediation can be a key intervention that stops people falling out of work. In addition to this, employers should be able to refer direct to the occupational health team. GPs should be mandated to refer those who have, or are expected to be, out of work for four weeks or more, to an occupational health professional in order to ascertain the issues preventing the employee from returning to work. In order to support this process, there should be an improvement in the education that GPs and allied health professionals receive that furthers knowledge, skills and confidence in matters of health and work (relevant to mental health), the welfare system and the Access to Work initiative.[88]**

88 The Access to Work grant helps pay for practical support if you have a disability, health or mental health condition so you can start working, stay in work or start your own business.

Chapter 7: Health and Social Care

We need to promote what is good, what works and what is needed to keep us well and safe but we also need to highlight unacceptable treatment that belongs to a bygone age. The rhetoric of 'parity of esteem' needs to mean more than being referred to as 'patients' and being 'on par' with physical health. It should mean that resources for mental health are comparative to physical health and not cut even further and people are treated and supported as equal citizens.

Sarah Yiannoullou
National Survivor User Network

The Commission believe a 'National Wellbeing Programme' that focuses on promotion and prevention is a core part of meeting the future needs of the nation. However as this is a long-term ambition that will take time to be realised, the need for comprehensive mental health services is likely to remain.

Primary Care

Primary care is central to the provision of services for people experiencing a mental health problem. In addressing the accessible disease burden of mental health problems, it is necessary to consider the current treatment gap. Depression and severe anxiety account for the majority of mental health problems diagnosed, yet 75 per cent of these people do not receive any form of treatment.[89] So far there has been insufficient attention given to this issue. However, as people become more aware of their own mental health and wellbeing and start to seek help, we can expect the demand on mental health services to increase in the short-term in relation to the incidence rates of mental health problems in the population. For instance, the number of antidepressants being dispensed in the community each year has risen from 15 million items in 1998 to 40 million items in 2012.[90]

The World Health Organisation recommends that in reducing the treatment gap for common mental health problems, mental health should be integrated within primary care with strong links to specialist care, informal community-based services and self-care.[91] The advantages of integrating mental health into primary care are that it enhances access as services are closer to home. It minimises the stigma and discrimination that may be experienced and is cost effective.[92]

One such scheme initiated five years ago by Dr Rhiannon England, Mental Health Director for City and Hackney CCG, and responsive to social circumstances (such as deprivation and housing) in addition to medical symptoms, now supports GPs in the management of patients with complex needs.[93] Patients include people with medically unexplained symptoms, those with personality disorders and those with chronic mental health problems. Many have two or more problems, often also with poor physical health.

The Service supports GPs partly through case discussions and training, partly through a direct clinical service on referral, partly through a range of brief psychological interventions. The number of referrals currently runs at 40–50 per month, of which 60 per cent are from black and minority ethnic

89 The Centre for Economic Performance's Mental Health Policy Group, How Mental Illness Loses out in the NHS, London: Centre for Economic Performance: http://cep.lse.ac.uk/_new/research/mentalhealth/default.asp.]
90 R Spence, A Roberts, C Ariti and M Bardsley, Focus On: Antidepressant Prescribing Trends in the Prescribing of Antidepressants in Primary Care, The Health Foundation and Nuffield Trust, May 2014.
91 World Health Organization and World Organization of Family Doctors (WONCA), Integrating Mental Health into Primary Care: A Global Perspective, Geneva, 2008.
92 World Health Organisation, Integrating Mental Health into Primary Care: A Global Perspective, 2008.
93 M Parsonage, E Hard and B Rock, 'Managing patients with complex needs', Centre for Mental Health, March 2014.

groups. A recent, detailed evaluation of the service, conducted by the Centre for Mental Health, found that 75 per cent of patients show improvement and 55 per cent show recovery (defined as moving below the clinical threshold after treatment). Data indicate that treatment through the Service reduced NHS service costs by £463 per patient, of which 34 per cent was in primary care (mainly fewer GP consultations) and 66 per cent was in secondary care (fewer A&E and outpatient attendances and in patient stays). Using the NICE cost-effectiveness framework, it is estimated that treatment by the service has a cost per QALY of around £10,900, well below the NICE threshold of £20,000 to £30,000. A survey of local GPs found high levels of satisfaction: an average of 8.5–9.0 for each question (on a 1–10 rating scale).

Our call for evidence found that:

- 45 per cent of service users had a negative experience in primary care, of whom;
  - 87.5 per cent were dissatisfied with their community mental health team;
  - 62 per cent were unhappy with the treatment they received from their GP;
  - 72 per cent of service users are not able to choose from a variety of treatment options for their mental health problem;
  - 94 per cent of service users are concerned about the treatments available to them, such as medical side effects.

ILLUSTRATION **Three Examples of Integrated Primary Care Hubs**

I – Sandwell

The Sandwell Esteem Team, part of the Sandwell Integrated Primary Care Mental Health and Wellbeing Service (the Sandwell Wellbeing Hub) in the West Midlands. The hub is a holistic primary and community care-based approach to improving social, mental and physical health and wellbeing in the borough of Sandwell; it forms a part of case study research by The King's Fund and funded by Aetna and the Aetna Foundation in the United States to compare five successful UK-based models of care co-ordination. The key aim of the Esteem Team is to support people with mild to moderate mental health conditions and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control of their own lives by offering guided therapies and tools for self-help.

Source: http://talkshopsandwell.co.uk/services-on-offer/esteem-team

II – North West London

Two North West London Integrated Care pilots cover eight boroughs and two million people. The Outer Pilot brings together over 200 GP practices, three hospital trusts, two community trusts, two mental health trusts and the social care services of five boroughs. Work is through a genuine partnership of health, social care, third sector and patient/user-led organisations. The vision is that individuals, their carers and families exercise choice and control in managing their health and wellbeing and that they receive needed care in their home or in the local community. GPs are at the centre of organising and coordinating people's care.

The four aims are to improve patient outcomes, to use NHS funds efficiently, to reduce hospital admissions and Accident and Emergengy (A&E), and to enable effective professional working (and training) across provider boundaries. Commissioners face a £1 billion funding gap in 2014/15 at the same time as healthcare demand is increasing by 4 per cent per anum. The view taken is that a silo approach to the provision of complex services creates perverse and costly incentives for providers. One pilot is currently developing a wider whole systems integrated care services, involving eight CCGs, local authorities, partner providers and service users.

