

Joint Commissioning Panel for Mental Health

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Practical Mental Health Commissioning

A framework for local authority
and NHS commissioners of mental health
and wellbeing services

Volume
One:
Setting
the Scene

Produced by
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Acknowledgements

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For better
mental health



rethink

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National Mental Health
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Foreword

Health and social care commissioners in England are operating in a time of considerable change. Shaped by the provisions of the Health and Social Care Bill, the new commissioning landscape for health and social care will be led at a local level by GP consortia and local authorities.

At the same time, mental health services will also be shaped by *No Health without Mental Health*, the new English mental health strategy. This has a focus on prevention, improved public mental health, and better outcomes for people experiencing mental ill health.

In response, the Joint Commissioning Panel for Mental Health (JCP-MH) has launched its first publication, *Practical Mental Health Commissioning – Volume One: Setting the Scene*. The JCP-MH is a new collaboration between a range of leading organisations with the aim of improving effective commissioning for mental health, learning disabilities and wellbeing (visit www.jcpmh.info for more details).

The JCP-MH represents:

- a coming together of the Royal Colleges of General Practitioners and Psychiatrists
- in partnership with the Association of Directors of Adult Social Services, British Psychological Society, Healthcare Finance Management Association, Interprofessional Collaborative on Mental Health, National Collaborating Centre for Mental Health, NHS Confederation and the Royal College of Nursing
- and spearheaded by the views of Mind, the National Involvement Partnership, National Survivor and User Network and Rethink Mental Illness.

Recognised by the Department of Health, and developed in collaboration with the JCP-MH and other professionals, *Practical Mental Health Commissioning – Volume One: Setting the Scene* both explains the current changes occurring within commissioning, and provides advice that aims to help all current and future commissioners to develop and deliver high quality, effective and efficient services. It encourages commissioners to take a broad whole systems approach to their work.

As the current reforms unfold, the JCP-MH will continue to develop and launch the further volumes of the mental health commissioning framework.

Drawing on the involvement of people with experience of using services, carers, clinicians, commissioners, and organisations providing services and support, we will aim to provide the values, evidence and practical advice that commissioners will need in these challenging times.

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**These organisations were involved in the production of Practical Mental Health Commissioning – Volume One: Setting the Scene. Since then, the Royal College of Nursing, Healthcare Finance Management Association, Interprofessional Collaborative on Mental Health, the National Collaborating Centre for Mental Health and the British Psychological Society have also become members of the JCP-MH, and will be involved in future work.*

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Introduction

This framework is the first of three briefing documents for commissioners in local authorities and the NHS. It is intended to explain the changing commissioning environment and how commissioners can make the most of available resources to improve the quality and outcomes of mental health and social care services in their area.

We are currently going through a period of change in the way mental health and social care services are commissioned. These changes are outlined in the Coalition Government's Health and Social Care Bill and were first published in the White Paper *Equity and Excellence: Liberating the NHS* and the related policy document *A Vision for Adult Social Care: Capable Communities and Active Citizens*.

At the same time, our understanding of the issues that mental health commissioning needs to address is developing just as radically, informed by the growing body of evidence on the influence of wider psychosocial factors on mental health and wellbeing.

A comprehensive, strategic approach to improving mental health needs to include not only direct service provision for people currently experiencing and recovering from mental health problems, but also prevention and early intervention for those at high risk, and mental health promotion for the wider community.

Mental health describes a broad continuum of mental states that extends from mental illness, through mental ill health that may not reach the threshold for a formal diagnosis, to positive mental health and wellbeing. People will move in and out of these states throughout their life course, depending on a range of factors and influences, although most of us will not experience severe mental ill health.

Mental health is important at individual and family levels; it is no less important within communities and still more widely within our society as a whole. Interventions that improve the mental health of individuals will also improve the mental health of communities and promote and protect the mental health and resilience of the wider population. Better levels of mental health within the wider population also mean less severe mental illness, and better levels of support for those who are unwell.

Health and social care services are rising to the challenge to maximise quality and cost effectiveness in all service provision while also supporting individuals along their recovery journey. Increasingly, services are evidence-based and the people receiving these services are genuinely engaged in decision-making, not just at individual level but at organisational/strategic levels too. Personalisation is now the key principle that guides all care and treatment. Personalisation places the individual at the heart of decision-making, enabling them to make informed choices about the care and support they need to achieve the outcomes and goals they have identified and that are meaningful to them.

The framework

This framework is intended to guide commissioners as they traverse this complex and changing terrain.

The framework's main focus is on the mental health system, across all tiers, but it also addresses population mental health and health improvement, and the links between mental and physical health,¹ especially for people with common and severe mental illnesses.

It takes an all-age approach, covering the whole of the life course from the very early years to old age. It does not delve in significant detail into children and young people's mental health and mental health in older age, but it will be supported by further, companion documents describing the key commissioning issues in these areas.

It explores the key policy imperatives driving commissioning for mental health into the future:

- improving population mental health and wellbeing and shifting the locus of power and responsibility to individuals, communities and local government
- increasing people's choice and control over services through personalisation of assessment processes and service provision
- system reform to support innovation and free up resources to follow people's choices through personalisation, Payment by Results (PbR) and related developments.

It describes the key commissioning enablers for achieving these three objectives. It seeks to knit into a coherent whole the multiple strands of improving quality, ensuring efficiency and productivity and supporting people to become more engaged in their own health care,² while also managing increasing need and demand for services.

It recognises the multiplicity of factors involved in achieving quality and effectiveness in mental health and social care. Services need to be person-centred, cost-effective, clinically effective and safe. They have to work upstream, at the preventive and promotion end of the spectrum, as well as downstream with people experiencing severe mental illness. This requires commissioners to work in partnership across the public, independent, voluntary and community sectors, beyond the conventional boundaries of mental health provision.

¹ Department of Health (2010). *Healthy Lives, Healthy People: Our strategy for public health in England*. London: The Stationery Office.

² Derek Wanless (2004). *Securing Good Health for the Whole Population: Final Report*. London: HM Treasury, Department of Health.

The framework is in three parts

- 1 **The changing commissioning landscape** – this section outlines the policy background, the shift to GP-led commissioning, the expanded role of local authorities, the new mental health strategy, and the other key points such as quality standards and outcomes frameworks that inform the commissioning process.
- 2 **What mental health commissioning looks like now** – this section outlines the nuts and bolts of the commissioning cycle, the joint strategic needs assessment and other key features of the commissioning process.
- 3 **Going forward: what mental health commissioners need to know** – this section describes, with examples from the field, the imperatives that will drive commissioning forward and the priorities that will continue through the period of transition and into the new health and social care system.

This framework does not attempt to provide a definitive and detailed guide to commissioning across the spectrum of mental health need. Rather, it aims to contribute to and inform ongoing policy and practice development nationally and across local government.

It has been written and produced with input from a broad range of professionals, individuals and organisations. In particular, it has been informed by and will be of particular relevance to the memberships of ADASS, the NHS Confederation and the Royal Colleges of Psychiatrists and General Practitioners.

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The changing commissioning landscape

Commissioning for mental health and wellbeing reflects and is informed by the current commissioning landscape and mental health policy, as well as wider health, social care and public health policy. These are shaped by two over-arching, linked aims:

- to improve access to, and the delivery of, mental health services with better outcomes for individuals with a mental health disorder (and their carers), and
- to improve mental health and wellbeing and prevent mental ill health in the whole population, including those recovering from a diagnosed mental or physical illness.

Importantly, these aims broaden the focus of intervention beyond the traditional arena of medical and social care to address the wider determinants of mental health and wellbeing, such as housing, the environment, education, employment and the social networks that generate social capital.

1.1 NHS strategy and developing policy frameworks

In recent months the Coalition Government has introduced legislation and strategic policies to support high quality health and social care interventions.

- The Health and Social Care Bill, together with the White Paper *Equity and Excellence: Liberating the NHS*, the Command paper *Liberating the NHS: Legislative Framework and Next Steps* and the *Operating Framework for the NHS in England 2010/11*, set out the Coalition Government's plan for the NHS in England.
- Children and young people's NHS services are covered in the companion document *Achieving Equity and Excellence for Children: how liberating the NHS will help us meet the needs of children and young people*.
- *A Vision for Adult Social Care: Capable Communities and Active Citizens* sets out the agenda for social care reform.
- *Healthy Lives, Healthy People: Our Strategy for Public Health in England* explains the Coalition Government's vision for public health, including the expanded role of local authorities in health and health improvement. It emphasises the importance of mental health, which is reflected in *Healthy Lives, Healthy People: Transparency in Outcomes – Proposals for a Public Health Outcomes Framework*.
- *No Health without Mental Health*, the new cross-Government mental health outcomes strategy, outlines the Coalition Government's vision for improving the mental health of the population through high quality mental health services, early intervention when mental illness arises, prevention of mental illness and promotion of population mental wellbeing.

1.2 GP commissioning consortia

Equity and Excellence: Liberating the NHS and the Health and Social Care Bill both describe a different NHS and local government landscape and architecture. A new clinical commissioning structure will see GP commissioning consortia (GPCC) largely replace primary care trusts (PCTs) and take on responsibility for commissioning the bulk of NHS primary and secondary mental health services, supported by and accountable to a new, independent, national NHS Commissioning Board.

The GPCC will include representation from every GP practice whose patient list they serve. They will be able to choose how best to carry out their commissioning responsibilities – for example, by employing staff themselves, by contracting with external organisations, or by collaborating with local authorities.

They will also be expected to draw on expert advice from health and care professionals and establish robust systems in partnership with local authorities to involve patients and communities in their work.

The GPCC will be required to commission some services on an 'any willing provider' basis – that is, the consortium will specify the services and quality standards required and any provider able to deliver those standards at the agreed price can express an interest in providing them.

GPCC will be able to form partnership arrangements with each other to commission some high cost, low volume specialist services that are not within the remit of the NHS Commissioning Board (see below).

It is recognised that some GPCC may initially lack the necessary expertise in some areas – care and support for children, for example, and for people with long-term mental health problems and people with learning disabilities. Joint commissioning arrangements with local authorities will be permitted to offset this.

1.3 The NHS Commissioning Board

The NHS Commissioning Board will have two main roles: it will support and regulate the GPCC, and it will have a limited commissioning function.

It will support and hold GPCC to account for the quality outcomes they achieve and for their financial performance, and will have the power to intervene if consortia are failing or are likely to fail to fulfil their functions.

It will support consortia by:

- publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it will commission the National Institute for Health and Clinical Excellence (NICE) to develop
- developing model contracts and standard contractual terms for providers
- designing the Commissioning Outcomes Framework and the new quality premium
- designing the structure of price-setting, including best-practice tariffs and the CQUIN framework
- helping, with NICE, to ensure that GPCC have access to the most up-to-date expert advice on the clinical and cost-effectiveness of different interventions, including medicines
- providing a forum for GPCC to share knowledge, and support collaboration.

The NHS Commissioning Board will also provide national leadership for driving up the quality of care, including safety, effectiveness and patient experience. It will promote patient and public involvement and will foster and support innovation and integration across the NHS, and with local authorities.

It will be responsible for commissioning the core primary medical care services provided by GP practices (including primary mental health care), and the other family health services (including pharmacy services, dental services and NHS sight tests).

It will also commission some national and regional specialist services, including prison and custody health care, high security psychiatric services, and health care for the armed forces and their families.

Additionally, it will be able to commission some services on behalf of GPCC and enter into pooled budget arrangements with consortia to commission services that fall outside the scope of national or regional specialised commissioning.

The functions of the NHS Commissioning Board will be set out in primary legislation, rather than being at the discretion of the Secretary of State. The Secretary of State will publish a mandate for the NHS Commissioning Board, setting out the Government's requirements and expectations for the NHS over a three-year period, updated annually. The mandate will include objectives for improvements in quality and outcomes, and equality and reduced inequality in health care provision, with specified targets. It will also specify financial allocations to the NHS Commissioning Board.

The Secretary of State will be required to undertake a formal public consultation on the priorities set out in the annual mandate before issuing the final version.

The legislative framework will ensure that GPCC are accountable for improving quality of care within the resources available to them. The GPCC and the NHS Commissioning Board will be subject to the duties in the Children Acts 1989 and 2004 to discharge their functions in ways that safeguard and promote the welfare of children, and to be members of Local Safeguarding Children Boards.

1.4 Health and wellbeing boards

Local authorities will lead the strategic co-ordination of commissioning prevention and promotion (health and wellbeing) services further upstream, drawing together NHS, social care and related children's and public health services and working with other local agencies and groups. They will do this through health and wellbeing boards, which will be a statutory requirement in every upper tier authority.

The core purpose of the health and wellbeing boards is to join up commissioning across the NHS, social care, public health and other services that the board agrees have a direct influence in health and wellbeing, in order to secure better health and wellbeing outcomes for their whole population, better quality of care for users of health and social care services, and better value for the taxpayer.

The boards will provide the platform for NHS, public health and local authority leaders and commissioners to work together on a geographical basis, both within and between local authority areas.

The core membership of these boards will include all the GPCC covering that area, the director of adult social services, the director of children's services, the director of public health and the local HealthWatch (see below), and at least one locally elected member. Additional membership will be at the discretion of each board, but might include representatives of the local voluntary sector and other relevant public service officials, professionals and community organisations that can advise on and give voice to the needs of vulnerable and less-heard groups. Board membership might also include some providers, so long as this does not prejudice the level playing field within the local health and social care market.

Local authorities and the GPCC for their areas will undertake a joint strategic needs assessment through the health and wellbeing boards.

Health and wellbeing boards will also be the vehicle for the production of the new joint health and wellbeing strategies (JHWS). The JHWS is intended to provide the overarching framework for the development of the commissioning plans agreed by the health and wellbeing board for local NHS, social care, public health and other services. The JHWS could include wider health determinants such as housing and education.

GPCC and local authorities will have statutory responsibility for the production of both the JSNA and JHWS, and be required to pay regard to both in their commissioning plans, which must be approved by the health and wellbeing board. The boards will be expected to play an influential role in the development of innovative solutions to commissioning challenges, not simply to comment on commissioning plans.

Health and wellbeing boards will be able to look at the totality of resources available for health and wellbeing in their local area, and decide how to make best use of the flexibilities at their disposal, such as pooled budgets. Using the JHWS, they will be able to consider how prioritising health improvement and prevention, the management of long-term conditions and the provision of rehabilitation, recovery and re-ablement services will best deliver reductions in demand for health services and wider benefits for the health and wellbeing of the local population.

1.5 HealthWatch

Local authorities will retain their current health scrutiny powers, either through the existing health Overview and Scrutiny Committees (OSCs) or through other means if they choose. Local Involvement Networks (LINKs) will evolve into local HealthWatch, supported and led by HealthWatch England. HealthWatch England will be based within the Care Quality Commission (CQC) and will act as an independent consumer champion. Local HealthWatch will ensure that the views of users of services, carers and the public are represented to commissioners, and will provide local intelligence for HealthWatch England. Local authorities will be able to commission local HealthWatch to provide advocacy, advice and information to support people if they have a complaint and to help people make choices about services.

1.6 Public health

Responsibility for public health, including public mental health, will be transferred to a new Public Health Service, Public Health England. This will be located within the Department of Health and will have its own ring-fenced budget. Directors of Public Health (DPH) will be located within local authorities, which will have responsibility for health improvement within their areas. The DPH will be expected to work with partner organisations – the NHS, the private, voluntary and public sectors and the GPCC – through the health and wellbeing board. Local authorities will receive a health premium to reward progress against the new public health outcomes framework.

Public health will be part of the NHS Commissioning Board's remit, and GPs potentially could receive enhanced incentives to deliver public health services.

1.7 Associated developments

Accompanying these major structural changes will be a number of other important developments in commissioning. These include:

- closer **collaboration between primary and secondary care** clinicians and professionals to enhance clinical leadership in commissioning. This collaboration should be built on the principles of integration and joint working in both commissioning and delivering a comprehensive mental health service across primary, secondary and social care sectors
- a major expansion of **choice and involvement opportunities** for individuals receiving primary, community and secondary care, with greater personalisation of services, increased freedom, choice and control and, crucially, a concentrated focus on improved health, public mental health and social care outcomes
- roll out of **Payment by Results (PbR)** for mental health services, and
- an imperative to achieve **value for public money** through QIPP and local government efficiency programmes, often predicated on economies of scale and joint or wider collaborative commissioning approaches.

1.8 Providers

On the provider side, there will be a continued move away from central control, with greater autonomy for NHS Foundation Trusts and greater opportunities for more, and larger, social enterprises to move into direct health and social care provision. The aim is to free up providers so that they can compete on a level playing field, focus on improving outcomes, be more responsive to the needs of people using services, and innovate.

This process will be facilitated by the 'any willing provider' concept outlined above.

1.9 Regulation – Monitor and the Care Quality Commission

There will be a new regulatory system. Monitor will take on the role of independent economic regulator, with three core functions: promoting competition; setting or regulating prices; and ensuring continuity of services (see figure 1). To support these functions, Monitor will license all providers of NHS-funded care.

Monitor’s overarching duty will be to protect the interests of users of health and adult social care services by promoting competition among providers, as appropriate, and regulation where necessary.

All providers of NHS care will compete on what is intended to be an equal basis, so that they succeed or fail according to the quality of care they give and the value for money they offer.

The role of the Care Quality Commission in maintaining and pushing forward quality and safety of services will be expanded and strengthened. All providers of services to the NHS will be required to register with the CQC, including primary care providers from 2011. The CQC will no longer be responsible for assessing the performance of NHS

commissioners and periodically reviewing NHS providers. Instead, it will focus its resources on its provider inspection role.

The quality of providers’ services will be judged from a wide range of sources: from patient feedback and complaints; staff experience; and information from HealthWatch England and local HealthWatch, health and wellbeing boards and OSCs, GPCC, Monitor and the NHS Commissioning Board.

The CQC will have wide-ranging enforcement powers, including the powers to issue statutory warnings, set additional registration conditions and impose fines. Where those using services are thought to be at serious and immediate risk, the CQC will have powers (as now) to suspend or remove registration – in effect closing down the service or provider.

The quality standards for all health care and treatment interventions will be commissioned by the NHS Commissioning Board from the National Institute for Health and Clinical Excellence (NICE).

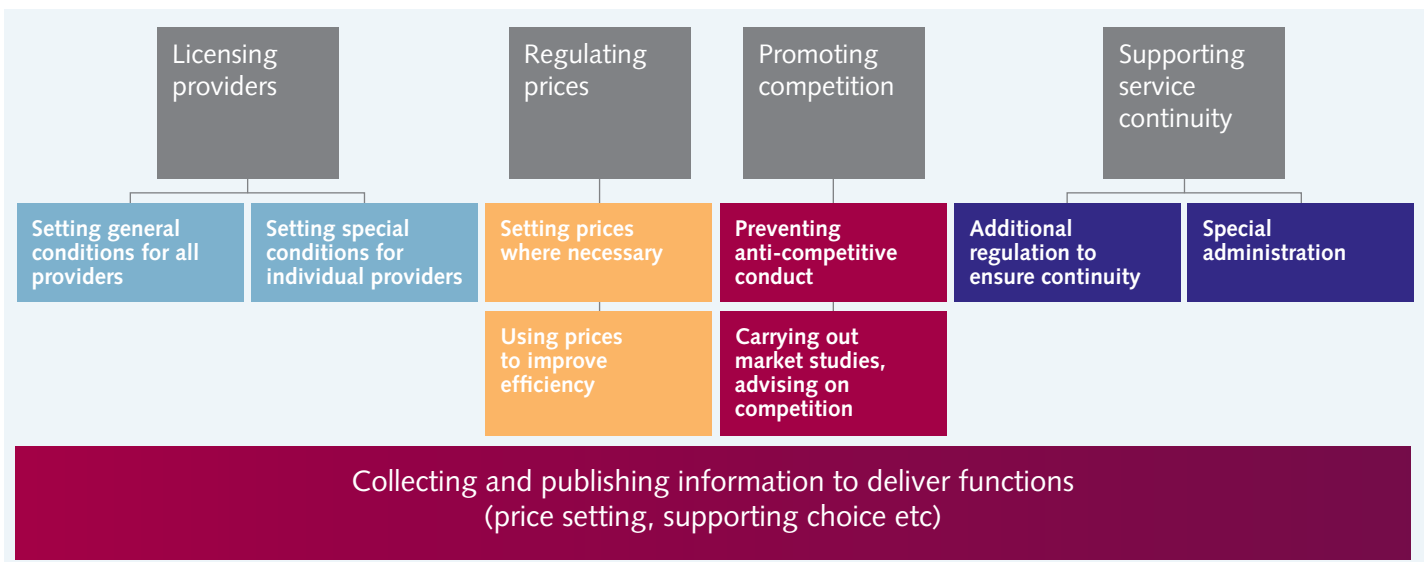
1.10 Mental health commissioning

Within this landscape, commissioners of mental health services will be freed from the traditional, activity-focused, specialist service-oriented model. Multi-agency and partnership commissioning for mental health and wellbeing will become much more the norm. Services will be commissioned from a wide range of organisations delivering a broad spectrum of services across a locality, area or region. Investment will be channelled into new areas of development, beyond the boundaries of traditional ‘mental illness’ treatment and care.

These new areas include:

- social capital – building community networks and resources, investment in peer support
- citizen pathways – creating opportunities for people’s active participation in local government
- mechanisms to ensure people have a voice at strategic, community and individual levels.

Figure 1: Monitor’s core functions



Adapted from Department of Health (2010). *Liberating the NHS: Regulating Healthcare Providers. A consultation on proposals.* London: Department of Health.

1.11 Commissioning structures and processes

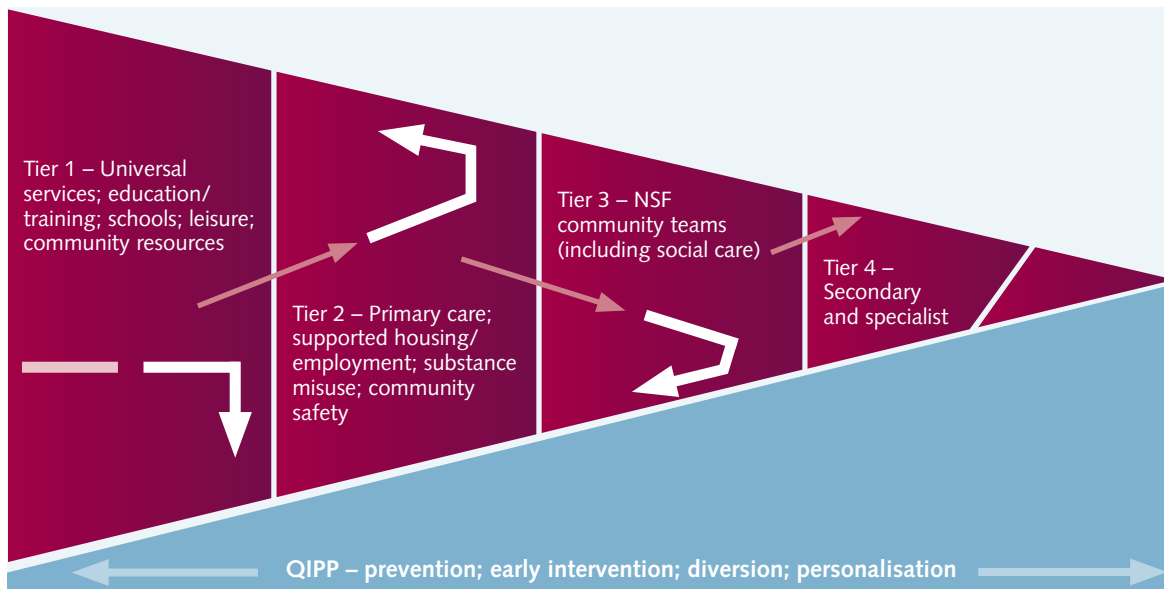
The basic structure and components of commissioning will remain largely constant:

- needs assessment and engagement with the public and partners
- strategy-making and prioritisation
- procurement and contracting, and
- monitoring and review, using outcomes and public value (quality and efficiency) as the yardstick.

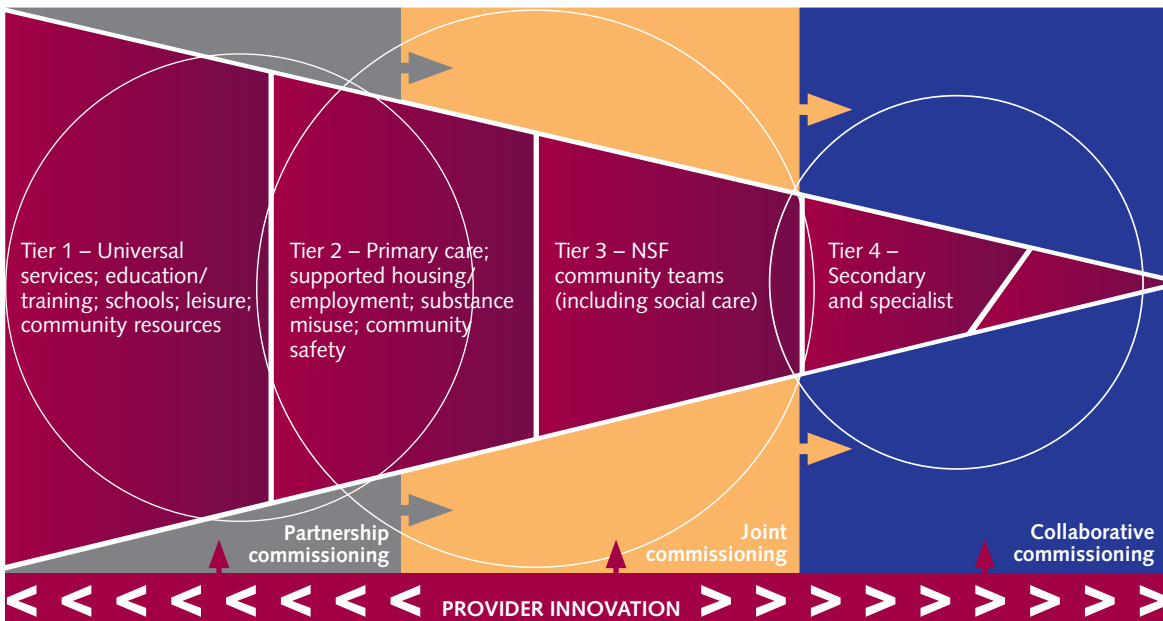
Figure 2 below and overleaf shows the potential components of a comprehensive mental health service, and where they may overlap and interlock within the commissioning process.

Figure 2: The new commissioning structure for mental health and wellbeing

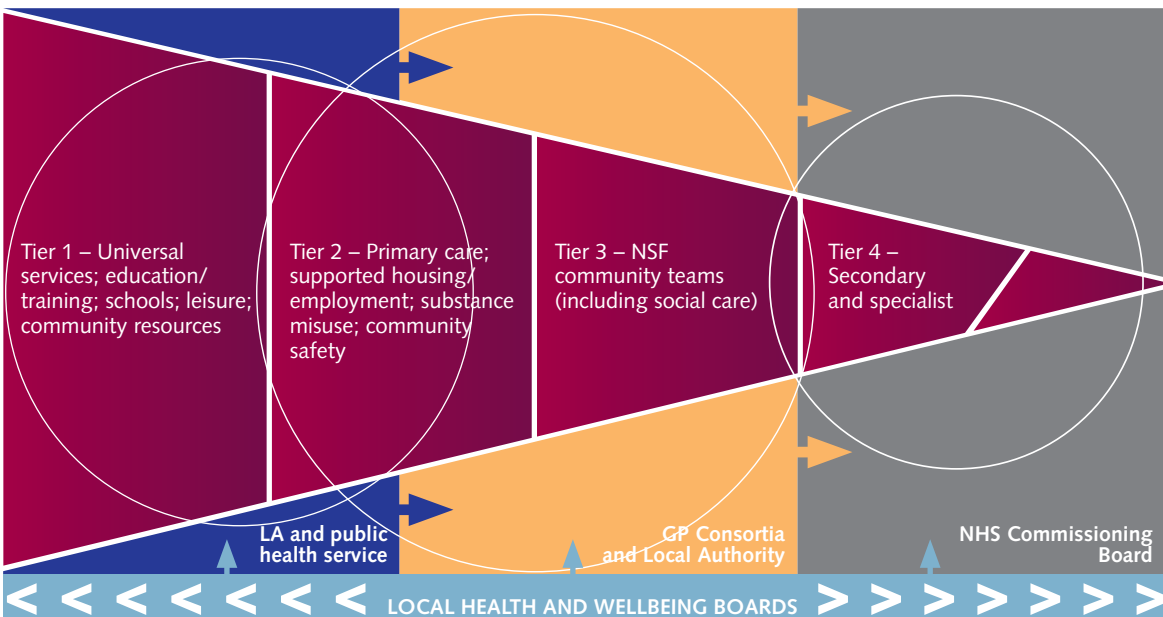
Commissioning for mental health and wellbeing takes place across four tiers, covering both universal and targeted services across the whole population. Currently most health resources are tied up at the narrow end of the triangle, at tiers 3 and 4, covering inpatient specialist services. But many of the quality and efficiency actions needed to change the profile of future demand rely on a connected approach at tiers 1 and 2, addressing population and public mental health, prevention, early intervention, personalisation and social care.



Putting strategy into action across the tiers also requires different approaches to commissioning, working through broader partnerships (such as Children’s Trusts or Community Safety Partnerships) at tier 1 and into tier 2. A greater concentration on joint commissioning between GPCCs and local authorities is needed at tiers 2 and 3 to ensure integration and best outcomes. Then, as services get more specialised, wider collaborative arrangements are required at tier 4, to make the best use of resources and maximise the effectiveness of acute and specialist mental health care pathways across organisations at a sub-regional or regional level. Each of these commissioning approaches also relies on close partnership with providers and frontline clinicians and teams to ensure the potential for innovation and improvement is harnessed across all the stages of the commissioning cycle.



Finally, following transition to the new NHS and expanded role of local government, the likely new local commissioning responsibilities and overlaps are shown here. Again, the diagram emphasises the need for inter-connectedness between all parts of the new system as it evolves.



1.12 GP commissioning and mental health

The concept of GP commissioning is built on the pivotal role that GP practices already play in co-ordinating care and advocating for their patients. Given this long-standing proximity to their patients, it is seen to be a natural extension for GP practices to play the lead role in deciding what wider health care services to commission on their patients' behalf.

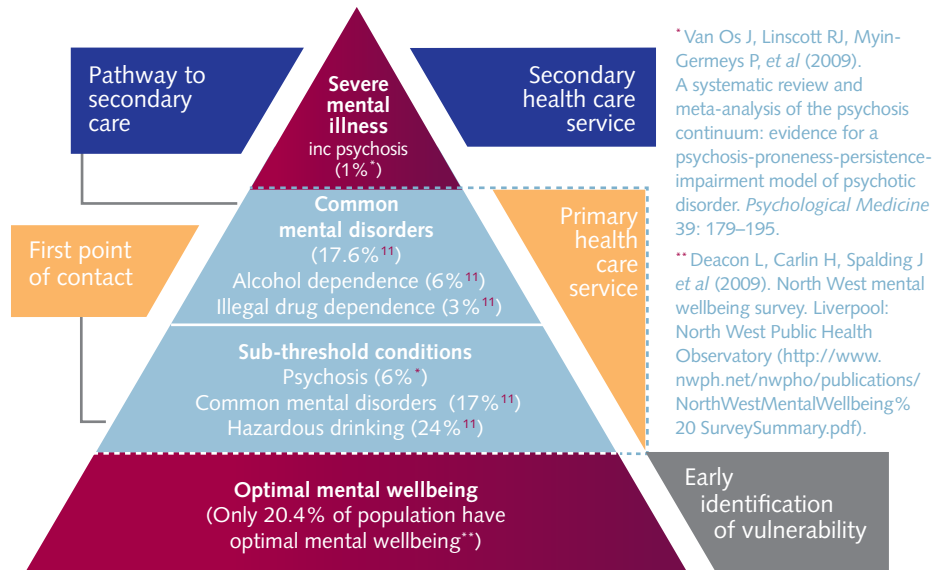
GPs also currently play an important role in influencing NHS expenditure, both through referral and prescribing decisions and (less directly) through the quality and accessibility of the services they provide and the impact these have on emergency and urgent care provided elsewhere in the health system. In this sense, GP commissioning gives groups of GP practices financial accountability for the consequences of their decisions.

There may be a tension in their dual role. On the one hand, GPs will be in a stronger position to develop services that meet the particular needs of their patients, resulting in far more personalised, individual care and treatment. However as commissioners, GPs within the commissioning consortia will also need to be concerned with the mental health and wellbeing of the local population as a whole.

GP commissioners will have a key role in local health improvement and improving mental wellbeing, as their remit will cover promotion of mental health as well as prevention of mental illness and they will be working directly with Directors of Public Health and local authorities through the local health and wellbeing boards, or equivalent structures.

The involvement of the GPCC on the health and wellbeing boards, and in the joint strategic needs assessment (JSNA)

Figure 3: Towards optimal primary mental health care³



*Van Os J, Linscott RJ, Myin-Germeys P, et al (2009). A systematic review and meta-analysis of the psychosis continuum: evidence for a psychosis-proneness-persistence-impairment model of psychotic disorder. *Psychological Medicine* 39: 179–195.

**Deacon L, Carlin H, Spalding J et al (2009). North West mental wellbeing survey. Liverpool: North West Public Health Observatory (<http://www.nwph.net/nwpho/publications/NorthWestMentalWellbeing%20SurveySummary.pdf>).

This diagram shows a stepped care pathway through the primary and specialist mental health care systems (the central area of the pyramid), built on the maintenance of mental health and prevention of ill-health. The clinician will ensure the individual person's needs are met with the required intensity of response at the appropriate level.

and joint health and wellbeing strategy (JHWS), will be critical to maintaining this balance. These will provide the platform and mechanisms for GPs to contribute their clinical knowledge to strategic planning for the mental health of the local population

as a whole, in partnership with the local authority and other concerned agencies.

Figure 3 illustrates the extent of territory for which primary care has responsibility along the patient's care pathway.

Transitional development and support

In mid-Essex, a pathfinder consortia of seven GP practices has prioritised a need for leadership in respect of transitional arrangements for mental health and learning disability commissioning. A partnership approach has been established with Essex County Council, the Primary Care Trust and local NHS Foundation Trust. A project manager will oversee a first phase of four workstreams. It is intended that these workstreams will inform development of the new commissioning structures that will be needed.

These will include reviewing:

- needs analysis, strategy and priorities
- finance, activity and performance data for NHS and Social Care spend for the consortia population
- NHS and Social Care partnership issues
- Health and Wellbeing Board representation, governance etc
- pathway redesign with providers to better meet local needs.

Design of collaborative commissioning arrangements and identification of priority outcomes for services will help to inform and shape the development of thinking within consortia across Essex and with the local authority.

³ Adapted from: Ministry of Health (2009). *Towards optimal primary mental health care in New Zealand: a discussion paper*. Wellington: Ministry of Health.

1.13 Primary care mental health

In the 1960s, when GPs in the UK were beginning to work in group practices, Shepherd and colleagues⁴ suggested:

“... the cardinal requirement for improvement of mental health services... is not a large expansion of and proliferation of psychiatric agencies, but rather a strengthening of the family doctor in his/her therapeutic role.”

The World Health Organization echoed this belief in 1978,⁵ stating that: *“the primary medical care team is the cornerstone of community psychiatry.”*

The World Health Organization has more recently defined ‘primary care mental health’ as:⁶

- *“First line interventions that are provided as an integral part of general health care”* and
- *“Mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health care services.”*

There are numerous advantages to providing mental health care in the primary care setting, from the perspectives both of people who use services and of the health and social care system. Care can be provided closer to home, in a setting that does not carry the stigma that is still associated with mental health facilities, by a health care worker who will ideally know the person and his or her family, who will be able to provide holistic treatment and continuity of care for the full range of problems including physical health needs, and who has good links to local services to help with associated social issues.

Primary care is also best placed to manage problems that straddle the interface between mind and body, such as medically unexplained symptoms. People with serious mental illness say they greatly value the care provided in primary care settings by their own GP.⁷

From the perspective of the health care system, effective primary care is cost-effective.⁸ Specialist mental health care resources can then be directed towards those most in need and most likely to benefit from more intensive care.