At the core are multi-disciplinary groups of professionals from community health, mental health, primary, secondary and social care, pharmacy and nursing—with the involvement of patients and carers. The groups (currently some 42) meet monthly and have produced some 36,700 care plans [by 2013]. The pilot partnership agrees population scope, needs, budgets and outcomes.

Source: http://www.northwestlondon.nhs.uk/publications/?category=1671-Integrated+Care+Pilot+(ICP)-d)

III – Colorado

Behavioural health providers in Colorado have used an innovative model to integrate behavioural health providers (BHP) into primary care. BHPs work alongside Primary Care Providers (PCP) who cross over two 'buckets', one being mental health, the other being medically related presentations. The mental health 'bucket' includes depression, anxiety, obsessive compulsive disorder and mild to moderate substance use and alcohol use disorders. The medical 'bucket' includes medically unexplained symptoms as weight loss, diabetes. In primary care, both streams of care providers work alongside at a 1:1 ratio for a population of 2500 patients and are accountable to case managers, who ensure integration is maintained.

BHP or PCP do not treat the 10–15 per cent of people with a severe and enduring mental illness but make sure care is coordinated by referring them to specialist services.

Source: http://www.innovations.ahrq.gov/content.aspx?id=3950

Secondary Care

In addition to the recommendations made in primary care, there need to be high quality services for people who are experiencing a more severe mental health problem in secondary care. This requires investment, training and connectedness across services. This is essential as 4.6 million people have a co-morbid mental and physical health problem and up to 80 per cent of all people admitted to a general hospital in England have a mental health problem.[94] [95] Co-morbidity significantly impacts upon health related outcomes and quality of life through interaction and exacerbation of different illnesses.

The economic burden is also high as the cost of mental health related co-morbidity is estimated at an additional £13 billion per year, on top of the £14 billion already spent on mental health services.[96] This additional spend is the result of people with long-term conditions and medically unexplained symptoms accessing services. In these circumstances, the cost of co-morbidity is increased by 45

94 Royal College of Psychiatrists, The Faculty of Liaison Psychiatry Submission to the Urgent and Emergency Care Review, 2013.
95 C Naylor, M Parsonage, D McDaid et al., Long-term Conditions and Mental Health. The Cost of Co-Morbidities, The King's Fund, Centre for Mental Health, 2012.
96 LSE Mental Health Policy Group, How Mental Health Loses out in the NHS, London: London School of Economics, 2012.

per cent to 75 per cent, possibly due to issues with early identification, effective assessment and treatment adherence, and is estimated to cost the NHS £10 billion per year. Similarly, medically unexplained symptoms are estimated to make up 50 per cent of acute outpatient activity and cost the NHS £3 billion per year.[97] [98]

In light of this, there is a further opportunity for prevention and early intervention within NHS Acute Trusts. People experiencing a mental health problem are more likely to access acute trust services through A&E departments, (78 per cent compared with 48 per cent of non-mental health service users). People with mental health problems are also more likely to access acute trusts through an emergency response: of those attending A&E by ambulance or helicopter, 54 per cent have a mental health problem.[99] Furthermore, there are also 200,000 self-harm presentations each year and alcohol-related admissions are increasing. Yet, people who have quick access to high quality care are more likely to recover and stay well.[100] [101]

Our call for evidence found that:

- 73 per cent of service users had a negative experience in secondary care, of whom;
  - 78 per cent were dissatisfied with the mental health outpatient clinic;
  - 62 per cent were unhappy with assessment or treatment from A&E;
  - 33 per cent were dissatisfied with treatment from a psychologist.

When entering an A&E office for a non-mental related medical problem things go OK until I am being asked what medication I am on. Then the medical staff next question is if I am bipolar and suddenly their focus shifts on my bipolar symptoms (for which I have not complained) and they ignore my original medical problem. This has happened to me many times . . . mentally ill people are not to be treated as a curiosity by A&E staff.

Service user
MHC Call for Evidence Survey

97 S Reid, S Wessely, T Crayford, M Hotopf, 'Medically Unexplained Symptoms in Frequent Attenders of Secondary Health Care: Retrospective Cohort Study', BMJ 2001; 322 (7289):767.
98 SL Bermingham, A Cohen, J Hague, M Parsonage, 'The Cost of Somatisation Among the Working–Age Population in England for the Year 2008–2009', Mental Health Fam Med 2010;7(2):71–84.
99 Health and Social Care Information Centre, HES-MHMDS Data Linkage Report: Additional Analysis; 2011–12, England (Experimental Statistics), 2013.
100 Department of Health, Multicentre Study of Self-Harm in England, 2013.
101 National Audit Office, Reducing Alcohol Harm: Health Services in England for Alcohol Misuse, 2008.

CASE STUDY **Integrated Health Services**

One radical solution seeks to answer the challenge of integrating mental and physical care. The acute Oxford University Hospitals Trust set up and funded its own psychological medicine service – one of the first acute trusts in England to do this.

Prior to 2013, Oxford University Hospitals, like many acute trusts, had a limited liaison psychiatry service focused largely on deliberate self-harm. Partly responding to the requests of its own physicians, the trust took the unprecedented step of establishing a psychological medicine service, employing its own psychiatrists for inpatient services. A key benefit was greater scope to align the objectives and processes of the psychological medicine service with those of the acute trust. This arrangement also affords more opportunity to be incorporated into training programmes for clinical staff.

With 1,800 beds, teaching and training is an essential strategy in delivering integrated care across the whole trust. The trust took another unprecedented step by establishing a consultant psychiatrist delivered service. This models and demonstrates a parity of esteem of psychological medicine alongside other medical and surgical specialties.