Indeed, as Goldberg and Bridges⁹ first demonstrated over 30 years ago, only a small number of people with mental health problems are referred to secondary, specialist mental health services, and even fewer are ever admitted to psychiatric units.

⁴ Shepherd M, Cooper B, Brown A *et al* (1966). *Psychiatric illness in general practice*. Oxford: Oxford University Press.

⁵ World Health Organization (1978). *Alma Ata: global strategy for Health for All by the Year 2000*. Geneva: World Health Organization.

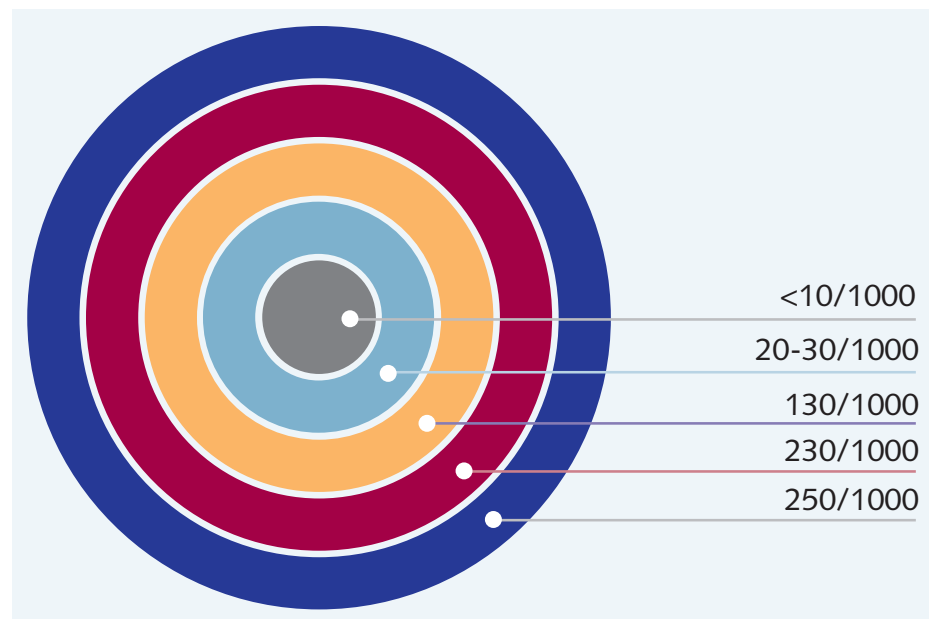
⁶ World Health Organization/ World Organization of Family Doctors (Wonca) (2008). *Integrating mental health into primary care: a global perspective*. Geneva: World Health Organization: 10.

⁷ Lester H, Tritter JQ, Sorohan H (2005). *Patients’ and health professionals’ views on primary care for people with serious mental illness: focus group study*. *British Medical Journal* 330: 1122.

⁸ Starfield B (1991). *Primary care and health: a cross-national comparison*. *Journal of the American Medical Association* 266: 2268–2271.

⁹ Goldberg D, Bridges K (1987). *Screening for psychiatric illness in general practice: the general practitioner versus the screening questionnaire*. *Journal of the Royal College of General Practitioners* 37(294):15–18.

Figure 4: Numbers of people affected by mental health problems



Mental health problems affect about one in four people – that is, 250 per 1000 at risk (see figure 4). Of those 250 people, the vast majority – about 230 – attend their general practice. Of these 230, about 130 are subsequently diagnosed as having a mental health problem, only between 20 and 30 are referred to a specialist mental health service, and fewer than 10 are ever admitted to a mental health hospital.

This means that over 90% of people with any severity of mental health problems are managed entirely in primary care – including roughly one in four people receiving treatment for psychosis. If this number is disaggregated into levels of mental ill health, a GP with a list size of 2000 patients would expect to be treating about 50 people with depression, 10 people with a serious mental illness such as schizophrenia or bipolar disorder, about 180 people with anxiety disorders and a further 180 or so with milder degrees of depression and anxiety.¹⁰

Analysis of the latest Adult Psychiatry Morbidity Survey shows:¹¹

- 16.2% of the population experience at least one common mental disorder (anxiety and depressive disorders) in the previous week
- 23% of adults with a common mental disorder receive treatment
- 14% receive psychoactive medication only
- 5% receive counselling or therapy, and
- 5% receive both medication and therapy.

Most (38%) of those with common mental disorders accessed GP services and 18% made use of community or day care services. For those with two or more common mental disorders, 16% made use of community day centres, 10% accessed psychiatry and 10% received social work input.

GPs used to be seen to have a poor record on identifying depression among their patients. More recent studies have found that they are very good at recognising moderate to severe depression,¹² where there is more benefit to be gained from treatment.

Physical and mental health problems often co-exist and overlay and interact with each other. The difficulties inherent in disentangling the two, and the associated stigma of mental illness, may in part explain the gap between presentation and diagnosis in primary care and why only 23% of adults with a common mental disorder (anxiety and depressive disorders) receive any treatment.¹¹ Improved recognition, diagnosis and intervention for mental illness in primary care have the potential to significantly reduce the burden of these illnesses. The Improving Access to Psychological Therapies (IAPT) programme is also progressively increasing treatment choice in primary care settings.

Mental health policy for primary care has developed considerably over the last two decades. There is growing policy interest in the configuration and delivery of evidence-based mental health care in the post-institution era.¹³ Historically, from 1999–2009, primary care had specific responsibility for delivering standards two and three of the National Service Framework (NSF) for mental health and was also integrally involved in the delivery of the other five NSF standards. *The NHS Plan*¹⁴ invested more than £300 million in the implementation of the NSF, including funding for 1000 new graduate mental health workers to work in primary care and promote a shared care approach. NICE guidelines for treating people with anxiety,¹⁵ depression,¹⁶ schizophrenia¹⁷ and bipolar disorder¹⁸ all emphasise the important role played by primary care.

Numerous models have been developed to provide genuinely 'shared care' across primary and secondary care.¹⁹ Much of the research has focused on attempting to improve outcomes for people with common mental health problems by integrating new specialist mental health staff, such as counsellors and psychologists, into the primary care team.²⁰ However, collaborative care, which originates from the US²¹ and is based on new approaches to treating people with chronic health problems such as diabetes, is now attracting much interest as a model for treating people with depression and serious mental illness.

¹⁰ Singleton N, Bumpstead R, O'Brien M *et al* (2001). *Psychiatric morbidity among adults living in private households*. London: The Stationery Office.

¹¹ McManus S, Meltzer H, Brugha T, Bebbington P, Jenkins R (eds) (2009). *Adult psychiatric morbidity in England, 2007*. Leeds: NHS Information Centre.

¹² Thompson C, Ostler K, Peveler RC *et al* (2001). *Dimensional perspective on the recognition of depressive symptoms in primary care*. *British Journal of Psychiatry* 179: 317–323.

¹³ Department of Health (1999). *National service framework for mental health: modern standards and service models*. London: Department of Health.

¹⁴ Department of Health (2000). *The NHS Plan: a plan for investment, a plan for reform*. London: Department of Health.

¹⁵ <http://guidance.nice.org.uk/CG22>

¹⁶ <http://guidance.nice.org.uk/CG90>

¹⁷ <http://guidance.nice.org.uk/CG82>

¹⁸ <http://guidance.nice.org.uk/CG38>

¹⁹ Bower P, Gilbody S (2005). *Managing common mental health disorders in primary care: conceptual models and evidence base*. *British Medical Journal* 330 839–842.

²⁰ Bower P, Sibbald B (2000). *On-site mental health workers in primary care: effects on professional practice*. *Cochrane Database Systematic Review* (3): CD000532.

²¹ Katon W, Unutzer J (2006). *Collaborative care models for depression: time to move from evidence to practice*. *Archives of Internal Medicine* 66 2304–2306.

The new NHS, the advent of GP-led commissioning and the Government's vision for social care provide real opportunities to further revitalise primary care mental health, in line with the Government's principles of devolution of decision-making, personalisation and localism. GP commissioning has the potential to make primary care the hub of all mental health services and support, and thus ensure services are better able to meet the spectrum of need of the wider population, as well as those with severe mental illnesses.

This model also takes a wellness and recovery approach; it can enable people to continue living independently in their communities; it can, where appropriate, shift resources (investment and skills) towards the community end of people's care pathways. It may also enable better and more active management of people's journeys into and out of specialist mental health services, in part through increased availability of these services in surgeries and health centres.

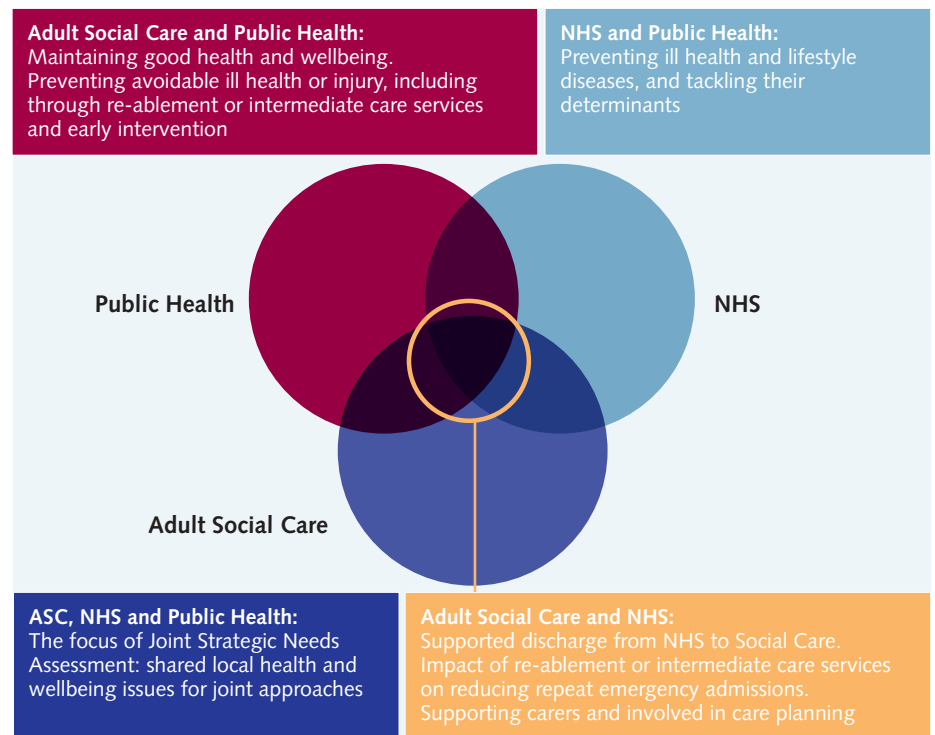
Enhanced co-working and collaboration between primary care and mental health teams, reinforced in service specifications, can help to minimise risk and maximise opportunities for recovery.

Overall, such an approach offers multiple benefits. It gives increased potential for health, social care and other key stakeholders to collaborate at locality level to meet the totality of individual or family needs. It ensures that commissioning is better locked onto local needs. It gives GP commissioners and local authorities greater flexibility to design and deliver specific services that meet specific local needs. It extends opportunities for shared care and expands access to specialist professional skills where they are most needed and most useful, closest to people's homes and within their communities.

1.14 Outcomes frameworks

New outcomes frameworks have been developed connecting public health, the NHS and social care. These have been designed to interlink so they work together towards shared outcomes and goals (see figure 5 below).

Figure 5: Intersection between the NHS, social care and public health outcomes frameworks



Adapted from *Healthy Lives, Healthy People: Transparency in Outcomes. Proposals for a Public Health Outcomes Framework. A consultation document.* Department of Health. December 2010.

Importantly, all three frameworks accord equal importance to mental health and physical health outcomes as a measure of effectiveness. Commissioners' performance will be judged against these outcomes by the national NHS Commissioning Board, and potentially at local level by health and wellbeing boards and local HealthWatch.

1.14.1: The NHS outcomes framework

The NHS outcomes framework has five outcome domains, each with a set of indicators to measure progress. For the first year, 2011/12, the framework will be used only to set direction of travel and to obtain baseline data. From 2012/13 it will include 'levels of ambition' and the NHS Commissioning Board will be held to account (and will hold GPCC to account) for delivery on these indicators.

Some of the NHS outcomes framework domains have been given a mental health specific indicator (see table 1 below). Others do not have a specific indicator that relates to mental health but will still have direct relevance to mental health service commissioning and provision.

Domain 1, for example, connects to actions around suicide prevention and lifestyle risk management.

Domain 2 could apply directly to enhancing quality of life for people with long-term severe mental illnesses and to the mental health contribution to physical long-term conditions, such as diabetes.

Domain 3 could apply to recovery from episodes of severe mental ill health. This – alongside medical treatment – might include education, training and employment support, housing, social networks and attention to wider social care and skills development issues.

Domain 4 might encompass people's experience of mental health care, treatment and support, including choice, personalisation, peer support, involvement in developing care plans, decisions about care and treatment, and use of recognised measures such as Patient Reported Outcome Measures (PROMs) and NICE Quality Standards.

Domain 5 is about safeguarding people's wellbeing when accessing mental health care and treatment, including clinical safety, informed by PROMS, NICE Quality Standards, and Care Quality Commission inspections of the care environment and standards of practice.

Table 1: NHS outcomes framework – the five domains

Domain	Overarching indicators	Improvement areas
1. Preventing people from dying prematurely	Mortality from causes considered amenable to health care	Reducing premature death in people with serious mental illness <i>Mental health indicator: Under 75 mortality rate in people with serious mental illness (shared responsibility with Public Health England)</i>
2. Enhancing quality of life for people with long-term conditions	Health-related quality of life for people with long-term conditions	Enhancing quality of life for people with mental illness <i>Mental health indicator: Employment of people with mental illness</i>
3. Helping people to recover from episodes of ill health or following injury	Emergency admissions for acute conditions that should not usually require hospital admission; Emergency readmissions within 28 days of discharge from hospital	
4. Ensuring people have a positive experience of care	Patient experience of primary care; Patient experience of hospital care	Improving experience of health care for people with mental illness <i>Mental health indicator: Patient experience of community mental health services</i>
5. Treating and caring for people in a safe environment and protecting them from avoidable harm	Patient safety incident reporting; Severity of harm; Number of similar incidents	

1.14.2: The public health outcomes framework

The public health outcomes are still pending finalisation. Table 2 lists the domains and outcomes proposed in the consultation document *Healthy Lives, Healthy People: Transparency in Outcomes*.²²

Table 2: Proposed public health outcomes framework

The overarching vision for public health:

To improve and protect the nation's health and to improve the health of the poorest, fastest. Supported by five key domains for public health outcomes that reflect national, local and community level actions and target groups at higher risk.

Domain	
1. Health protection and resilience	Protect the population's health from major emergencies and remain resilient to harm This includes all the elements of the Public Health Outcomes Framework that relate to mental health
2. Tackling the wider determinants of health	Tackling factors that affect health and wellbeing and health inequalities
3. Health improvement	Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities
4. Prevention of ill health	Reducing the number of people living with preventable ill health and reduce health inequalities
5. Healthy life expectancy and preventable mortality	Preventing people from dying prematurely and reduce health inequalities

Domain 1 sets the overarching goal that the Government expects Public Health England to achieve, supported by local delivery mechanisms. The other domains are sequenced across the spectrum of public health, from influencing the wider determinants of health, to opportunities to improve and protect health, to preventing ill health (morbidity) and avoiding premature death (mortality).

²² Department of Health (2010). *Healthy Lives, Healthy People: Transparency in Outcomes. Proposals for a Public Health Outcomes Framework. A consultation document.* London: Department of Health.

1.14.3: Proposed social care outcomes framework

The vision informing *Transparency in Outcomes: a framework for adult social care*, the proposed quality and outcomes strategy for social care, is three-fold:

- **to empower local citizens and support transparency.** The focus of accountability will be local, with consistent evidence of improvement for local communities and support for holding organisations to account
- **to improve outcomes for those with care and support needs.** This means building the evidence base on how to achieve the best outcomes in adult social care, and ensuring this underpins service design, commissioning and delivery. In doing so, the focus must be on what matters most to people and ensuring action to highlight and tackle inequalities
- **to improve the quality of social care services.** This requires understanding what 'high quality' means in adult social care, and how it can be delivered efficiently and effectively.

Table 3 lists the overarching measures and outcomes proposed in the consultation document. Again, only the outcome measures related to mental health are included here.²³

The Coalition Government has made clear that it expects social care services to work not just with the NHS and Public Health England towards these outcomes but also, just as importantly, with partners in local government and with local independent, mutual and voluntary and community organisations.

²³ Department of Health (2010). *Transparency in Outcomes: a framework for adult social care. A consultation on proposals*. London: Department of Health.

Table 3: The proposed social care outcomes framework

Domain	Overarching measures	Outcome measures	Supporting quality measures
1. Promoting personalisation and enhancing quality of life for people with care and support needs	Social care-related quality of life	<p>Enhancing independence and control over own support</p> <ul style="list-style-type: none"> The proportion of those using social care who have control over their daily life <p>Enhancing quality of life for carers</p> <ul style="list-style-type: none"> Carer-reported quality of life <p>Enhancing quality of life for people with mental illness</p> <ul style="list-style-type: none"> Proportion of adults in contact with secondary mental health services in employment <p>Ensuring people feel supported to manage their condition</p> <ul style="list-style-type: none"> Proportion of people with long-term conditions feeling supported to be independent and manage their condition 	<p>Promoting personalised services</p> <ul style="list-style-type: none"> Proportion of people using social care who receive self-directed support
2. Preventing deterioration, delaying dependency and supporting recovery	Emergency readmissions within 28 days of discharge from hospital; admissions to residential care homes per 1,000 population		
3. Ensuring a positive experience of care and support	Overall satisfaction with local adult social care services	<p>Improving access to information about care and support</p> <ul style="list-style-type: none"> The proportion of people using social care and carers who express difficulty in finding information and advice about local services <p>Treating carers as equal partners</p> <ul style="list-style-type: none"> The proportion of carers who report that they have been included or consulted in discussions about the person they care for 	Could be supported by relevant activity and finance data related to adult social care, as identified locally through the services provided to users and carers who respond positively or negatively to their experience of care. This domain is also likely to be able to be supplemented by local survey activity and complaints information
4. Protecting from avoidable harm and caring in a safe environment	The proportion of people using social care services who feel safe and secure	<p>Ensuring a safe environment for people with mental illness</p> <ul style="list-style-type: none"> Proportion of adults in contact with secondary mental health services in settled accommodation 	<p>Providing effective safeguarding services</p> <ul style="list-style-type: none"> The proportion of repeat referrals to adult safeguarding services

1.14.4: Mental health strategy

The mental health outcomes strategy, *No Health without Mental Health*, is built around a two-track, life course approach that aims to:

- improve outcomes for people with mental problems, and
- build individual and community resilience and wellbeing in order to prevent ill health.

It links closely with the Healthy Lives, Healthy People strategy for public health in England and – as a cross-Government, rather than a Department of Health strategy – expects input from all relevant Government departments towards meeting these aims.

The strategy is structured around six shared, cross-Government and multi-agency mental health objectives (see table 4). These are consistent with those set out in the NHS, social care and public health frameworks. The objectives are designed to support delivery of the twin aims.

Table 4: Mental health strategy shared objectives

1. More people will have good mental health
More people of all ages and backgrounds will have better wellbeing and good mental health and fewer people will develop mental health problems
2. More people with mental health problems will recover
More people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live
3. More people with mental health problems will have good physical health
Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health
4. More people will have a positive experience of care and support
Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment; and should ensure people's human rights are protected
5. Fewer people will suffer avoidable harm
People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service
6. Fewer people will experience stigma and discrimination
Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will reduce

1.15 Quality standards

As previously explained, the delivery of the NHS, social care and public health outcomes and objectives will be supported by a suite of quality standards to be commissioned from NICE over the next five years. These will provide a detailed description of what high quality care looks like for each care pathway, drawing on best available evidence and practice. Quality standards for depression and patient experience have already been developed, or are currently in process. GP commissioning consortia will use these standards when commissioning services locally. The quality standards will provide the bridge between the outcomes the NHS is expected to deliver and the processes that will make delivery possible.

Seven indicators to improve assessment

NHS Yorkshire and the Humber's Quality Assurance and Improvement Scheme sets out seven indicators for mental health services aimed at improving assessment for people experiencing acute mental health crisis.

Key standards are improved client experience, reduced distress for individuals and families and significantly reduced suicide rates. The indicators specify the data to be collected, the sources of these data and how and when performance will be measured. NHS commissioners and their partners can use these data both to demonstrate the outcomes achieved and to inform strategies for future investment and service direction.

See: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin_schemes_in_mental_health.html#3

1.16 Quality, innovation, productivity and prevention (QIPP)

QIPP in the NHS and similar approaches in local authorities to delivering efficiency and value for money are intended to enable commissioners to drive up quality while improving productivity.

A wide range of actions can and are being taken in health and social care economies nationally to improve quality and efficiency in mental health and related services. These actions can impact in the short, medium and long term to help create a sustainable service and financial strategy. In terms of productivity and savings, some of these actions will provide one-off benefits, while others will be recurrent in full or in part. It will be important to be able to quantify and project these effects accurately.

The range of possible actions can be grouped into four distinct models:

- changes to the clinical pathway or evidence-based service model, including public health improvement, mental illness prevention, promotion and primary care mental health
- increasing people's choice and control and enhancing personalisation of services
- improved procurement and contracting, including collaborative approaches
- productivity improvements, either in service delivery or by minimising 'back office' costs.

A partnership between the Department of Health, NMH DU, ADASS, the Royal College of Psychiatrists and the NHS Confederation is taking forward three work programmes to support delivery of QIPP in mental health at local consortium/ neighbourhood, health and social care economy, sub-regional and regional levels. The work programmes are:

- out of area and other high cost services (including secure provision)
- acute care pathways, and
- physical health and long-term conditions.

Health and social care services, through their SHAs and regions, have supported these areas of national work alongside specific projects of their own that reflect local need and priorities. One example is a project set up by Yorkshire & Humber Improvement Partnership to explore how better provision of a range of different kinds of housing and housing-related support can reduce use of out of area placements and improve people's journeys along their care pathways.

Support available online

QIPP efficiency programmes are underway in all regions. A National Advisory Group is collecting examples of good practice from across the country.

These examples are available on the NHS Evidence website at: <http://www.library.nhs.uk/qualityandproductivity/>

A number of forums and tools have been designed to help local authorities and NHS commissioners identify potential areas for generating efficiency savings and improving quality. They include:

<http://www.csed.dh.gov.uk>

http://www.institute.nhs.uk/option_com_joomcart/Itemid,26/main_page,document_product_info/products_id,183.html

<http://vfm.auditcommission.gov.uk/RenderReport.aspx?Gkey=282VqlaaVSLhf8izWEP0TODL6gywy9mlA6o%2bD1QFon2tve0r3eelWw%3d%3d>

<http://www.idea.gov.uk/idk/core/page.do?pagelid=11216560>

1.17 Public mental health

The greatest opportunities to reduce the levels of mental ill health in the population in the long term lie in mental health promotion, as well as mental illness prevention and early intervention. Improving individual and population mental health sits within the wider public health agenda and brings together a broad range of local stakeholders to work towards a society that values and promotes mental wellbeing as being of equal importance with physical health. They include primary and secondary health care, voluntary, community and statutory agencies, and local communities, schools, businesses and individuals.

²⁴ World Health Organization (2008). *Global burden of disease report*. Geneva: WHO. (http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html)

²⁵ Centre for Mental Health (2010). *The economic and social costs of mental health problems in 2009/10*. London: Centre for Mental Health.

²⁶ Green H, McGinnity A, Meltzer H *et al* (2005). *Mental health of children and young people in Great Britain, 2004*. London: Office for National Statistics.

²⁷ Royal College of Psychiatrists (2010). *No health without public mental health: the case for action*. Position statement. London: Royal College of Psychiatrists.

<http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf>

²⁸ Godfrey M, Townsend J, Surr C *et al* (2005). *Prevention and service provision: mental health problems in later life*. Leeds/Bradford: Institute of Health Sciences and Public Health Research, Leeds University/ Division of Dementia Studies, Bradford University.

²⁹ Knapp M, Prince M (2007). *Dementia UK: a report into the prevalence and cost of dementia*. London: Alzheimer's Society.

³⁰ Colman I, Murray J, Abbott RA *et al* (2009). *Outcomes of conduct problems in adolescence: 40 year follow-up of national cohort*. British Medical Journal 338: a2981.

The case for public mental health

- Mental disorder and self-harm constitute around 23% of burden of illness in the UK – in comparison with 16% for cancer and 16% for cardiovascular disease.²⁴
 - A recent estimate, cited in the mental health strategy *No Health without Mental Health*, puts the economic, human and social costs of mental health problems in England at close to £105 billion per year.²⁵
 - 10% of children and young people have a diagnosable mental disorder although only a small percentage receive treatment,²⁶ 17.6% of adults have at least one common mental disorder,¹¹ approximately 11 million people of working age in the UK have mental health problems,²⁷ and 25% of older people have depressive symptoms, rising to 40% in people aged over 85.²⁸ Dementia affects 5% of those over 65 and 20% of those over 80.²⁹
 - A large proportion of the population also experiences mental disorder at levels that may not meet the threshold for a formal diagnosis but may still have an impact on quality of life and will significantly increase risk of developing more severe disorder. For instance, six per cent of 5–16 year olds have conduct disorder,²⁶ but 18% have sub-threshold conduct disorder.³⁰
 - Children from families with gross weekly household income of less than £100 have a three-fold increased risk of mental disorder compared with those children from families with gross weekly income of £600 or more.²⁶ Socio-economic inequality is one of the two main determinants of mental health in adults, alongside alcohol dependence – mental illness is several times more common in people on the lowest 20% of household income than in those on the top 20% household income.^{*11}
 - The total annual costs (2007 figures for England) of treating mental illness, including statutory public sector services and informal mental health and social care, are £22.5 billion. These costs are projected to increase by 45% by 2026.³¹
 - Health promotion and prevention are particularly significant in relation to mental illness, as even optimal treatment at optimal coverage is only able to reduce the burden of mental illness by 28%.³²
 - Half of all lifetime mental illnesses first appear by age 14³³ and three quarters by the mid-20s. Childhood and adolescence are thus important opportunities for preventing lifetime mental ill health in adult life.
 - Between 25–50% of adult mental illness may be prevented through early intervention in childhood and adolescence.³⁴ The economic benefits of early childhood interventions have been estimated on average to exceed their costs by a ratio of 1:6.³⁵
- * Further, detailed information on mental health inequalities can be found in the equalities impact report accompanying the new mental health strategy.³⁶

The evidence base for interventions to prevent mental illness and promote mental health is summarised in a comprehensive framework for promoting wellbeing published by the Department of Health.³⁷ Further data can be found in the Royal College of Psychiatrists' position statement on public mental health.²⁷ The mental health strategy for England, *No Health without Mental Health*, recognises the importance of locating mental health improvement within the context of improving public health more generally.

This is a lifetime approach – from laying down the foundations of good mental health in early childhood through to maintaining resilience into older age. It sees physical health as being central to good mental health, and vice versa.

Public mental health encompasses a broad span of interventions to address people's holistic mental health and wellbeing needs, including:

- parenting programmes
- pre-school and early education programmes
- school-based mental health promotion
- prevention of violence and abuse
- prevention of suicide
- early intervention in mental illness
- alcohol, smoking and substance abuse reduction and prevention
- promoting healthy lifestyle behaviours
- promoting healthy workplaces and increasing employment
- reducing isolation and increasing social networks for older people
- addressing social inequalities and enhancing social cohesion
- improving housing conditions
- reducing stigma and discrimination
- reducing health inequalities.

Within these categories, programmes may be universal and available to everyone or targeted at specific groups or individuals with particular needs, such as people with learning disabilities, homeless people or people with dementia. One area where primary care approaches may be well placed to support families is in targeting parenting support to families where there is mental illness or drug and alcohol misuse.

Public mental health also offers opportunities for building efficiency and sustainability into the system by reducing the burden of mental disorder and consequent use of specialist services and secondary care. In this way it can help achieve economic savings across key public service sectors, in both the short and longer term. These self-evidently include health and social care economies. But they also include any sector where mental wellbeing and good physical health are factors in improved outcomes. Education, employment, criminal justice, the Department for Work and Pensions and the Treasury, and their local equivalents, all stand to benefit from effective public mental health interventions.

At its heart, public mental health is everyone's business – we all need to take responsibility for improving mental health and wellbeing, as individuals and within organisations. As an example, the transition to GP-led commissioning may provide opportunities to engage families and, in particular, parents in efforts to improve mental health at community level. Local authorities will be well placed to support this work, given their role in improving both educational and social outcomes for children, young people and families. Approaches may include promoting exercise and physical activity, which are both known to be linked with good mental health and wellbeing.

³¹ McCrone P, Dhanasiri S, Patel A *et al* (2008). *Paying the price: the cost of mental health care in England to 2026*. London: King's Fund.

³² Andrews G, Issakidis C, Sanderson K *et al* (2004). *Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders*. *British Journal of Psychiatry* 184, 526–533.

³³ Kessler RC, Amminger GP, Aguilar-Gaxiola S *et al* (2007). *Age of onset of mental disorders: a review of recent literature*. *Current Opinion in Psychiatry* 20 359–364.

³⁴ Kim-Cohen J, Caspi A, Moffitt TE *et al* (2003). *Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort*. *Archives of General Psychiatry*, 60, 709–717.

³⁵ National Institute for Health and Clinical Excellence (2009). *Antisocial personality disorder: treatment, management and prevention*. London: NICE. <http://guidance.nice.org.uk/CG77>

³⁶ Department of Health (2011). *No health without mental health: a cross-government mental health outcomes strategy for people of all ages. Impact assessment*. London: Department of Health.

³⁷ HM Government (2010). *Confident communities, brighter futures: a framework for developing wellbeing*. London: The Stationery Office. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774

Five ways to wellbeing

The Foresight Mental Capital and Wellbeing Project³⁸ report produced wide-ranging recommendations on how to enhance the mental health and wellbeing of the population in order to maximise individual and collective mental capital. It included a set of public messages to encourage individuals to improve their mental wellbeing. These are:

- Connect – with the people around you
- Be active – go for a walk or run
- Take notice – be curious
- Keep learning – try something new
- Give – do something nice for a friend, or a stranger.

The effectiveness of this approach to behaviour-change to improve mental wellbeing is being evaluated.

³⁸ Foresight Mental Capital and Wellbeing Project (2008). *Final project report*. London: Government Office for Science.

³⁹ Glover H (2010). Presentation at the Lifelong Learning and Empowerment in Mental Health conference. Paris, February.

⁴⁰ <http://www.personalhealthbudgets.dh.gov.uk>

⁴¹ SCIE (2009). *Personalisation briefing for commissioners*. London: SCIE.

1.18 Personalisation

Personalisation recognises the role of the individual as commissioner of their own care and support. However, personalisation cannot be achieved without a major cultural, attitudinal and behavioural transformation across the whole mental health economy.

Personalisation includes, but also goes well beyond, allocating people personal social and health care budgets so that they can arrange and pay for their own care and support with the aim of achieving better mental health outcomes and life goals. It requires health and social care workers to encourage and enable people using services to exercise more choice and control over their own lives, including taking a much more instrumental role in deciding the care and treatment they receive from social care and health services.

Personalisation is about empowering individuals to make their own informed decisions and choices about how they want to live their lives and the help they need to do so. This represents a significant shift away from traditional models of health and social care. Personalisation also foregrounds the concept of personal responsibility; it is about equipping people with the information, freedom and confidence to manage their own health and take control of their lives. This marks a radical departure from the historical dependency on traditional services and passive acceptance of 'professional gifts'.³⁹

Personalisation is also about respecting people's 'right to fail', where someone may choose to take informed risks or make choices that do not always work out, and they may need to try again or try out different approaches. This is also an area where governance systems will need further development to ensure that this can happen within an agreed framework, both for people using services and for professionals.

The *Operating Framework for the NHS 2011/12* highlights the work currently being undertaken to pilot personal health budgets across England (including a number of mental health sites⁴⁰) and reinforces the Coalition Government's commitment to expanding their availability and uptake. Personal health budgets are seen not only to give individuals greater choice and control over the services but also to permit greater integration between health and social care at the level of the individual.

Personalisation encourages commissioners to move away from purchasing block contracts of care and directly commissioning individual service packages. Instead, their role is likely to encompass activities such as achieving the right balance of investment in local services to ensure that those who still wish to can access more traditional forms of care. Their role may also include shaping and developing the market to ensure that personal health budget holders and people funding their own care have access to high quality, flexible, responsive and person-centred services to support their continued recovery and mental wellbeing.

Commissioners will need to switch their focus towards commissioning for outcomes. This will in turn influence the development of a far more diverse provider market, bringing greater choice of providers and services. There is also likely to be considerable potential for GPCC and local

Good practice guide

The National Mental Health Development Unit (NMHDU) has produced a good practice guide on how to make personalisation a reality for people with mental health support needs. It includes information on what personalisation means for mental health services, examples of what needs to be in place to make personalisation work, and pointers to good practice and sources of advice and information.

See: <http://www.pathstopersonalisation.org.uk>

authority commissioners to work more collaboratively with others to develop new personalised and cost-effective approaches to achieving better mental health and wellbeing outcomes for the populations they serve.

As well as enabling an individual and their carer(s) to exert greater control and choice, personalisation also provides the means for everyone in a given community to play an active role in promoting their own good mental health and wellbeing. Personalisation requires everyone to have ready access to information and advice about local services so they can make informed decisions about what would best meet their health needs.

Additionally, everyone should have equal access to universal public services that will enable them to maintain and promote their own wellbeing. These include transport, leisure and education, housing and health services, and opportunities for employment.

SCIE personalisation tasks

The Social Care Institute for Excellence (SCIE)⁴¹ has summarised the main tasks of personalisation for local authority commissioners. These can be seen to apply equally to mental health commissioners. They include:

- ensuring the right balance of investment between different services
- shaping the market to ensure that high quality, flexible and responsive services are available for personal budget holders and self-funders
- ensuring that people have access to information and advice to make good decisions about their care and support
- using co-production as means to support and actively engage people in the design, delivery and evaluation of services
- developing local partnerships to produce a range of services for people to choose from
- providing opportunities for social inclusion and community development.

1.19 Payment by Results

PbR means that providers are paid for the number and type of people treated, in accordance with national rules and a national currency. It relies on improved availability of data on activity and outcomes to support funding flows from commissioners to providers. This can have the added benefit of backing up clinical commissioning conversations across primary, secondary, social care and public mental health about service effectiveness and options for redesign. Measures of the effectiveness of the new system will need to be comprehensive to ensure that 'upstream' actions around health improvement, prevention and early intervention are also incentivised, alongside the delivery of core services.

A set of currencies will be introduced for working age adult mental health services from 2012/13, based on a system of PbR mental health care clusters.

The PbR mental health care clusters have been available for use since April 2010. In 2011/12, all those accessing mental health services for working age adults and older people should be allocated to a cluster and local prices agreed. These should be ready for 2012/13 when the use of clusters with local prices becomes mandatory for contracting and payment purposes. Options for moving to a national tariff will also be explored, although the feasibility is under examination.

Implementing mental health PbR may appear to be an additional task in the current climate of change. However, two over-arching benefits make it a worthwhile task:

- it provides the opportunity to better understand the needs of users of services and ensure that service responses to their needs are high quality (safe, effective and a positive experience) and good value (by being efficient and productive)

- it provides the chance to make more informed operational and strategic decisions for mental health services by improving the information available to commissioners.

Beyond these two key benefits, there are a number of other, related advantages for commissioners, providers and people using services.

- People using services should have well-defined responses to their individual care needs, with clarity over treatment and support options. This approach could support the setting of personal health budgets by allowing funding to be aligned with and reflect people's individual needs.
- The mental health system will have contractual parity with other providers who are also contracted on an activity basis.
- Commissioners can expect to have a clearer understanding of the number and nature of people being treated. They will also have a transparent framework within which to align outcome measures and the opportunity to have more meaningful discussions with providers about the service response to each care cluster. Given that clusters focus on individuals, they should also facilitate the co-ordination of multiple providers delivering different aspects of care.
- In carrying out their preparation, providers will be able to gain a more detailed understanding of their business. This includes the costs of interventions for individual users of services, the ability to design and develop service provision based on their characteristics, and a transparent means of demonstrating their productivity and efficiency through benchmarking with other providers.