Source: http://www.hsj.co.uk/home/commissioning/integration-the-future-of-liaison-psychiatry/5069736.article#.U6Q2evldXA8

Training

Our ambitions for primary and secondary care cannot be achieved unless the health and social care workforce are adequately equipped with the knowledge, skills and expertise to meet demand. Current mental health related training for professionals working in physical health care is inadequate.[102] Medical students receive limited training on mental health if they are not specialising in psychiatry. Similarly, GPs and paramedics get very little training in mental health, even though 4.6 million people have a co-morbid mental and physical health problem and up to 80 per cent of all people admitted to a general hospital have a mental health problem.[103] [104] Furthermore, 30 per cent of GP caseloads are mental health related.[105]

Positive attitudes towards mental health need to be fostered during medical and professional training. Of young people in sixth form, 49 per cent said they found psychiatry an attractive career option.[106] However, this drops significantly during medical training since only 3 per cent of medics want to pursue a career in psychiatry.[107] Something happens during their training that discourages them from specialising in mental health.

People experiencing a mental health problem may also be stigmatised because of their condition when trying to access physical health care. This can be due to 'diagnostic overshadowing', where the physical needs of a patient are over-shadowed by their psychiatric diagnosis. The experience of stigma in this way can prevent people from seeking help at an early stage, particularly in people from BME communities. It can lead to poorer physical health and, consequently, a 20-year mortality

102 C Gerada, B Riley and C Simon, Enhanced GP Training: The Educational Case, Royal College of GPs, 2012.
103 C Naylor, M Parsonage, D McDaid et al., Long-term Conditions and Mental Health. The Cost of Co-Morbidities, The King's Fund, Centre for Mental Health, 2012.
104 Royal College of Psychiatrists, The Faculty of Liaison Psychiatry Submission to the Urgent and Emergency Care Review, 2013.
105 National Institute for Clinical Excellence, Common Mental Health Disorders: Identification and Pathways to Care, 2011.
106 R Maidment, G Livingstone, M Katona et al., 'Carry on Shrinking: Career Intentions and Attitudes to Psychiatry of Prospective Medical Students', Psychiatric Bulletin, 27, 30 –32.
107 S Rajagopal, KS Rehill and E Godfrey, 'Psychiatry as a career choice compared with other specialties: A survey of medical students', Psychiatric Bulletin, 28, 444 –446.

gap for men, and 15 years for women.[108 109 110 111] Progress is being made to change this but we need to make sure that the current momentum is not lost.[112]

Our call for evidence found that 70 per cent of service users stated they had been treated unfairly by mental health staff, either through their direct experience of treatment and the behaviour of staff or by feeling disrespected or humiliated.

Recommendations – primary care

- **Primary care requires transformation. Mental and behavioural health should be fully integrated into primary care provision. This integrated model can be defined as 'the care that results from a practice team of primary care and behavioural health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centred care for a defined population. This care may address mental health, substance abuse conditions, health behaviours (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, [and/or] ineffective patterns of health care utilization'.[113] The aim would be to support the whole primary care team and join up mental health community services, rather than just provide a bolt on of mental health to the existing GP practice.**

- **Mental health providers working with GPs must be properly equipped for this new setting and must see their skill set extending beyond 'just' mental health to include the ability to address chronic disease, health behaviour change, and psychosocial components. It is not expected that mental health professionals would be confined to mental health functions in primary care, when they have expertise in long term and chronic conditions.**

- **Mental health is 30 per cent of the daily work of GPs and this rises to 50 per cent in more deprived areas of the country. There is also a need to ensure primary care professionals are able to address the social determinants that are affecting their patients' lives, such as debt, interpersonal violence, and unemployment. Therefore there is a need to ensure the skill mix represents the local burden of disease through a multi-disciplinary and multi-agency team.**

- **In order to achieve this, primary care practices should expand to include a wider range of health and social care professionals. This is not just about community psychiatric nurses but a broad spectrum of professionals. Social workers are central to community mental health services. Trained to focus on the social aspects of mental health, they also play important roles in safeguarding, and in assessing people's entitlement to services. The key to success lies in recruiting a highly skilled workforce, committed to the principles and practice of working in partnership across different professional disciplines. There is therefore a need for a cadre of highly trained social workers who**

108 Social Exclusion Unit, Mental health and Social Exclusion, London: ODPM, 2004.
109 C Enger, L Weatherby, RF Reynolds, et al., 'Serious Cardiovascular Events and Mortality Among Patients with Schizophrenia', Journal of Nervous and Mental Disease, 2004 192, 19–27.
110 M Joukamaa, M Heliövaara, P Knekt, et al., 'Schizophrenia, Neuroleptic Medication and Mortality', British Journal of Psychiatry, 2006 188, 122–127.
111 G Thornicroft, 'Physical Health Disparities and Mental Illness: The Scandal of Premature Mortality', British Journal of Psychiatry 2011, 199:441-442.
112 D Greenway, Securing the Future of Excellent Patient Care, Shape of Training, 2013.
113 C J Peek, (2013). 'Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus', in Agency for Healthcare Research and Quality (ed.), AHRQ Publication No.13-IP001-EF.

are able to lead the integration agenda in mental health.[114]

- There should also be devolution of commissioning responsibilities. Currently primary care is commissioned by NHS England through its local area teams. We propose that the Department of Health take steps to enable NHS England to pilot the delegation of primary care commissioning to HWBs as part of a further wave of pioneers, building on the arrangements for agreeing local plans for delivering the Better Care Fund.

- Implementation of Improving Access to Psychological Therapies (IAPT) programmes for adults and children and young people should be continued; as should the Secretary of State's Mandate to the NHS in England requiring it to offer a full range of evidence-based psychological therapies to everyone who needs them, including children and young people, within 28 days of requesting a referral. In achieving this, there should be greater investment, an introduction of national access standards and waiting times, improved local access and waiting times, and an improved and increasing choice of therapies. Access rates should increase from 15 per cent of the population to 25 per cent and 80 per cent of patients should receive psychological therapies within 28 days of referral. At a time when funding is limited, there is a need to deliver psychological and other therapies more creatively and efficiently.

- Social prescribing is helpful for: vulnerable and at risk groups (e.g. low-income single mothers, recently bereaved elderly people, people with chronic physical illness, and newly arrived communities); people with mild to moderate depression and anxiety; people with long-term and enduring mental health problems; and frequent attenders in primary care.[115] The Commission recommend that GP social prescribing should be available in every primary care practice in order to connect patients to local wellbeing services and other support available in the wider community that can address the psychosocial factors that influence wellbeing. However, this will only be effective if the community structures previously discussed are in place.