1.20 Equalities, diversity and inclusion

Equalities, diversity and inclusion are key areas for commissioners. Commissioning provides the mechanism to tackle health inequalities by ensuring that disadvantaged and minority communities and individuals with specialist and complex needs receive the levels of service provision needed to maintain and improve their mental health and wellbeing.

The Equality Act 2010 pulls together existing equalities legislation covering disability, gender, race, religion/belief and sexual orientation, and also introduces an age equality duty on the public sector and a duty to consider reducing socio-economic inequalities.

A core requirement is to pay due regard to the need to eliminate discrimination and promote equality. This provides an opportunity for commissioners to assess the likely impact of proposed policies and service developments on groups with protected characteristics (see table 5). Commissioners of mental health services will need to ensure that their decisions do not impact disproportionately on any one segment of the local population and that they protect the interests of minority and social excluded groups and individuals.

There is a continued need to focus on equality of access to services and that services are responsive to local diversity of need and experience. Failure to do this can perpetuate inequality in service provision.

Local authorities and the NHS can also make a significant contribution⁴² to building resilient and cohesive communities, which in turn contributes to achieving the Coalition Government's visions for the Big Society, public mental health and social care.

Table 5: Equalities issues for mental health commissioners

Equalities cover a range of issues that impact on health across and within communities. Inequalities will be identified through the Joint Strategic Needs Assessment. Inequalities commonly encountered within NHS and social care services include:

Age
Access for older people to services available to working age adults; failure to recognise mental health needs of older adults.
Disability
Access to physical and mental health care for people with other disabilities – e.g. people with learning disability who can be overlooked both by mental health services and public health initiatives such as screening.
Marriage and civil partnership
Rights and recognition of same sex partnerships.
Race
Inequalities in health and health outcomes; poorer access to and experience of services.
Religion or belief
Provision of appropriate facilities, sensitive services.
Gender
Safety issues, single sex accommodation, mental health impact of violence and abuse, gender variations in mental disorders and access to treatments; gender reassignment.
Sexual orientation
Gaps in service provision for lesbian, gay, bisexual and transgender people; discrimination.

1.21 Involving individuals and communities

The Coalition Government has set out its vision for the Big Society. The aim is to give communities and individuals more influence over local public service provision.⁴³ This includes encouragement to people to play an active role in their communities; devolution of power and greater financial autonomy to local government; support for non-statutory organisations; powers to take over local facilities and services threatened with closure; and opportunities for public sector workers to establish employee-owned co-operatives and bid to run the services they currently deliver.⁴² The result should be increased choice for local people, and greater responsiveness and accountability from providers.

This approach resonates strongly with the recovery approach to mental health treatment, with its emphasis on individual empowerment and self-actualisation, drawing on peer (community) support.

⁴² Lawrence A (2008). *Better together: a guide for people in the health service on how you can help to build more cohesive communities*. Coventry: Institute of Community Cohesion. <http://www.cohesioninstitute.org.uk/Resources/Toolkits/Health/HealthAndCommunityCohesion/KeyNhsPriorities>

⁴³ Cabinet Office (2010). *Building the Big Society*. London: Cabinet Office. <http://www.cabinetoffice.gov.uk/media/407789/building-big-society.pdf>

⁴⁴ Russell G, Ford T, Steer C, Golding J (2010). *Identification of children with the same level of impairment as children on the autistic spectrum, and analysis of their service use*. *Journal of Child Psychology and Psychiatry* 51(6): 643–651.

1.22 Safeguarding children and vulnerable adults

In mental health, safeguarding duties cover three core dimensions:

- people with mental health issues (as individuals or as parents/carers)
- safeguarding others, with particular relevance to children and families
- wider public protection issues and the application of statutory mental health powers.

In mental health, safeguarding requires connections to be further strengthened and maintained across primary care, social care, community, specialist and acute health care services and also link with the public, private, voluntary and community sectors.

A significant level of unmet need currently exists among children and young people with mental health problems. This, as highlighted above, is a particularly important group to target to prevent adult mental disorder. For instance, in 2004 only 25% of children and adolescents with conduct or emotional disorder had active contact with CAMHS, even though these are the most common mental disorders in this age group.²⁶ Similarly, more than half of all children with autism or Asperger's syndrome were not diagnosed and did not receive any additional support in education or health. Safeguarding requires appropriate capacity to enable early intervention for childhood and adolescent mental disorder to prevent more serious and long-lasting problems developing into adulthood.

1.23 Expanding choice of providers

The introduction of PbR in mental health, the development of the new care clusters and the continued roll-out of personal budgets will promote further expansion in the provider market to include a far wider range and diversity of providers. This sits within the framework of competition and collaboration that applies to the NHS and local authorities. It will be important for GP commissioning consortia to take advice from specialist clinicians in secondary care to ensure that the right clinical pathways are commissioned in a collaborative way. This is not incompatible with the need to ensure competition as long as commissioners can demonstrate that no one has been either positively or inappropriately excluded from those collaborative conversations.

NHS trusts will find themselves in competition with independent and voluntary sector providers. This presents both opportunities and challenges for commissioners. They will have a much greater choice of care providers, but may also need to support smaller, specialist voluntary sector agencies whose services may be more acceptable and accessible to particular groups – and no less effective – than those offered by larger agencies. The 'any willing provider' requirement is likely also to bring much greater choice for users of services.

Local commissioners will need to ensure the place of these smaller, specialist providers is protected in this more commercial market place. A balance also needs to be maintained between individual choice and collective protection.

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- 2.2 Commissioning, contracting and procurement
- 2.3 Specialist commissioning
- 2.4 The commissioning process
- 2.5 Integrated and collaborative commissioning
- 2.6 Current market characteristics

What mental health commissioning looks like now

Over the last ten years, commissioning in mental health has been driven largely by the National Service Framework (NSF) for mental health. Building on the NSF achievements, government policy has focused on the dual priorities of improving the mental health and wellbeing of individuals and the population and improving the quality of clinical services for people with high level needs.

Commissioners and providers have focused primarily on developing and embedding a range of primary and community based services to support the shift in locus of care away from the acute inpatient hospital. These include specialist community mental health teams and services that deliver:

- crisis resolution and home treatment
- assertive outreach
- early intervention in psychosis.

A number of new roles have also been introduced to the mental health arena, including primary care mental health workers, support, time and recovery (STaR) workers, and community development workers, with a particular focus on minority ethnic communities. Peer support services have also emerged, making visible the contribution people with experience of using services (personally, or as a carer) can bring to improving health and recovery outcomes.

The Improving Access to Psychological Therapies programme has also significantly expanded access to talking treatments in primary care settings for people with mild to moderate mental health problems.⁴⁵

The new mental health strategy confirms the importance of promotion of mental wellbeing, early intervention for mental illness and approaches supporting choice, personalised care and recovery. There will be a strong focus on achieving improved outcomes for people with a range of mental health needs, regardless of their age and background.

⁴⁵ <http://www.nmhdu.org.uk/our-work/personalisation-in-mental-health-emerging-programme/peer-support-initiatives-practice-examples/?keywords=peer+support>

2.1 Needs assessment (JSNA)

Local authorities and NHS commissioners have a statutory duty to produce a joint strategic needs assessment (JSNA),⁴⁶ as required by the Local Government and Public Involvement in Health Act 2007. The JSNA forms the basis for local agreements, strategies, and plans for meeting the health needs of the local population and addressing health inequalities. This responsibility will continue as part of local authorities' responsibilities for co-ordinating local commissioning.

The JSNA process draws in a wide range of partner organisations to obtain a genuinely holistic picture of current and future local health need that will allow organisations and individuals to make more informed decisions about the level and type of services required.⁴⁷ It places individual and population needs and outcomes at the heart of the commissioning process.

The JSNA should capture not just the needs that are currently being met by existing services but also unmet needs and those that may be masked by more dominant needs within the wider community. This requires close collaboration between partner agencies.

Guidance about conducting JSNAs for mental health can be found in *The Joint Strategic Needs Assessment and Mental Health Commissioning Toolkit – A practical guide* at www.nmhdu.org.uk

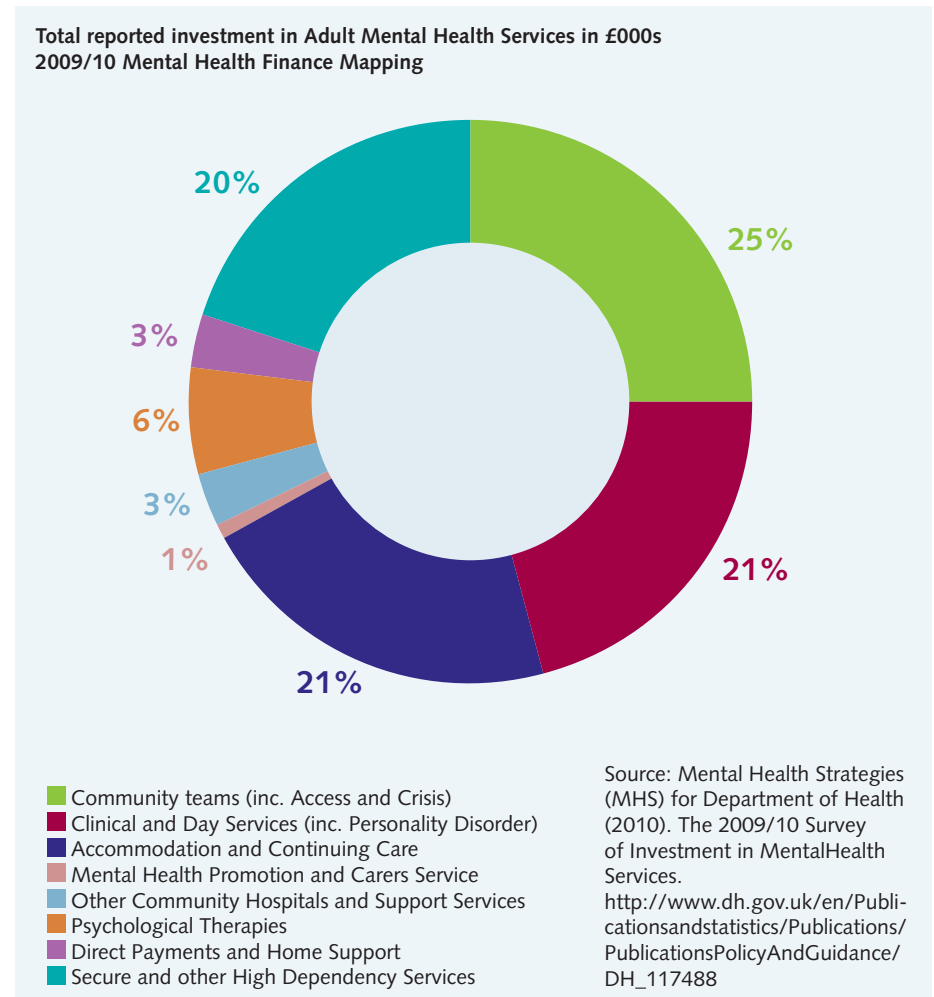
⁴⁶ Department of Health (2007). *Guidance on joint strategic needs assessment*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

⁴⁷ NMH DU/CSL (2009). *The commissioning friend for mental health services*. London: NMH DU/CSL.

2.2 Commissioning, contracting and procurement

The main areas of spend on specialist adult mental health and social care services are shown in figure 6 below.

Figure 6: Commissioning spend by service areas for mental health and social care



Current approaches to mental health commissioning vary widely across the country and often depend on the tier at which services are being commissioned. At tiers one to three, the most common approach will be joint commissioning between local authorities and PCTs, lead commissioning, where one PCT takes the lead for a number of PCTs, and individual or aligned commissioning, where individual PCTs or local authorities commission separately or collaboratively.

At tier four, due to the low volume and high cost of the services being commissioned, specialist commissioning groups have been established that operate at a regional level, so that risk is shared and procurement terms can be more beneficial.

2.3 Specialist commissioning

There are currently ten regional specialised commissioning groups in England. They are responsible for commissioning some, or all, of the Specialist Services National Definition Set. These include forensic/secure mental health services; perinatal mental health services (mother and baby units); tier four severe personality disorder services; and tier four child and adolescent mental health services.

In addition, secure forensic services for young people and high secure commissioning are commissioned at a national level by the National Specialised Commissioning Group.

These specialised commissioning arrangements can work well in terms of strategic management of investment and resources (for example, collaborative commissioning of perinatal inpatient services), consistent management of clinical gate-keeping and achieving procurement efficiencies through economies of scale.

However, establishing pathways into specialist services and back into mainstream community mental health services continues to present a considerable challenge, requiring collaboration between local and specialist commissioners.

The new commissioning system will deliver new opportunities to develop alternatives along this pathway (such as step down care) in order to facilitate throughput and discharge, as well as other potential approaches (such as robust multi-agency protection panels).

2.4 The commissioning process

The commissioning process is a continuous cycle through three stages: strategic planning, procuring services, and monitoring and evaluation.

Commissioning is a dynamic process that is about identifying and prioritising need and apportioning resources to meet those needs and achieve positive outcomes in a spiral of continuous improvement.

Commissioning to improve population mental health and wellbeing requires the co-ordination of commissioning activity for the whole population:

- at a universal (tier one) level for people accessing primary care and lower-level advice and support services for a range of issues including depression, anxiety, and medically unexplained symptoms. This level also involves universal and targeted interventions to promote mental health and prevent mental illness
- for people recovering from severe mental illness (tier two)
- for people receiving active treatment for severe mental illness, and people using medium/long-term care services (tier three)
- for people using specialist, intensive medical or forensic services (tier four).

This requires working across local/sub-regional/regional partnerships, and collaboratively with others, to specify services and outcomes, maximise procurement efficiencies and strengthen joint contacting and performance management.

A range of system/market management and procurement approaches can be used to ensure service choice, diversity, quality, safety and effectiveness. These include some of the newer system reform tools, such as the commissioning for quality and innovation framework (CQUIN), user/patient reported outcome measures (PROMS), person-based resource allocation systems and commissioning currencies.

The requirement to reduce management and infrastructure costs requires consideration of effective collaborative structural arrangements to manage the stages of the commissioning cycle. This may include, for example, merger of shared services and clustering of NHS commissioners' functions.

2.5 Integrated and collaborative commissioning

Joint and wider collaborative commissioning arrangements for mental health and wellbeing vary across the country. They range from individual mental health commissioners working together across agencies, through *Care Trust Plus* models, to fully integrated, joint mental health commissioning organisations. Some are using devolved joint budgets secured under Section 75 commissioning agreements. Some are sharing risk through regional or sub-regional procurement or specialist commissioning arrangements covering a number of 'member' commissioning organisations.

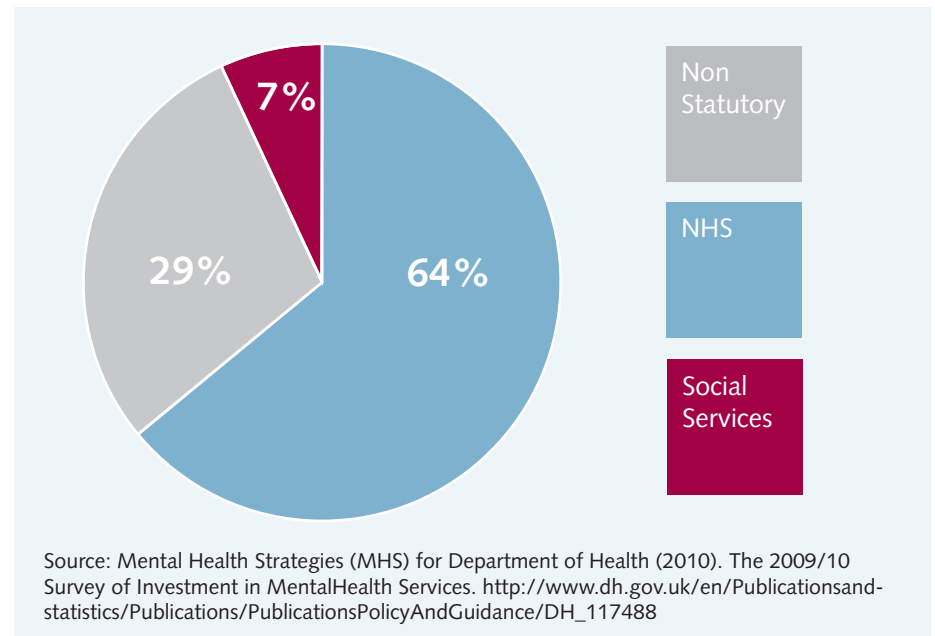
The increasingly integrated nature of commissioning and provision brings together different organisational cultures. Working with each others' cultures, systems and processes presents particular challenges.⁴⁷ How to align different priorities and competing targets in order to facilitate partnership working remains a key challenge on the commissioning agenda.

Joint commissioning between the NHS (currently PCTs and, in time, the new GPCC) and local authorities requires the alignment of mutual business functions around finance, governance arrangements and risk-sharing. This is particularly important for public mental health interventions where the bulk of economic savings tend to accrue to areas outside health.

2.6 Current market characteristics

Figure 7 illustrates the current share of the NHS mental health provider market between NHS, non-statutory and social services.

Figure 7: Mental health providers by sector



Mental health touches all aspects of life. For this reason, the mental health provider market is already well developed and contains a wider selection of agencies than most other sectors of health or social care.

This is most noticeable at the community and social inclusion end of the spectrum, where the voluntary sector plays a significant role in the expansion of access to talking treatments and the development of social businesses.

At the other end of the spectrum are specialist placements and rehabilitation services. Here too there is a good range and large selection of independent providers, as well as voluntary sector and NHS provision.

However the core secondary mental health services are still contracted in the main from NHS mental health trusts, through large block contracts. This has limited the introduction of the 'any willing provider' model that is better able to increase innovation, market diversity and choice for users of services.

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Going forward: what mental health commissioners need to know

The Coalition Government's plans for the redesign of health and social care commissioning will see the implementation of GP-led commissioning, the transfer of public health responsibilities to local authorities and the abolition of SHAs and PCTs by 2013.

The transition process is outlined in the Command paper, *Liberating the NHS: Legislative Framework and Next Steps*.⁴⁸

Transition to the new arrangements will be carefully staged. From December 2010, cohorts of pathfinder GPCC have started to test the key elements of GP-led commissioning. From January 2011 and throughout 2011/12, a growing number of shadow consortia will become pathfinders and start to take on responsibilities for commissioning, using powers and budgets delegated to them by PCTs within the current statutory framework. PCTs will start making staff available to assist consortia in their new role. Early implementer arrangements for health and wellbeing boards will also be tested in 2011/12, in preparation to be fully operative in 2012/13.

During the first transitional year, 2011/12, emerging GPCC will have the opportunity to plan how they intend to carry out their future functions. In particular, they will need to decide what activities they will undertake for themselves by employing or engaging their own staff, what activities they will carry out on a collaborative basis (for example, through a lead consortium arrangement or through collaboration with local authorities), and what activities they wish to buy from external support organisations.

Building on these early findings, during 2011/12 emerging GPCC and local authorities will work with PCTs to develop transition plans that include:

- identifying posts for a transfer of staff from PCTs to consortia
- identifying consortia intend to fill other posts within their future staffing structures
- enabling PCTs, SHAs and the shadow NHS Commissioning Board to identify where there will be significant demand for external commissioning support, to encourage potential providers to develop support in these areas, and to consider how best to support consortia in accessing cost-efficient and effective support
- agreeing a managed process for transferring any information and IT systems associated with these commissioning functions
- identifying the individual contracts that will need to be transferred from PCTs to consortia
- identifying partnership arrangements, including pooled budget and lead commissioner agreements, that will transfer to consortia working with local authorities to make future plans for these areas
- identifying how arrangements will operate for public health services and health and wellbeing boards at a local level, and

- further developing relationships with Local Involvement Networks (as they develop into local HealthWatch) and with other community partners and advocacy groups.

In the final transitional year (2012/13) consortia will typically take on the lead responsibility for commissioning health care services. PCTs will still be statutorily accountable but will transfer responsibility for budgets and commissioning decisions to GPCC.

From April 2012, the NHS Commissioning Board will establish GPCC, based on the applications prepared in the previous year, or work with prospective consortia to help resolve any difficulties.

Once established as statutory bodies in their own right, GPCC will be able to take on staff from PCTs. In the autumn of 2012, consortia will receive notification of the budgets for which they will be statutorily accountable from April 2013 onwards. From April 2013 it is likely there will be a period of embedding and consolidating the new system, with further adaptation as consortia learn from experience.

There are, however, risks to services in times of transition. The transfer of commissioning responsibilities is also taking place within a highly challenging financial context. As GP-led commissioning begins to identify and address local priorities, it will be important to engage with strategic and collaborative planning for mental health so that shifts in investment are consistent with the overarching strategic direction of the commissioning system as a whole.

The focus of commissioning has broadened, reflecting the need to view mental health through a whole population lens. This includes moving towards more holistic service delivery.⁴⁷

⁴⁸ Department of Health (2010). *Liberating the NHS: Legislative Framework and Next Steps*. London: The Stationery Office.

3.1 Population mental health and wellbeing

To achieve sustainability in the medium and long term, commissioners need to look beyond the high profile specialist and acute services that are traditionally labelled 'mental health' and commissioned primarily from mental health trusts.

The clear message from public health analysis and evidence is that commissioners in both the NHS and local authorities also need to focus more on mental health promotion, prevention and early intervention. They need to invest in improving the life chances and circumstances of everyone in the communities they serve, particularly those at higher risk, as highlighted earlier.

Half of lifetime mental illness emerges by the age of 14, and three quarters by the mid-20s. Given this evidence and the limited resources available, it will clearly be in the interests of commissioners to invest in early interventions for people experiencing mental health problems in order to help reduce use of more expensive, longer-term interventions at a later point.

This links to current work to develop a connected economic model for early intervention for conduct disorder, early diagnosis and treatment of depression in the workplace, early intervention in psychosis and early detection of psychosis.⁴⁹

Moreover, as the Government Office for Science has evidenced conclusively in its Foresight Project,³⁸ investment in population mental capital and wellbeing is essential for society as a whole, and the nation's economic prosperity. Mental capital is defined as an individual's cognitive and emotional resources. Wellbeing describes the state in which a person is able to develop their potential, work productively and creatively, and build strong and positive relationships with others. Both are fundamental attributes of resilient individuals and also of cohesive, productive and mutually supportive communities.

It is therefore important for commissioners to take both a broad and a long view, and ensure a focus on commissioning for mental health as well as mental illness. As previously referenced, even if all those experiencing mental illness received optimal treatment, only 28% of the burden of disease would be averted.

Feeling good about where you live

Feeling Good About Where You Live (FGAWYL) is a multi-agency mental health promotion project targeting a deprived area of the London borough of Greenwich with high levels of poor mental health. It is a multi-partner initiative that involves NHS Greenwich and Greenwich Council (which jointly fund the project), the Metropolitan Police, local community groups and residents.

The project builds on previous research with residents of Greenwich that revealed a strong cross-sectional association between the residential environment and mental wellbeing, independent of demographic/socio-economic characteristics of residents. The research highlighted the need to intervene in both design and social features of residential areas to promote psychological health.

FGAWYL is piloting an integrated, multi-agency approach to delivering low cost physical and social interventions that maximise the effectiveness of existing routine services and local funding sources to address each of 13 factors operating at estate level (damp; noise; overcrowding; fear of going out during the day and night; liking the look of the place; needles and syringes left around; access to open space; lack of places to stop and chat; community and entertainment facilities; transport and accessibility).

An intervention estate is being matched with a 'control' estate, which will enable the project to provide causal evidence of the relationships between the physical and social aspects of residential environments and psychological wellbeing and to develop a model that will be replicable across other areas of Greenwich. It is envisaged that the 'control' estate will also receive interventions following completion of the intervention research stage.

[http://webcache.googleusercontent.com/search?q=cache:DJVDol-0XT4J:www.selondonhousing.org/Documents/Aideen%20Silke%20presentation%20Feeling%20Good%20about%20where%20your%20live.ppt+\"Feeling+Good+About+Where+You+Live\"+\(FGAWYL\)&cd=1&hl=en&ct=clnk&gl=uko](http://webcache.googleusercontent.com/search?q=cache:DJVDol-0XT4J:www.selondonhousing.org/Documents/Aideen%20Silke%20presentation%20Feeling%20Good%20about%20where%20your%20live.ppt+\)

⁴⁹ Knapp M, McDaid D and Parsonage M (2011). *Mental health promotion and mental illness prevention: The economic case*. Personal Social Services Research Unit, London School of Economics and Political Science. Report to be published by the Department of Health, London.

3.2 Recovery

The proposed health and wellbeing boards may provide a catalyst for this, bringing together GPCC with local authority colleagues and citizens to develop a strategy for the long-term, holistic investment in future mental health, as well as current treatment and recovery.

Commissioners will need to align their inputs with the broader strategies for community wellbeing that are devised and delivered through local partnership activity in other sectors, such as housing, transport, and employment.

Investment in community outreach and voluntary sector groups with a prevention and mental wellbeing focus can help reduce the likelihood of vulnerable groups with severe and long-term mental health needs requiring support from specialist secondary mental health services.

Ensuring that the necessary range of preventive services and treatment options are in place or are being developed will be central to improving mental health and wellbeing across localities.

Mental health practice should aim always to put the person's needs at the centre of care planning and service delivery. The mental health strategy, *No Health without Mental Health*, encourages recovery-based approaches. This is further reinforced by the inclusion of recovery in the NHS Outcomes Framework and the proposed social care outcomes framework.

The recovery model underpins the Care Programme Approach (CPA) and its four key elements: assessment, care planning, provision of a care co-ordinator and regular review.

The CPA process aims to promote social inclusion and recovery, encourage the individual to take responsibility for their own wellbeing, recognise the role of carers in facilitating recovery, and promote genuine partnership working between the individual and their mental health team. Systems have been developed that have further supported and ensured these aims and ensure a continuous link from the promotion of wellbeing through relapse prevention to recovery, in line with the public mental health agenda.

In a mental health context, the term 'recovery' does not refer to 'clinical recovery' from a mental illness. Rather, it is used very specifically to describe the individual's personal, self-directed journey through life with mental illness. Recovery has been described as:

*"...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond catastrophic effects of mental illness."*⁵⁰

Recovery challenges conventional approaches to treating mental ill health. It is consistent with the Government's vision for public health. This, as previously explained, takes a more holistic approach to mental wellbeing and mental health improvement, rather than addressing mental illness in isolation from other important factors in people's lives.

The recovery approach has been adopted by many mental health services in England, with varying success.

The Mental Health Recovery Star⁵¹ enables users of services to gauge and record their recovery progress, and enables providers to identify individual outcomes and benchmark across services. The Centre for Mental Health and the National Mental Health Development Unit have produced a methodology to support commissioners and providers to work collaboratively on organisational improvements that will deliver recovery-oriented services.⁵²

⁵⁰ Anthony WA (1993). *Recovery from mental illness: the guiding vision of the mental health service system in the 1990s*. Psychosocial Rehabilitation Journal 16(4): 11-23.

⁵¹ <http://www.mhpf.org.uk/recoveryStarApproach.asp>

⁵² Shepherd G, Boardman J, Burns M (2010). *Implementing recovery: a methodology for organisational change*. London: Centre for Mental Health.

Mind's portfolio of innovation

Mind in Croydon won the NHS Health and Social Care Award for mental health and wellbeing for their highly innovative approach to working with people with mental health problems. Mind in Croydon's 'portfolio of innovation' includes services such as sailing, boxercise, horticulture and a service user documentary film group.

The work has enabled clients to engage in unique and innovative projects that promote their recovery and wellbeing. The projects also go a long way to challenging stereotypes and overcoming the stigma associated with mental health problems as well as challenging ideas about what are seen as 'suitable activities' for those with mental health problems.

People's self-esteem and self-confidence improved greatly – success in one area of their lives gave people the impetus and confidence to move forward in other areas, such as returning to college or work.

Danni, who has benefited from the multi-award winning Mind in Croydon boxercise project, which is run in partnership with three times world champion boxer, Duke McKenzie, accepted the award on behalf of the team. She said: *"Boxercise has been the miracle I needed to put myself back together. In March I got my Level 2 YMCA fitness qualification...the project has changed my life."*

The projects, funded by NHS Croydon, City Bridge Trust, Film London and the Big Lottery and Comic Relief via the Time to Change anti-stigma campaign, also helped tackle some of the physical health problems associated with mental health problems and psychiatric medication, such as diabetes, heart disease and cancer.

The recovery model and the objectives of the CPA require mental health commissioners to promote and increase the support and treatment choices available to individuals. They will need to stimulate the market to include a wider range of providers and further unlock payment mechanisms (linked in to PbR) to allow the expansion of personal health and social care budgets, giving more personalised options and choices to people across health and social care. Also, where an evidence base is building, commissioners might consider the value of certain complementary and alternative therapeutic approaches.

The stimulation of the market will increase the need to monitor types and levels of activity to ensure best value across services and to review and change what does not work or is not used. Access to good quality, up-to-date information is key if people are going to be able to exercise far greater choice. To support this, a national website has been developed to help people directly with this issue, at:

<http://www.nhs.uk/Livewell/MentalHealth/Pages/Mentalhealthhome.aspx>

3.3 All-age commissioning

The aspiration for all-age inclusivity in commissioning is not always reflected in current resource allocation across adult health and social care. A similar disparity is found between services for children and young people and services for working age adults. Limiting access to services on the basis of age is not only potentially discriminatory; it can also hinder transitions between care pathways and services.

All-age commissioning means taking a wider approach to population health. Mental health, public health and other commissioners can address these difficulties by designing services and care pathways around need rather than age.

Of particular importance when considering all-age commissioning is the issue of transitions. The transition from adolescence to adulthood is a crucial stage in social, personal and emotional development.⁵³ For young people in contact with mental health services, this period usually coincides with another important transition – from child and adolescent mental health services (CAMHS) to adult mental health or other relevant services.

Services that meet the needs of young people and provide safe and co-ordinated transitions between CAMHS and adult services are rare. Health and social care commissioners will need to work closely with providers in the NHS, local authorities, schools, colleges and the third sector to ensure that appropriate, acceptable and accessible services are commissioned and delivered to achieve improved outcomes for young people.

⁵³ Lamb C, Hall D, Kelvin R, Van Beinum M (2008). *Working at the CAMHS/adult interface: good practice guidance for the provision of psychiatric services to adolescents/young adults*. London: Royal College of Psychiatrists.

3.4 Clinical leadership and engagement

Clinical leadership in commissioning in England is still in development. It takes time away from clinical care to be involved in the commissioning process, but many clinicians have found that the resulting improvement in resources and services is worthwhile.⁵⁴

The information that clinicians hold is invaluable to developing services and enabling innovation. In mental health, the GP, psychiatrist and public health clinician bring to the commissioning process a particular knowledge of local needs and circumstances to augment that provided by partner agencies. Leadership is needed to develop commissioning networks that will facilitate conversations between clinicians and the sharing of expertise.

Psychiatrists and other senior mental health staff can advise on aspects of the care of people with severe and enduring mental illness as well as other areas, about which most GPs have generic, rather than specialist, knowledge. GPs can advise on the physical health care of these patients, including care of those with diabetes and cardiovascular disease. They may also have some specific mental health knowledge from a primary care perspective that can apply in day-to-day care. GPs can also advise on the management of people with common mental health problems, including the deployment of talking therapy services.

⁵⁴ Simpson C (2000). *Commissioning mental health services: role of the consultant psychiatrist*. *Advances in Psychiatric Treatment* 6 :72.

Local leadership is needed to bring these two groups of clinicians together to discuss these issues and agree innovative solutions, and also to ensure the public mental health agenda is not overlooked. To make these conversations effective requires action from both primary care organisations and mental health trusts. Clinical leadership and engagement will be of particular benefit to the development of pathways, outcomes standards and access to services.

Improving access to psychological therapies

Data relating to how IAPT services are planned, commissioned and delivered, including health outcomes and users' experience, is routinely collected locally, with some information optionally reported centrally to track implementation progress and for benchmarking service performance.

Full data were provided by 32 year-one IAPT sites. Overall, the findings support the IAPT model. Findings of particular significance for clinicians, mental health commissioners and GP commissioners include:

- psychological wellbeing practitioners and high intensity therapists are equally valuable and services do best if they deploy both (plus employment advisors) in a functional, stepped care approach
- initial symptom scores influenced the amount and type of treatment patients received (in line with NICE guidance) and its outcome
- self-referred patients recovered in fewer sessions
- therapy that complied with NICE recommendations was associated with better outcomes
- sites that offered more sessions had better outcomes
- sites with more experienced staff achieved better outcomes.

Commissioners, working with their providers, can use these data to improve patient outcomes by changing and refocusing local IAPT provision.

Data can be used to monitor the access of people with depression and anxiety disorders to the full range of NICE-recommended, evidence-based psychological therapies, in accordance with the principles of stepped care.

Working with IAPT service managers and clinical leads, outcome data may also be used to support investment in the continuing professional development needs of IAPT workers.

Experience from other specialities in health, and from the Improving Access to Psychological Therapies programme, emphasises the importance of robust data in commissioning. The developing data set for mental health is beginning to yield useful information for clinicians about their practice. Using this data, and sharing information about effective clinical outcomes from around the country, can help to promote wider clinical and professional engagement in the practical aspects of commissioning. This can also be further improved through more accurate data collection, feedback and dissemination between clinicians, information analysts and providers.

Mental health pathways

A wide variation was noted in the mental health services provided in the different localities across Yorkshire and Humber. Clinicians recommended actions for the SHA to take forward to improve provision. Of critical importance has been the implementation of generic mental health pathways.

The key features of these pathways are:

- integrated primary/secondary and health and social care
- care planning and care navigation supported by advocacy
- single point of access
- open access to a range of supportive interventions provided by a range of providers.
- care packages underpinned by NICE guidelines/good practice/evidence
- care elements/packages can be allocated a cost so people can have their own budget
- personal advisers or advocates available to support people to access the appropriate support
- national standards for services enable benchmarking to take place.

http://www.healthyambitions.co.uk/Documents/HealthyAmbitions/NHS_The_Mental_Health_Pathway.pdf

3.5 Co-production and engagement

Co-production is a general description for a process whereby people who use services, and in particular those who can find it hard to access services (such as people from minority ethnic communities or people with learning disabilities), work alongside professionals as partners in the planning, commissioning and delivery of services.

Co-production requires commissioners to engage meaningfully with other commissioners across sectors to ensure clinically effective and cost-effective outcomes. Commissioners also need to engage with people who use services, carers and the public, to obtain information to inform commissioning decisions.

Co-production in Kirklees

Joint work with the New Economics Foundation (nef) provided the impetus for commissioners across adult social care and health in Kirklees to test the principles of co-production within a formal procurement process that prioritised outcomes rather than outputs. Three contracts were specified and assessed using the language of co-production.

From a commissioner perspective, potential providers were given much more freedom to describe how they would contribute to achieving the desired outcomes. The quality of tenders exceeded previous experience as providers responded creatively to the invitation. One tender was orientated towards prevention in the context of work with nef on commissioning for wellbeing. With reference to outcomes associated with community capacity and personal resilience, this project additionally specified that a range of different delivery models should be included, specifically social enterprise, user-led organisations, micro businesses and timebanking.

A further product of the work with nef has been to accelerate an approach to looking at social return on investment (SROI). All specifications in mental health now ask providers to demonstrate how they evidence social return. Initial pilot work on employment confirmed the prevailing view about the value of work. In six actual cases, the 'savings to the state' worked out at between £600 and £11,000 pa.

A full SROI exercise is now underway on the employment project in parallel with Sheffield University. The general work on SROI is enhanced by the use of the Recovery Star⁵¹ to look at outcomes. A physical activity project (Active for Life), for example, only accepts referrals from people supported by the Care Programme Approach. This project's participants report a quarterly improvement in their general wellbeing of around 25%.