Recommendations – secondary care

- Everyone should have guaranteed access to mental health crisis care in England. At least 95 per cent of patients attending an emergency department must be seen, treated, admitted or discharged in under four hours.

- In support of this, the Commission also recommend that every NHS Acute Trust should provide and fund liaison psychiatry (or psychological medicine) and be inspected by the Care Quality Commission. Liaison psychiatric teams assess, treat, triage and signpost people experiencing mental health problems, as well as providing training to other health professionals. Liaison psychiatric teams can also provide a targeted intervention, specialising in children and adolescents, working age adults and older people. Effective integration reduces duplication of services between different organisations. The Centre for Mental Health estimate that a saving of £1.2 billion could be achieved nationally if liaison psychiatry were rolled out across England.[116] [117].

114 Jonathan Clifton and Craig Thorley, Think Ahead: Meeting the Workforce Challenges in Mental Health Social Work, IPPR, May 2014.
115 L Friedli, C Jackson, H Abernethy and J Stansfield, Social Prescribing for Mental Health – A Guide to Commissioning and Delivery, Centre for Welfare Reform, 2009.
116 Department of Health, High Quality Care For All: NHS Next Stage Review, 2008, available from: www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825
117 M Parsonage, M Fossey and C Tutty, Liaison Psychiatry in the Modern NHS, Centre for Mental Health, 2012.

This should provide mental health service users with a safe and effective pathway to the appropriate care and support.

Recommendations – training

- **That medical and professional related training should be reformed to include mental health across all specialities to create a more psychologically minded workforce. The Commission support the extra year of GP training to include further modules in mental health. Health Education England (HEE) must lead this reform working with the Colleges and other stakeholders.**

- **That the cost of mental health in terms of human misery and costs to society cannot wait for a generation of psychologically minded professionals to emerge. The Commission believe that there is a need for appropriate continuing professional development, such as through modular training programmes or needs-led master classes, to deliver the scale and pace of change needed.**

- **That the need for a psychologically minded workforce goes beyond health and care to all public, private and voluntary sector organisations that should be making mental health their business (such as police officers, prison officers, housing officers, the Citizens Advice Bureau etc.). HEE should lead the development of a training and professional development framework that other public, private and voluntary sectors can follow.**

Chapter 8: Making it Happen

> **The failure to listen, empathise and most importantly consult left me reluctant to seek help until reaching crisis. I still feel unsupported and alone with my diagnosis.**
>
> *Service user*
> *MHC Call for Evidence Survey*

In order to achieve most of what has been set out in this report, there needs to be a comprehensive and cohesive transformation in operational and financial areas.

Operational

National and local leadership

The Commission recommend the creation of a dedicated Cabinet-level mental health minister in the Department of Health with responsibility for mental health services. As part of this responsibility, the new and existing metrics discussed in this report should be included in the wellbeing outcomes framework proposed by the Commission. This will provide much needed data on the mental health of the nation.

We also recommend that the Secretary of State for Health should have to report annually to Parliament on progress towards the goal of parity of esteem between mental and physical health. The report would inform an annual parliamentary debate on progress.

In further supporting the emphasis on wellbeing and mental capital, every HWB should appoint a Wellbeing Champion to advocate parity of esteem between mental and physical health and promote wellbeing. However, this needs a co-ordinated effort at a national level. To support and encourage work right across government, we recommend the appointment of a Minister for Wellbeing in the Cabinet Office reporting to the Prime Minister. This role is not primarily about health care; it is about ensuring that government at all levels is working on the social determinants of mental ill health. This role should include working with and supporting Mental Wellbeing Champions and ensuring mental wellbeing and mental capital is prioritised by HWBs and government departments. This will ensure that a focus on mental health and wellbeing is embedded across the work of government, including in the formulation of policies affecting housing, education, employment, planning, welfare and policing.

Commissioning

The Commission do not believe that a further reorganisation of commissioning structures would help to realise the goals of the government's Mental Health Strategy, nor support the implementation of its recommendations. We believe that the current structures should be allowed to mature and adapt to meet the needs of the population, both locally and nationally.

There has been a lot of concern in relation to the capability and structure of HWBs. However, the Commission believe that HWBs can be strengthened to enable them to lead commissioning for population wellbeing as they are best placed at a local level to embed the over-arching approach advocated in this paper. While this is not necessarily about new resources, it would enable a common framework to be adopted for local priorities to be assessed against the goal of promoting wellbeing and mental capital and for opportunities and gaps to be identified. HWBs need to be guided by the same set of principles but with the freedom to work together and deliver local health and wellbeing services that meets the needs of their population.

CASE STUDY **Strengthening Health and Wellbeing Boards**

Cheshire West and Chester Health and Wellbeing Board made priorities of improving mental health, wellbeing and personal resilience in its 2014–19 Strategy. Mental ill health represents one of the largest burdens for the region: for example, a tenth of 5–16 year olds have a mental health problem. In seeking to combat such issues, the principles of the Local Government Association's Systems Leadership Programme are to:

- Reduce demand on acute services;
- Improve the quality of life for a significant proportion of local residents;
- Empower residents in addressing their challenges and needs;
- Foster co-operation between a broad range of partners.

In Cheshire, the potential, local power of HWBs is acknowledged. The Board made an issue of excess winter deaths in its strategy. The CCG took this up and worked with the local authority to create ten evidence-based outcomes that would reduce winter deaths. The two organisations discovered that the issue mainly affected vulnerable groups, such as the elderly and those with mental health problems. They used the local authority's bins list to identify and target people who needed help (and should be visited when the weather was bad).

Source: http://www.westcheshiretogether.org.uk/strategic_themes/health_and_wellbeing.aspx

To support this work, we believe that a developmental approach should be taken to roll out, with HWBs bidding to act as pathfinders for the enhanced role, starting in 2016 with all HWBs participating by 2020. This is essential as evidence suggests that the accessible treatment gap may be explained by poor mental health coverage in JSNAs.[118]

Nationally, NHS England is currently responsible for the direct commissioning of services outside the remit of clinical commissioning groups, such as primary care, public health, offender health, military and veteran health and specialised services. Specifically in relation to primary care, the Commission recommend that NHS England should be able to pilot the delegation of primary care commissioning to HWBs as part of a further wave of pioneers, building on the arrangements for agreeing local plans for delivering the Better Care Fund.