Overall, there is a more cohesive approach to results, given that the framework includes outcomes, outputs, costs, social return and personal testimony.

This recognises that people who have used services have unique knowledge that can be used to improve their development and delivery. All those who offer services therefore need to be able to promote and support the engagement of people using those services.⁵⁵

Every citizen is entitled to expect the same from life and society as anyone else, including opportunities to have a say in deciding priorities, strategies and services that will meet local needs. Co-production requires commissioners to break down professional and organisational barriers and promote an inclusive, citizen-focused approach to the planning, commissioning and delivery of services.

Currently this can take place in mental health through a range of forums and other routes to engagement, including Partnership Boards and targeted social marketing initiatives. It is important to build on these structures, and further opportunities are likely to arise through the new commissioning system to better link into primary care and extend the influence of people who use mental health services on the whole health and social care system.

Co-production is also embedded in the recovery model. The recovery concept sees the individual as an equal partner in their own care and treatment, drawing on a range of supports that may include formal mental health services and medical treatment alongside other less formal sources. Thus, co-production has huge potential at individual/clinician and commissioning levels.

This approach is also key to ensuring individuals have more choice and control over their care and treatment. Involvement of those using services in their own care, and also in providing support and peer services to others with similar care and treatment needs, has been shown to be both clinically effective and supportive of recovery from mental illness and maintenance of mental health, for provider and service receiver alike.

Co-productive commissioning will require investment in innovative peer support initiatives and enabling access to activities and resources outside the conventional understanding of mental health treatments, in alliance with social care and wider local government services.

Peer support in Australia

A mental health peer support service was introduced in an Australian adult mental health service with the aim to reduce hospital admissions and lengths of stay and improve early discharge support.

The evaluation looked in particular at bed days saved, crisis service contact, A&E presentations, and readmission rates, and sought feedback from various stakeholders including users of services, carers, mental health staff, GPs and peer support workers.

In the first three months of operation, 49 support packages were provided and 300 bed days saved.

Feedback from all stakeholders was overwhelmingly positive. The study concluded that using peers to provide support to consumers at this stage of their recovery appeared highly effective as an adjunct to mainstream mental health services, has personal benefit to users of services and peers, results in substantial savings to mental health services, and has much potential for encouraging mental health service culture and practice towards a greater recovery focus and improved collaboration with GPs.⁵⁶

⁵⁵ Foster J (2005). *Where are we going? The social work contribution to mental health services*. London: Social Perspectives Network for Mental Health.

⁵⁶ Lawn S, Smith A, Hunter K (2008). *Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service*. *Journal of Mental Health* 17(5): 498-508.

Carer engagement

Herefordshire Health and Social Care Mental Health Procurement Project Board (which included representation from providers, board members, clinicians and commissioners) consulted the local mental health reference group early in the process of procuring mental health services from out of county. The report of findings identified for the commissioners several worthwhile projects and validated an emerging model for effective engagement of carers, or other stakeholders, for service improvement. Information in advance of the formal report can be obtained from:
alison.bolton@nhs.net

Co-production with service users

Camden Council, the New Economics Foundation (nef) and the local voluntary and community sector have jointly developed an outcomes-based commissioning model based on principles of social inclusion, using funding from a government Invest to Save programme.⁵⁷ The model is designed to promote co-production with service users; use existing social assets and networks; improve outcomes for those using services; and ensure that these outcomes are enduring and embedded in local communities. The resulting service model promotes volunteering and timebanking, both among people using services and within the wider community.

⁵⁷ Department of Health (2010). *Volunteering: involving people and communities in delivering and developing health and social care services*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113969

3.6 Effective use of resources

As in most health and social care-related areas, the demand for services in mental health can outpace the available resources. Commissioning systems – clinical, locality-based, regional or national – will need to be able to demonstrate that resource allocation decisions have been clearly and systematically linked to meeting defined priorities.

Needs assessment, planning, prioritisation and budgeting cycles work best when they are aligned across agencies, and where investment plans are jointly agreed for the medium to long term (see figure 8 below).

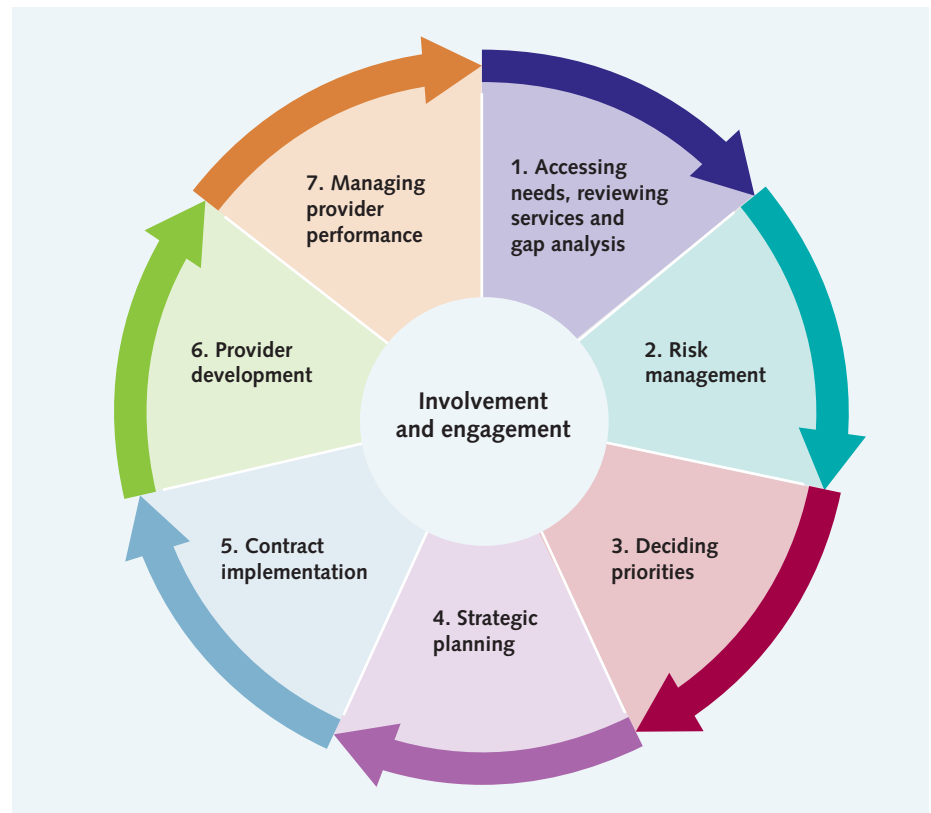
Longer term goals for health and wellbeing improvements allow outcomes to be measured in the round – ie. covering all mental health programme investment across NHS and local authority commissioners

(social care, housing and elements of universal services) in a given locality – with the risks and benefits explicitly described and allocated across partners.

An example of the commissioning cycle is set out in figure 8. This figure is a modified version of a commissioning guide for mental health professionals produced by the London Development Centre and the National Mental Health Development Unit.

It demonstrates how prioritisation, investment decisions and the setting of outcome criteria flow directly from the needs assessment and gap analysis process, as well as joint mental health or wider strategic priorities, and how the review process similarly can be used to inform future commissioning and decommissioning decisions.

Figure 8: Commissioning cycle at strategic, practice and individual levels



3.7 Realigning investment

Mental health policy and practice share a common aim: to improve outcomes for people, with treatment and services provided as close to home as possible, in order to enable investment to be shifted from complex, specialist and inpatient services to local community services. The transfer of budget and commissioning responsibilities directly to GPCC is intended to introduce greater flexibility at local level for service remodelling and pathway redesign to meet identified needs.

Knowing where resources are committed, and for what outcomes, is key to delivering service redesign. In this respect, Payment by Results for mental health has significant potential to assist the delivery of efficient, high quality and innovative services by supporting economic modelling and scenario-planning, as well as real-time shifts in investment.

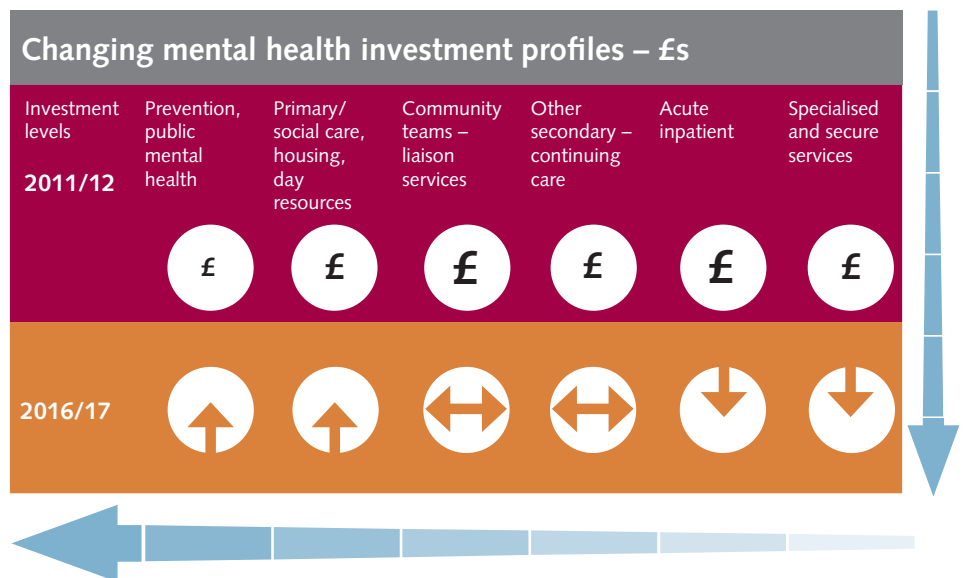
Delivery of government policy for mental health and wellbeing, coupled with the quality and productivity challenge for the NHS and the need to improve value for money in local authorities, requires a double shift in investment. Overall spend has to be reduced through increased productivity, and a proportion of the investment currently funding acute, specialist and other secondary care services (covering all tiers of provision) needs to be moved upstream, where appropriate, to preventive and early intervention services, in order to reduce demand on these downstream services in the longer term.

In this way, it will be necessary to free up resources in order both to deliver efficiencies in the short term and to re-invest in public mental health, social care, employment, housing, psychological therapies, prison health care, the criminal justice system and other areas. Such investments have the potential to deliver further medium and long-term reductions on the demand side.

This is likely to require the implementation of wider clinically-owned and championed mental health care pathways, in order to reduce admissions and average lengths of stay. Enhancing diversion or 'step-up' and 'step-down' options around crisis services and secondary care will also reduce the need for lengthy, high-cost placements (in or out of the local area) and admissions to secure services.

Figure 9 below was developed to show, in practical terms, what such a shift in spending might look like. By using local figures and categories, it can be used to help build a common narrative/shared vision in commissioning forums and partnerships. It also illustrates how savings can potentially be freed up by, where appropriate, shifting investment from tier three and four services to public mental health, prevention, early intervention and personalisation.

Figure 9: Changing mental health investment profiles



3.8 Elements of a whole system approach

Meeting people's needs and using resources more effectively to reduce dependence on high intensity provision requires attention to a number of other key areas that impact on mental health and wellbeing.

3.8.1: The NHS outcomes framework

Housing is generally recognised to be central part of an effective, recovery-focused care pathway. It provides the basis for individuals to re-engage with their lives outside the hospital environment, receive support and help from their social networks and communities, and in many cases return to work or education. This can be addressed both through primary prevention (good housing associated with improved physical and mental wellbeing), secondary prevention (targeted interventions aimed at those at high risk of mental illness such as people living in unstable accommodation – 'the homeless with housing') and tertiary prevention, as illustrated in the case study below

However, accessing decent housing and moving along a pathway of care to appropriate accommodation still requires people to negotiate a range of obstacles.⁵⁸

⁵⁸ Appleton N, Molyneux P (2009). *The impact of choice based lettings on the access of vulnerable adults to social housing*. London: Housing Learning and improvement Network. http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Reports/Report17.pdf

Supported housing

The Supported Living Outreach Team (SLOT) Birmingham is a specialist outreach team that has enabled 26 people who previously lived in specialist out-of-area placements and forensic services to move back to the city and live in ordinary housing. The team includes specialist NHS staff with experience in behavioural approaches and support planning. Each person lives in private rented housing, with daily support using people recruited from the local area and employed by non-specialist third sector providers. Individual support planning helps people to build links with the local area, find work and get to know people.

The outreach team provides advice, crisis intervention and training, and is available 24 hours a day. This input reduces gradually over time. The scheme was identified by the Department of Health as a Beacon Service in 2007.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4898076

The outcomes delivered include large reductions in 'challenging' behaviour, offending and use of medication. Eight people no longer need any specialist support. Cost savings average around 33% (£50,000 per person per year).

http://benpct.nhs.uk/download/doc-type/board-papers/ben-tb-0608learning_disabilities_services.pdf

Lack of appropriate housing can be a significant contributor to delayed discharge from hospital. A lack of housing or support can also lead to increased readmission rates, over-use of residential care and, in some cases, the use of out of area or other high-cost services. Investment in housing and housing-related support can contribute significantly to reducing demand on acute and specialist services.

Social care, housing and health commissioners, particularly where joint commissioning arrangements cover all these responsibilities, will need to work with providers to ensure that the role of housing in effective care pathway planning is recognised and prioritised.

Housing-related support

The evaluation of Lambeth's Supporting People programme providing housing-related support demonstrated its transferability across the system. The commissioning board of the PCT and local authority was expanded to become a cross-cutting commissioning board to identify opportunities across partner organisations for seeking employment (an intrinsic theme of the wellbeing agenda for mental health).

A series of shared goals and outcomes have been defined to underpin joint and cross-cutting commissioning, which is monitored via an integrated governance structure. This is an example of a system improving the use of resources (money, people and places) through better partnership and joint commissioning. The programme is outlined in a presentation available at:

<http://www.lambeth.gov.uk/NR/rdonlyres/BF622544-9D08-4811-934E-DEC2FABF8469/0/LambethSPandtheLAAajourneynotadestination.pdf>

3.8.2: Physical health

The links between physical and mental health are clear. There are shared risk factors for both illnesses. People with physical illnesses frequently present with both psychological and physical symptoms, and being physically ill, particularly with chronic illnesses and disabilities, often negatively affects mental health. People with two or more long-term conditions are seven times more likely to have co-morbid depression than those without long-term conditions.⁵⁹ As a result, they are more likely to use health care resources at all levels of the system. Providing psychological treatments has been shown to improve outcomes and use of health services for both the physical and mental health needs.

It is also widely accepted that people with mental illness have significantly higher rates of mortality and morbidity from physical illnesses such as cardiovascular disease, diabetes and obesity. In the UK, men with chronic schizophrenia die 20.5 years earlier than the population norm, and women die 16.4 years earlier.⁶⁰ Despite this, people with severe mental illnesses frequently do not receive the health interventions they need, including screening. In particular, smoking is the leading factor in health inequalities affecting people with mental illness and yet they are less likely than the rest of the population to be offered smoking cessation support.

People with long-term physical illness are also at raised risk of mental ill health. Commissioning needs to address this increased risk. Improved liaison between the physical and mental health sectors (based on more accurate coding/needs recording) will also improve care and treatment of those with medically unexplained symptoms. Similarly, improved commissioning of early interventions to promote physical health, prevent and treat physical illness in those recovering from mental illness, will address health inequalities.

Physical health standards in mental health services

Scoping work by the Royal College of Psychiatrists, published in 2009, explored a range of issues concerning the general health of people with mental health problems. It made recommendations about clinical practice, training and the identification of other priorities in physical health care. The scoping included examples of good or improving practice, including the initiative outlined below.⁶¹

Work done by the West London Mental Health Trust highlighted the need for clear standards in relation to the physical health of the people using its services. The standards they recommended are:

- initial physical examination at admission
- a full physical health review to be completed with two weeks of admission
- appropriate physical investigations to be completed within first week of admission
- plans to be put in place for ongoing physical health care
- use of health promotion
- use of physical health standards for people in the community, including a section on physical health in CPA and discharge plans, and for CPA to include a review of physical health needs.

<http://www.rcpsych.ac.uk/files/pdfversion/OP67.pdf>

⁵⁹ Moussavi S, Chatterji S, Verdes E *et al* (2007). *Depression, chronic disease and decrements in health: results from the World Health Surveys*. *Lancet* 370: 851–858.

⁶⁰ Brown S, Kim M, Mitchell C *et al* (2010). *Twenty-five year mortality of a community cohort with schizophrenia*. *British Journal of Psychiatry* 196: 116–121.

⁶¹ Royal College of Psychiatrists (2009). *Physical health in mental health: final report of a scoping group*. London: Royal College of Psychiatrists.

3.8.3: Criminal justice

Striking the balance between public safety and individual freedom presents all commissioners of mental health and related services with a major challenge. People with severe mental illness are more often victims than perpetrators of violence. However a very small minority of people with mental health problems do pose a risk to the public and/or themselves, and are in contact both with the NHS and the criminal justice system.

Rates of prevalence of mental illness are significantly higher among prisoners. For example, the prevalence of psychosis is 15-20 times higher among prisoners than in the general population;⁶² the suicide rate is ten times higher for prisoners, at 91 per 100,000, compared with 8.5 per 100,000 in the general population.⁶³ Commissioners have recognised this and have sought to find ways to knit together policy and service development to ensure the provision of effective services and reduce the potential risks to public safety.

The transfer of responsibility for commissioning prison health services to the NHS has been the catalyst for a shift in culture and attitudes within prison health care services. Prison health care services are now required to meet the same standards as the rest of the NHS, which is a key driver for improving quality.

Given that this is a very complex and high cost area of mental health provision, GPs and other commissioners are likely to want to work creatively with local community safety agencies and structures to address the health needs of offenders and support primary prevention and diversion.

Revolving Doors Service, Warrington

Warrington police link adults they believe to have low level mental health needs and unaddressed problems with a full range of services. The person can be a victim or complaining about the police; they do not have to be an offender.

If someone agrees to be helped, the police refer them to the Revolving Doors Service, part of the mental health service. The police unit that screens all referrals for vulnerable adults makes additional referrals to the service if anyone could benefit from its support. 'Mental health' is deliberately not mentioned, to avoid stigma and unnecessary concern.