Financial

The commitment to parity of esteem for mental health must be backed up by action to deliver parity in funding. The gap is significant, with mental health accounting for only 13 per cent of NHS spend while accounting for 23 per cent of demand. From the total mental health budget, only 6 per cent is allocated to CAMHS. The Commission recommend a clear commitment by the Secretary of State for Health in the mandate to NHS England to achieve parity of funding for mental health over a ten-year period. To achieve this, the Commission believes that through the tariff deflator, or other means, the proportion of NHS spending on mental health should grow by one per cent a year over the next 10 years, equivalent in current terms to an increase in spending on mental health of the order of £1 billion per annum.

The Commission recognise the difficulty of shifting resources at a time when public expenditure is under pressure but is clear this must happen. This is not only an issue of justice but also a policy shift

118 J Campion, 'Public Mental Health: The Local Tangibles', The Psychiatrists, 2013.

that will support the long term sustainability of the NHS by ensuring that appropriate investment is made in services that address co-morbid mental health issues, which, if left untreated, are estimated to cost the NHS £13 billion per annum.[119] If the transformation of the way we deliver current services towards an integrated physical, mental, health and social care model that is recommended in this paper is to be achieved, there needs to be a systematic reapportioning of funds to meet individual and collective need. This may require a government-backed spend to save approach and a longer-term strategic and funding vision that goes beyond the NHS annual spending round. However, there is considerable scope in the NHS for savings to be made through the delivery of more efficient services by adopting the best evidence-based preventative interventions demonstrated through economic modelling for the Department of Health.[120]

Similarly, wider local authority budgets should dedicate a larger proportion of funds to investment in the wellbeing and mental capital of the population, as well as health and social care services, given that much of the work to improve wellbeing would be done through local authorities, health and wellbeing boards, and public health professionals within councils.

There is also a role for private sector partners to do more than provide forensic and specialist services to the NHS. These organisations are a resource that is under-utilised and they have the capital to invest.

The Integration Pioneers and Better Care Fund approach offers a way of delivering this change at the pace and scale required. We would expect the Better Care Fund approach to be extended to drive integrated models of care in relation to mental health, schools, housing and justice in order to achieve the truly holistic place-based approach recommended in this report.

119 LSE Mental Health Policy Group, How Mental Health Loses out in the NHS, London: London School of Economics, 2012.

120 M Knapp, D McDaid and M Parsonage (eds), Mental Health Promotion and Mental Illness Prevention: The Economic Case, Department of Health, 2010, available from: www.dh.gov.uk/prod_consum_dhdigital assets/documents/digitalassets/dh126386.pdf.

Chapter 9: Conclusion

Mental health services have traditionally been built around minimising risk and treating symptoms. I think we have come a long way in terms of helping professionals to see it is about more than just living without symptoms, it is about people finding meaning and happiness in their life, based on who they are as a person, regardless of what their diagnosis is.

Health professional
MHC Call for Evidence Survey

The Commission goal was to set out a new ambition for the nation's mental health by 2020. A major change in approach is needed. The change goes well beyond the confines of the NHS.

Taken together, the recommendations in this report would have a significant impact on the wellbeing or 'happiness' of the nation, reduce the number of people living with lifelong mental health problems, and increase the number recovering from mental illness.

The NHS has developed to cater for the medical needs of body parts, rather than whole people. The psychological, biological, and the sociological needs of people are placed in separate silos at huge cost to the individual and to society.

What is required is a system that creates equity in all things to do with health, that does not artificially tease apart mental from physical. Realising this goal challenges a long established status quo.

Good mental health and wellbeing policy is simply good health policy, and investment in this new ambition would do more to reduce the human and financial costs of misery and mental health problems. Investment in this ambition could work towards the following achievements:

- Reduce poverty and social disadvantage;
- Promote human rights and inclusion;
- Reduce the human impact of mental health problems;
- Prevent premature death;
- Reduce the economic costs to society;
- Put knowledge of cost-effective treatments into practice.[121]

Public attitudes towards mental health problems are changing for the better. The mental health strategy, No Health Without Mental Health, set the right direction; now we need ambition and action. Some will argue that because the NHS has gone through an intense period of structural change and is facing huge financial pressures, now is not the right time. The Commission disagree. Now is the time to go further and faster.

As the economic recovery takes hold it will not be good enough simply to measure progress and set policy on the basis of GDP: the wellbeing of the nation matters too.

The price of doing nothing is much more than the multi-billion pound cost of mental health problems, it is the wasted potential and human misery that could have been prevented for want of the willingness to act on the evidence.

Now is the time to act.

121 V Patel, S Saxena, M De Silva and C Samele, Transforming Lives, Enhancing Communities: Innovations in Mental Health, WISH, 2013.

Appendix 1: Commissioner Biographies

Rt Hon Paul Burstow MP (Chair)

Paul Burstow has served as Liberal Democrat MP for Sutton and Cheam since 1997. He was Minister of State for Care Services in the Department of Health from 2010–2012.

Paul is currently Chair of the Liberal Democrat Health Backbench Committee. In 2013, he chaired the influential Joint Committee on the Draft Care and Support Bill, now the Care Act 2014 and is currently chairing a yearlong commission on the future of residential care for the think tank, Demos.

Lord Victor Adebowale CBE

Victor is Chief Executive of Turning Point, a leading health and social care organisation which provides services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems, and those with a learning disability. The organisation has designed, implemented and grown Connected Care community commissioning and service design. On any given day, Turning Point is engaged with over 25,000 people in over 200 locations across England and Wales, employing 2,000 people with a turnover of £85 million.

Victor is a champion for the cause of those affected by poverty, mental ill health, drugs, alcohol addictions, a learning disability and those with cross-cutting and complex needs. He has driven forward government policy, been instrumental in negotiating significant change within large organisations, chaired regeneration projects and managed large organisational budgets. He is one of the country's top sector leaders in the policy and delivery of health and social care.

He is a Visiting Professor at the University of Lincoln and holds numerous honorary doctorates as well as being a Fellow of the City & Guilds of London Institute, an associate member of the Health Service Management Centre at the University of Birmingham, and of Cambridge University Judge Business School. He is the founder and Chair of Collaborate at London South Bank University.

Victor has a passionate interest in public service reform and reversing the inverse care law, (i.e. those who need public services most tend to get them least). In pursuit of this interest, he lectures and speaks widely on the subjects of poverty, social exclusion, equality and human rights, leadership, and change management.

Victor Adebowale started a career in housing as Estate Manager with Newham Council, moving to become Head of Permanent Property at Patchwork Housing Association in 1985 and then Regional Director of Ujima Housing Association. From 1990 to 1995 he was Director of the Alcohol Recovery Project in London and from 1995 to 2001 was Chief Executive of Centre Point, the National Youth Homelessness Charity.

Victor is a Non-Executive Director of NHS England, on the Board of English Touring Theatre, President of the International Association of Philosophy and Psychiatry, Chair of Vision Development, and Chancellor of Lincoln University. He is a Non Executive Director at 360 IT Collaboration Ltd and Leadership in Mind.

In 2000, Victor was awarded the CBE in the New Year Honours List for services to the New Deal, the unemployed, and homeless young people. In 2001, he was appointed a crossbench member of the House of Lords.

Professor Dame Sue Bailey

For over thirty years, based in the North West of England, Sue Bailey is a Child and Adolescent Forensic Clinician and Researcher, made an OBE in 2002 for services to young offenders.

She found herself working in a field where young people's high risk to others and self behaviour has arisen from their complex unmet bio psychosocial needs being, frequently compounded by their

families living in circumstances of gross inequality.

Through her several roles in the Royal College of Psychiatrists, most recently as President, she has therefore lobbied to shape primary legislation, policy and practice to improve mental health services in the UK and internationally, always working with multi-agency, disciplinary partners, most importantly with patients, young people and families. She has recently been appointed Chair of the Children and Young Peoples' Mental Health Coalition (CYPMHC), a group of 14 charities.

Chair of the UEMS CAP Section and recently appointed as Senior Mental Health Clinical Advisor at Health Education England she believes that outcomes across the whole of the health profession could be significantly improved if all health and social care professionals were more psychologically minded.

Until recently Vice Chair of the Academy of Royal Medical Colleges she has now become Chair of the Academy's inequalities Forum.

She was made a DBE in the 2013 New Years Honours list for services to mental health services and mental health charities.

Paul Farmer

Paul Farmer has been Chief Executive of Mind, the leading mental health charity working in England and Wales since May 2006.

Paul is Chair of the NHS England Mental Health Patient Safety Board, he is an advisor to the Catholic Bishops on mental health, and was a member of the Metropolitan Police commission on policing and mental health.

He is a trustee at the Mental Health Providers Forum, an umbrella body for voluntary organisations supporting people with mental distress. Paul is also a trustee of Lloyds Banking Foundation and an elected member of the ACEVO board.

In November 2012, Paul received an Honorary Doctorate of Science from the University of East London in recognition of his achievements in promoting understanding and support for mental health.

Nominated by sector experts and voted for by chief executives, Paul was selected most admired charity chief executive in the Third Sector Most Admired Charities Awards 2013.

Angela Greatley OBE

Angela Greatley has been chair of the Tavistock and Portman NHS Foundation Trust since November 2009. The Trust is a specialist mental health trust focusing on psychological, social, and developmental approaches to treating emotional disturbance and mental ill-health, and on promoting mental health and wellbeing. The Trust provides clinical services, training and consultancy.

Prior to taking the chair, Angela was for five years, the Chief Executive of the Sainsbury Centre for Mental Health, having previously been Fellow in Mental Health at the King's Fund.

Angela Greatley has been a commissioner and a manager in the NHS and has also been a local authority member. She served for ten years on the board of a large college providing adult and continuing education and, until recently, Angela was a board member of Headstrong, the Irish Centre for Youth Mental Health based in Dublin.

Paul Jenkins OBE

Paul Jenkins is the Chief Executive of the Tavistock and Portman NHS Foundation Trust, a specialist mental health trust focusing on psychological, social, and developmental approaches to understanding and treating emotional disturbance and mental ill health, and to promoting mental health.

Paul was previously the Chief Executive of Rethink Mental Illness, the leading national mental health membership charity working to help those affected by severe mental illness to recover and lead a better quality of life. He has an MBA from Manchester Business School and has over 20 years of experience in management and policy making in Central Government and the National Health Service (NHS). Paul has previously served as Director of Service Development for NHS Direct. He has been involved in the implementation of a number of other major national government initiatives, including the Next Steps Programme and the 1993 Community Care Reforms. In 2002, he was awarded an OBE for his role in setting up NHS Direct.

As a part of Rethink Mental Illness, Paul aimed to make a practical and positive difference by providing hope and empowerment through effective services and support to all those who need it. Paul also campaigns for equal rights for the mentally ill by creating greater awareness and understanding. He is a member of the Carers' Standing Commission, set up to advise the Government on the implementation of the Prime Minister's new strategy for carers.

Dr Alison Rose-Quirie

Alison spent 25 years in the criminal justice sector, starting on an accelerated training scheme as a Prison Officer in HMP Holloway. Alison was the first female Manager to work at HMP Wandsworth in 1987, paving the way for today's multi-sex staffing across the Prison Service.

She left the Public Sector Prison service in 1992 to join Group 4 in the first private sector Prison Management contract in the UK at HMP Wolds. Leaving Wolds as the Prison Director, Alison went on to commission and open a 600 bed PFI Prison in the Midlands before moving into Business Development, eventually becoming Managing Director of International Service Development for GSL Care and Justice Division (now G4S).

Alison left the criminal justice sector to manage the Secure and Step Down Service Division of the Priory Group in 2007, fulfilling a long-term ambition to seek to provide an appropriate and timely care pathway for forensic patients both within the Criminal Justice System and within Secure Hospital settings. Until recently, she led the Mental Health Services division of Care UK, a large national health and social care company. Alison remains committed to improving the lives of those less fortunate and is actively involved in shaping national mental health policy. She is Chair of the Independent Mental Health Sector Alliance and an active member of the Mental Health Network, the NHS Confederation. She represents the Alliance on the Ministerial Advisory Group on Mental Health, the IS Reference Group and Future Forum Working Groups.

Alison has a Law degree from UCW, an MBA, a PhD in prison management and has completed the Cabinet Office Top Management Programme.

Appendix 2: Acknowledgments

The Commission are extremely grateful to everyone who has contributed to the work of the Commission.

Thanks to everyone who contributed, in writing or in person, both those who have remained anonymous, and those listed below:

Sue Baker
Andrew Bell
Sarah Brennan
Richard Bryant-Jefferies
Janet Burgess
Pam Creaven
Ed Davie
Dame Sally Davies
Dr Rhiannon England
Carolyn Gullery
Dr Peter Hindley
Felicia Huppert
Jan Hutchinson
Sandra Lawman
Professor Emeritus Lord Layard
Chris Leaman
James Lloyd
David Maher
Daniel Maughan
Dr Benjamin Miller
Professor Geoff Shepherd
Professor Mike Slade
Dr Emma Stanton
Professor Graham Thornicroft
Professor Sir Simon Wessely
Sarah Yiannoullou

Thanks to the organisations whose representatives or members contributed in person or in writing:

Alzheimer's Society
Big White Wall
Bright
British Association for Counselling and Psychotherapy
British Psychological Society
Carers Trust
Centre for Mental Health
Chartered Institute of Linguists
Child and Adolescent Clinical Academic Group
Colour Breathing Relaxation Therapy
Family Therapy and Systemic Practice
Harmless
Helplines Partnership
Human Givens Institute
Independent Mental Health Service Alliance
Leeds University
Living Change
MCCH
Mental Fight Club
Mental Health Foundation
MIND
National Hearing Voices Network
Nuffield Trust
The Priory
PTSD Resolution
Recovery in Sight
Self-help services
SignHealth
St. Mungo's
Student Minds
Time To Change
Turning Point
UK Council for Psychotherapy
Young Minds

Thanks to the people and organisations that hosted a visit:

Visit to Boston, Massachusetts:

Dr Asaf Bitton
Richard Gabriel Frank
Jamie Heywood
Dr Nick Hicks
Ursula Koch
David Maltz
Robert Master
Tim Murphy
Dr Trishan Panch
Michael E Porter
Scott Rauch and clinical team
Jeff Selberg
Lois Simon
Brian Wheelan
Ali Williams

Visit to the Eastern Lille community mental health services–Mental Health Public Trust Lille Metropole:

Chti Bonheur, Amitié et Partage
Ms Boulongne, Nurse Manager
Ms Bourabia, Nurse Manager
Dr Defromont, Head of MH Service
Mr Dekerf, Nurse Manager
Ms Duhal, Project Manager
Dr Garcin, Head of Service
Ms Guezennec, WHO CC Project Manager
Mr Joignant, Lead Nurse Manager
Mr Kruhelsky, Top Nurse Manager
Ms Lemaire, Cultural Manager
Ms Lombart, Host Family
Mr Malbranque, Nurse Manager
Ms Noel, Peer Support Worker
Ms Poitevin, Peer Support Worker
Ms Provost, Local MH Council Coordinator
Dr Roelandt, Head of the WHO CC (Lille, France),
Dr Verriest, General Practitioner
Ms Vittu, Administrative Manager

Thanks to those who spoke at the Commission's meetings or round tables

Sarah Brennan
Dr Paul Dolan
Sue Forber
Dr Peter Hindley
Dr Geoff Shepherd
Dr Mike Shooter
Prof Mike Slade
Dr Geraldine Strathdee
Prof Graham Thornicroft
Prof Sir Simon Wessely
Sarah Yiannoullou

Thanks to those people who peer reviewed the interim report:

John Ashton
Andy Bell
Dame Carol Black
Dr Jacqueline Cornish
Sue Forber
Helen Gilburt
Paula Lavis
Sally McManus
Dr Benjamin Miller
Kathryn Pugh
Geoff Shepherd
Prof Mike Slade
Dr Emma Stanton
Dr Geraldine Strathdee
Graham Thornicroft
Patrick Vernon
Prof Sir Simon Wessely
Sarah Yiannoullou

The policy teams of:

- Mind
- Rethink
- Turning Point

Thanks to those people who assisted the staff team:

Tom Frostick
Natasha Kutchinsky
Stephen Lee
Laura McDonald
Joe Moxham
Tom Rathborn
Nikki Stickland

Appendix 3: Terms of Reference

Aims and objectives

- To examine the current state of mental health in England;
- To set out liberal values, principles and approaches to mental health care;
- To evaluate the effectiveness of, and progress made by, the implementation framework for the government's mental health strategy, No Health Without Mental Health and, in doing this;
- Identify, and provide liberal solutions based on key policy issues in this area looking towards 2020.

Activity

The Commission will consider:

- The scope for strength or asset based approaches in preventing the onset or reducing the impact of mental illness including opportunities to further develop the economic and 'investment' case associated with alternate approaches to mental health care provision;
- The evidence for extending the concept and practice of self-defined or co-produced recovery and the lessons that can be drawn from models of survivorship in physical health;
- The scope for extending user-led approaches to commissioning and provision of interventions and support, including the contribution of user and carer voice in setting outcomes and shaping services;
- The scope for sustained change in attitudes and behaviours towards people experiencing mental illness, drawing lessons from anti-stigma campaigns;
- The potential for interventions to be delivered at different points in time in order to prevent or reduce the severity of mental illness and reduce health inequalities, for example the contribution of schools and criminal justice system, and the scope for better managing the transition from children's services to adult services;
- The opportunities for delivering public mental health, support and treatment in a variety of settings including schools, care homes, and places of work;
- The current institutional arrangements for the commissioning and delivery of mental health services and how these might be developed to promote a person's wellbeing through approaches that co-ordinate the physical, psychological, social and spiritual aspects; including training and awareness amongst primary, secondary and other care staff;
- The Commission is keen to draw lessons from both domestic and international policy and practice to inform its work.
- Identifying the opportunities available to further amend and develop additional primary and secondary legislation impacting the future provision of mental health post 2015, not least the opportunities to address the further enhancement of user rights in gaining access to services and the removal of legal impediments and obstacles to the further development of service provision;
- The Commission also want to consider the contribution that data can make to better commissioning, delivery and outcomes.

Timescale

- The Commission will report in July 2014.

Appendix 4: Methodology

In order to support the deliberations of the Commission, CentreForum ran a call for evidence, held five internal meetings and six evidence giving sessions, ran three policy round-tables, carried out ten national and 16 international site visits, and conducted two pieces of primary research.

CentreForum is extremely grateful to everyone who contributed to this work. Please see the acknowledgements in Appendix 2 for further details of the organisations that gave evidence or hosted a visit. The Commission developed their views in discussion with each other, based on this evidence, background briefings and their own knowledge.

Call for Evidence

The Commission communicated with three key 'stakeholder groups' during the call for evidence period. These were institutions, health and social care professionals, service users and carers. The call for evidence was launched on 1 July 2013, at which point CentreForum contacted more than 120 institutions (stakeholder organisations, academic institutions, inter-mediary organisations and organisations from the business sector) by telephone and email with an electronic copy of the call as evidence. CentreForum also created 13 surveys (five of which used validated measures) that asked about issues of recovery, stigma, access to care, commissioning, best practice and carer experiences.

CentreForum also raised awareness of the work of the Commission through social media channels and press releases, through the institutional call for evidence forms, through intermediary organisations and through the commissioners' existing networks. CentreForum has also engaged with the following organisations to promote this work further: British Association for Counselling and Psychotherapy, College of Occupational Therapy, College of Social Work, Independent Mental Health Services Alliance, Royal College of Nurses, Royal College of General Practitioners, Royal College of Physicians, Royal College of Psychiatrists, Social Care Institute for Excellence, NICE, Citizens Advice Bureau and Carers UK.

The call for evidence closed on 13 December 2013. There were a total of 427 responses, of which 69 per cent were from service users, 16 per cent were from health and social care professionals, 8 per cent were from carers and 6 per cent were submitted on behalf of institutions. Key findings have been documented within this report and the complete version is available in Appendix 2.

Site Visits

CentreForum and commissioners participated in ten site visits in the UK in order to gather evidence and learn about specific practices in innovative areas of work. These included:

- Centre for Mental Health;
- Goodmayes Hospital;
- Islington Borough Council;
- Lambeth Borough Council;
- Local Government Association;
- NHS City and Hackney CCG;
- NSUN;
- Rethink;
- Strategic Society Centre.

Furthermore, one commissioner travelled to Boston, Massachusetts for a five day study trip. The programme included eight meetings/ visits to academics, provider organisations and practitioners. There was opportunity to discuss the development of mental health in primary care, the role of peer support, and opportunities for innovation in practice and in the use of technology.

The organisations visited included:

- Beacon Healthcare Strategies;
- Centre for Primary Care, Harvard Medical School;
- Commonwealth Care Alliance;
- Institute for Healthcare Improvement;
- McLean Hospital;
- Michael Porter, Bishop Lawrence University Professor, Harvard Business School;

- Mount Pleasant Primary Care Center;
- Patients Like Me;
- Richard Gabriel Frank, Margaret T. Morris Professor of Health Economics in the Department of Health Care Policy at Harvard Medical School.

Additionally, two commissioners travelled to Lille, France in order to visit the following areas of work:

- Eastern Lille community mental health services:
    - Mobile team for intensive home care treatment, emergencies and assertive outreach treatment;
    - Mobiles team for community mental health care;
    - Service activities and leisure (cultural, sports, social etc.) integrated in the city.
- Child and Teenager mental health services and mobile teams;
- Local Mental Health Council;
- Visit to Mutual Self Help Groups (clubs run by users or ex-users);
- Visit to Jérôme Bosch Clinic;
- Presentation of «Habicité/reHabicity» scheme (supportive housing service with specific assertive community team);
- Presentation of the professional insertion support team and partners (Working Life Support Center (CAVA) and work-based support institution and services integrated in the city (ESAT ETIC).

Primary Research

CentreForum conducted two independent pieces of research in order to support the deliberations of the Commission. This included a Mental Health Atlas of Variation, which identified unwarranted variation across several mental health indicators through thematic maps across England.

The second piece of research involved a cross-sectional study that aimed to ascertain the perceived level of mental health need within the student population of English secondary schools and the current service provisions implemented to meet the need of this population.

Both reports are available to download in full on the CentreForum website – www.centreforum.org.

Meetings and Roundtables

The Commission held its first meeting in May 2013 and final meeting in May 2014. Over a period of twelve months, commissioners were able to engage in discussions pertinent to the mental health debate.

The Commission produced an interim report in April, which was used to test out the key policy proposals. This report was peer reviewed by more than thirty stakeholders.

The Commission also held three roundtables in order to test out ideas and key recommendations emerging from the work. These policy roundtables focused upon communities, children and young people, and integrating healthcare.

The pursuit of happiness: a new ambition for our mental health

Our wellbeing and mental and social capital make a huge difference throughout our lives. They matter because, taken together, they affect our behaviour, our ability to benefit and feel part of the world around us, and our prosperity. Mental health problems are the biggest contributor to poor wellbeing. Therefore, in attempting to increase the proportion of the population who are feeling good and functioning well, and reducing the prevalence of misery, more needs to be done to help people recover from mental health problems.

The CentreForum Mental Health Commission was established to address some of these issues. Following a year-long evidence-based commission, this report sets out the responses to the challenges faced in mental health over the next five years. The Commission believes that it is vital in the next Parliament that mental health policy includes a more ambitious objective for investing in the wellbeing and mental and social capital of the nation. In achieving this, there should be a focused agenda that recognises and enhances the strengths and assets of our communities.

The price of doing nothing is much more than the multi-billion pound cost of mental health problems, it is the wasted potential and human misery that could have been prevented for want of the willingness to act on the evidence.

> "Mental health services have traditionally been built around minimising risk and treating symptoms. I think we have come a long way in terms of helping professionals to see it is about more than just living without symptoms, it is about people finding meaning and happiness in their life, based on who they are as a person, regardless of what their diagnosis is."
>
> **Health professional**
> **Mental Health Commission Call for Evidence Survey**

> "Any recovery that has taken place has been due to personal determination… I will not accept that this is a lifelong disability with no cure."
>
> **Service user**
> **Mental Health Commission Call for Evidence Survey**

THE PURSUIT OF HAPPINESS:
A NEW AMBITION FOR OUR MENTAL HEALTH

A **CENTREFORUM** COMMISSION

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To support the work of the Mental Health Commission, CentreForum has also produced the following reports.