Two social workers repeatedly attempt contact, including cold-calling where necessary. People are then offered a meeting in a place of their choice with a holistic assessment of all their needs, not just their mental health. The workers provide direct services and brief interventions. Where appropriate, they link individuals with a full range of agencies and offer support to help them keep appointments for up to eight weeks.

Over 25 organisations are involved with this service, which enables it to respond to all needs, not just mental health issues. Further solutions are discussed with colleagues and at a multi-agency panel if required.

<http://www.revolving-doors.org.uk/home/>

⁶² Sainsbury Centre for Mental Health (2008). *Short-changed: spending on prison mental health care*. London: SCM. <http://www.centreformentalhealth.org.uk/pdfs/short-changed.pdf>

⁶³ Mind (undated). *Statistics 8: the Criminal Justice System*. London: Mind. http://www.mind.org.uk/help/rights_and_legislation/statistics_8_the_criminal_justice_system

Prevention is particularly important in this regard. For instance, the annual cost of crime by adults with conduct disorder and sub-threshold conduct disorder in England and Wales is estimated at £60 billion.⁶⁴ Between 40% and 70% of children and adolescents with conduct disorder will go on to develop antisocial personality disorder in adulthood.⁶³

In the general population, 0.3% have antisocial personality disorder; the rate among remand prisoners is 63%.¹¹ However, there are effective low-cost interventions to address conduct disorder in childhood, such as intensive, targeted parenting programmes.

⁶⁴ Sainsbury Centre for Mental Health (2009). *The chance of a lifetime: preventing early conduct problems and reducing crime*. London: SCMH. http://www.scmh.org.uk/pdfs/chance_of_a_lifetime.pdf

Improving support for offenders with mental health needs

Faced with the challenge of one of the highest levels of offenders with mental health issues in the UK and increasing numbers of offenders with mental health problems and complex health needs who needed levels of intensive support unmet by current provision, NHS Manchester re-commissioned existing service supply. The Mental Health Joint Commissioning Team worked with Manchester City Council's Drug and Alcohol Strategy Team to develop a business case, in consultation with users, carers and stakeholders.

The resulting comprehensive and cohesive programme is increasing the range of services available, widening access to these services, raising awareness of mental disorders, enabling early detection and management of those at risk to themselves, and empowering people to make decisions that positively impact on their health. The achievements of the service have earned it a national Nursing Times Award, a regional award for innovation, and praise from Lord Bradley.

The outcomes have had a significant impact both on people using services and those working for service providers, including reductions in re-offending and risk to the community.

<http://www.northwest.nhs.uk/whatwedo/healthandsocialcareawardsexcellenceincommissioning/>

3.8.4: Employment

Employment (or meaningful activity) is now recognised as an essential element of recovery from mental ill health. The link between lack of meaningful occupation and mental ill health is well-evidenced.

A job is often top of the list when people with long-term mental health problems are asked about their goals in life. Yet people with mental health problems are among the least likely of all those with disabilities to be in employment, and the least likely to be able to get back into the job market following an episode of ill health.⁶⁵

Common elements of a work-focused recovery approach include:

- an emphasis on prevention and early intervention for people with common mental health problems in the general population, as well as people in contact with secondary mental health services
- mental health promotion in the workplace, which also results in a nine-fold return in investment after one year due to reduced absenteeism and improved productivity⁴⁹
- a focus on ensuring everyone, regardless of their mental health, has opportunity to work. This includes the provision of specialist help to gain and keep work for those in contact with secondary mental health services

- help for people in work to maintain their job through times of mental distress, as well as help for those with less serious mental health difficulties to return to the job market
- improved collaboration and integration between health and employment services, crossing a traditional divide
- reform of services to make better use of existing resources in difficult economic circumstances.

Individual Placement and Support

One of the main evidence-based approaches to delivering improved employment outcomes for people is Individual Placement and Support (IPS). Research has shown that large numbers of people with serious mental ill health have been supported by IPS to secure and maintain paid employment.

IPS has seven key principles, each of which is needed for the service to work well. They include focusing on paid employment of an individual's choice and continued support once the person gets a job, together with clinical care and welfare benefits advice. The service is tailored to a person's needs and wishes, seeks to obtain rapid placement in work and provides ongoing support for as long as needed.

The Centre for Mental Health has published a briefing paper summarising the evidence base for IPS.⁶⁶

Investing in employment-related support can be a highly cost-effective approach to treating long-term disabling conditions such as depression and other common mental disorders, for example through the early detection and treatment of depression at work.

Also of relevance is the Department for Work and Pensions proposed *Framework for the Provision of Employment Related Services*. This will see people seeking work given support tailored to their individual needs. The Work Programme replaces previous employment programmes and will be delivered by both private and voluntary sector providers. The scheme is expected to be in place during 2011.

'Place-based commissioning' (ie. working with all partners in a defined area to understand and harness joint investments, outcomes sought, and potential benefits/savings) provides a vehicle for partnership approaches to sharing the risks and cost-benefits of interventions with all concerned agencies within a geographical area.

⁶⁵ Carolan S (2010). *Mental health and employment – quality, innovation, productivity and prevention*. Horley: NHS South East Coast.

⁶⁶ Centre for Mental Health (2009). *Doing what works: individual placement and support into employment*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/publications/doing_what_works.aspx?ID=592

Conclusion

This framework describes the current and emerging landscape within which tomorrow's commissioners, pre- and post-transition to the new commissioning structures, will seek to promote the mental health and wellbeing of their populations. They will need to do this both through public mental health interventions and the cost-effective provision of clinically effective services.

The transition to the new commissioning arrangements will be guided both by national policy and detailed knowledge of local needs and provision. Effective commissioning strategies are likely to take a life-course approach to population health improvement; shift investment towards mental health promotion as well as prevention of mental illness and early intervention; enable greater freedom, choice and control through personalisation, and widen evidence-based service options available to people with diagnosed mental ill health, including peer-led services.

The current period of radical change and transition will require commissioners to work with public, private and third sector partners and providers to ensure continuity of service provision and financial accountability. They will also need to ensure that the mental health outcomes strategy is embedded into the system.

The policies and legislative machinery needed to progress the aims of the mental health strategy are rapidly falling into place. There is a robust and expanding knowledge base of what works best, for whom, and at what level.

It is clear that effective commissioning requires close collaborative working with partner agencies to address the determinants of mental health and physical health, both upstream before problems arise, and further downstream when symptoms of illness first emerge, and then later to promote and maintain recovery. It is also clear that successful commissioning will involve co-production with individuals, communities and organisations with experience of the mental health and social care system, and learning about what works to remove barriers to access and recovery.

Effective commissioning also recognises the key influence of inequalities on risk of mental disorder. The impact of resulting mental illness then further increases inequality across a broad range of outcomes, including physical health and premature mortality. Those at particular risk of mental illness and associated inequality include disadvantaged and minority groups – notably, people with learning disability. Addressing this through targeted prevention, promotion and early intervention is crucial if commissioners are to achieve the mental health improvement needed for a sustainable health and social care economy.

Commissioning can also promote recovery, choice and control for those with diagnosed mental illness, as well as safeguard and improve mental wellbeing among the general population. This will contribute to the accumulation of mental capital, with all the benefits that this brings to individuals, communities and national prosperity and productivity.

The major challenge for commissioners for the foreseeable future will be to continue to achieve improved clinical and recovery outcomes at all five levels described in the NHS Outcomes Framework, while maintaining quality and safety at individual and community level and promoting wider population mental health. They will have to do this within tighter budgets, and in the face of the known demographic and health needs pressures.

A follow-up publication will provide further evidence and information as legislation is enacted and the detail of the new commissioning system takes shape. Other materials will also be produced to assist commissioners with specific areas, such as commissioning for children and young people's services and the role of housing in mental health.

Glossary

This glossary includes technical and other terms commonly used in commissioning

Accountability

Legal and/or professional responsibility for the outcomes of decisions

Acute care pathway

The person's journey through acute psychiatric inpatient care and crisis/home treatment (see also Care pathway below)

Added value

Additional benefit brought to a group or process (for example, through the varied expertise, experience and contacts of the individual members of the group)

Any willing provider

Open to all providers that can meet required quality standards

Best practice tariff

The cost or price of a programme that contains most or all of the elements of best practice

Block contract

An agreement, renewed annually, between a commissioner and a contractor to provide a complete programme or service for a set amount of money over a set amount of time

Care pathway

The person's journey (and that of their carer) through the mental health system setting out the planned care and treatment at each stage, what should be provided, by whom, how, when and where, and which indicators of quality improvement and clinical and social care outcomes should be used to demonstrate return on investment

Case management

A system of care where one practitioner is identified as responsible for managing a person's care and co-ordinating the input from a range of other professionals and services

Clinical commissioning

Groups of clinicians coming together to agree best practice and advise commissioners on what to procure, the service specification and how outcomes can be measured

Cluster

A group of people with a recognisable shared set of symptoms and signs of illness

Collaborative care

Clinicians and teams working together to meet the needs of people and carers, including learning and liaison for professionals and teaching and information to help people manage their own health conditions

Collaborative commissioning

Commissioners working with partners – clinicians and providers – to assess, plan, procure and review service provision to meet local health and care needs

Common mental health problems

Mental health conditions with a mild to moderate and/or time-limited impact on the person (often depression or anxiety)

Co-morbidity

The co-existence of two or more disorders (eg. diabetes and depression, alcohol misuse and psychosis)

Contract

A legally binding agreement between a commissioner (the contract owner) and a provider (the contractor) to deliver a product to an agreed specification (quality and outcome) for a specific amount of money over a set period of time

Contract negotiation

The process of agreeing the terms of a contract between a commissioner and a provider or supplier

Cost and volume contract

An agreement between a commissioner and a contractor to provide services to a specific number of people for a specific purpose and for a specific amount of money

Currency

The elements of a service that can be costed and priced

Diagnosis

A classification system for illnesses that enables clinicians to predict the natural course of a particular disorder and how it will respond to treatment

Framework agreement

A set of contractual terms, conditions and standards that providers have to show they can meet when tendering for a contract

Framework

A structural plan for activity

Functionality

The purpose for which a specific mental health service is designed (eg. crisis/home treatment, assertive outreach etc). Can also be used to mean how well teams/services/people work

Invest to Save

Spending money on a service that can be shown through economic modelling to save money or produce better outcomes and/or better use of resources (human, technical or financial) in the long term

Joint commissioning

The pooling of expertise, responsibilities, and/or budgets between two agencies (most commonly health and social care services) to integrate service provision

Liaison psychiatry

A specialist psychiatric service that delivers mental health services, training and skills development in general hospital settings

Localism

The devolution of power and responsibilities from the centre to local authorities and communities

Marginal analysis

Annual review of elements of a programme to determine those that add value and those that do not

Marginal rates

Different levels of payments (usually less than standard values) for under- or over-performance against a contract

Medically unexplained symptoms

Physical symptoms without an easily recognisable physical cause (also referred to as somatisation).

Outcomes

The effect or result of commissioning process (ie. commissioning), service or intervention/treatment

Out-of-area services

Treatment delivered in a care setting outside the person's home locality – either because of lack of resources or because they have special needs that can only be met elsewhere

Patient-centred

Practice that is respectful of and responsive to individual preferences, needs, and values and that ensures that the person's values guide all clinical decisions

Payment by Results

An annual transaction between a commissioner and a contractor that means the provider must be able to demonstrate that they have delivered the agreed level of activity and outcomes

Performance management

The analysis, monitoring and management of organisational performance or delivery against contracts and agreed outcomes.

Personalisation

Enabling people to make decisions about their own care and support and organising services and systems around their needs

Person-centred

An approach to care that builds on a person's strengths and capabilities to work towards recovery and maintain mental health

Place-based commissioning

A holistic approach to commissioning services across all responsible agencies within a defined geographic area

Primary care mental health

Mental health services delivered in primary care settings (GP surgeries and health centres)

Primary prevention

The prevention of a disorder occurring through interventions targeted at individuals or groups of people at high risk

Productivity

Efficiency, turnover (eg. the number of people that can be seen in a clinic or assessed at their own homes in a single day)

Professionalism

Practice that is based on the values and body of knowledge and skills acquired through education, training and formal qualification in a profession

Programme budget

The amount of money allocated to procure, deliver and manage a service for a particular disease cluster, diagnosis or service

Quality

The effectiveness and safety of clinical practice and services

Recovery

The achievement of wellbeing despite the presence of ill health

Regulation

The monitoring of adherence to professional or corporate standards of clinical or managerial practice

Relapse

The return of symptoms while in treatment

Remission

The control of symptoms with treatment

Research

The scientific testing of a hypothesis or exploration of a phenomenon

Return on investment

The effect of an intervention in relation to the amount spent on it

Right care

Efficiency and effectiveness in clinical practice (do it right, do it once)

Secondary prevention

The prevention of a serious disorder developing through intervention in response to early signs/symptoms

Severe mental illness (SMI)

Serious, high-risk or complex forms of mental distress (often as applied to schizophrenia and bipolar disorder)

Social capital

The combined total resource of physical, emotional and mental health, wellbeing and resilience within a community

Social return on investment

Value measured in wellbeing and environmental benefits/impact (ie. not money)

Spot contract

A one-off contract for an individual's care

Standards

The acceptable level at which specific activities, skills, competencies or behaviours should be delivered to ensure quality and consistency in experience and outcomes of services/processes and by which professionals or agencies can be held to account

Tariff

The overall cost or price of a programme or service or unit of activity

Tertiary prevention

The treatment of an established illness that aims to stop it getting any worse

Transaction

A change required by policy within organisational operating procedures. Can also be used to describe the purchasing of goods or services.

Transformation

Large scale, negotiated change to behaviour and culture across an organisation/community

Value

The desirability, worth, merit or importance of something (actual or perceived); the effectiveness of an intervention or procedure; related to the bio-ethical principles of beneficence (acting in the best interests of people using services) and non-maleficence (doing no harm)

Value for money

The cost effectiveness of interventions or models of care as demonstrated by productivity against investment or economic modelling of financial benefit from investment

Values-based commissioning

The integration of scientific evidence with the wishes/preferences of the population, customers and/or other interest groups to inform commissioning decisions

Values-based practice

The integration of scientific evidence with the wishes/preferences of the person and/or carer to inform a clinical or other professional decision

Whole-person or holism

The inclusion of the physical, psychological, social and spiritual in assessing people's needs and planning and delivering a therapeutic response that addresses all these aspects together

Useful links

Policy**Equity and Excellence:****Liberating the NHS**

The NHS White Paper

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

NHS outcomes framework

Sets out the outcomes and indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it delivers through commissioning health services from 2012/13.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

Liberating the NHS:**Legislative Framework and Next Steps**

Sets out further policy development based on the consultation feedback to the Equity and Excellence white paper.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

A Vision for Adult Social Care:**Capable Communities and Active Citizens**

Sets a new agenda for adult social care in England to make services more personalised, more preventative and more focused on delivering the best outcomes for those who use them.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971.pdf

Transparency in Outcomes: a Framework for Adult Social Care – A consultation on proposals

Consultation document proposing a new strategy for transparency, quality and outcomes in adult social care.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122037.pdf

Healthy Lives, Healthy People: our Strategy for Public Health in England

White Paper outlining how the Government plans to tackle the public health challenge in England.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122252.pdf

Healthy Lives, Healthy People: Transparency in Outcomes. Proposals for a Public Health Outcomes Framework. A Consultation Document

Consultation paper setting out the Government's proposed outcomes and indicators that will set goals and measure progress in public mental health.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123113.pdf

No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Quality and productivity**NHS Evidence – mental health**

NHS library that collects data from published research in Annual Evidence Updates (AEUs) on a range of mental health topics.

<http://www.library.nhs.uk/mentalHealth/>

CQUIN payment framework

The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation. Guidance on using the payment framework to develop CQUIN schemes is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

Acute and mental health example schemes, along with other material to support use of the CQUIN framework, can be found at: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Mental health and employment

Removing Barriers: The facts about mental health and employment. Briefing from the Centre for Mental Health on the barriers to employment for people with both common and severe mental health problems and at the initiatives that are being undertaken by the public, voluntary and commercial sectors to support their efforts to find and sustain work.

http://www.scmh.org.uk/pdfs/briefing40_Removing_barriers_employment_mental_health.pdf

Adult social care

Care Services Efficiency Delivery (CSED) helps councils to identify and develop more efficient ways of delivering adult social care.

<http://www.dhcarenetworks.org.uk/csed/>

Public mental health

The NMH DU public mental health programme website includes useful information on the evidence for public mental health.

<http://www.nmhd.org.uk/our-work/promoting-wellbeing-and-public-mental-health/>

Enabling effective delivery of health and wellbeing

An independent report commissioned by the Department of Health with information and recommendations on how better to improve public health and wellbeing.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111692

Local Government Improvement and Development

Local Government (LG) Improvement and Development supports improvement and innovation in local government, including public mental health activities.

<http://www.idea.gov.uk>

System reform

NHS Standard Contracts

Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

Best practice

NHS Information Centre

Central source of health and social care information for frontline decision makers in England.

<http://www.ic.nhs.uk/>

Mental Health Minimum Data Set

A resource with data about the care of adults and older people using secondary mental health services 2003–2007.

<http://www.ic.nhs.uk/mhmds>

Social Care and Mental Health Indicators

Further analysis on indicators drawn from the National Indicator Set for England 2008–09

<http://www.ic.nhs.uk/pubs/socmhi08-09>

The Quality and Outcomes Framework 2009/10

QOF indicators and prevalence for depression
www.ic.nhs.uk/qof

NHSIC Commissioning resources

Resources available from the NHS Information Centre, including workforce information, public health indicators, patient-reported outcomes measures

<http://www.ic.nhs.uk/commissioning>

NICE commissioning guides

Including mental health and behavioural conditions and public health

http://www.dhcarenetworks.org.uk/nl/?ln=606_1_1

No Health without Mental Health: the Case for Action

Royal College of Psychiatrists position statement on public mental health.

<http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf>



Partner
and other
organisations

ADASS

<http://www.adass.org.uk/>

CQC

<http://www.cqc.org.uk/>

Department of Health

<http://www.dh.gov.uk>

DH Care Networks

<http://www.dhcarenetworks.org.uk/>

Local Government Association

<http://www.lga.gov.uk>

National Involvement Partnership

<http://www.nsun.org.uk/>

NHS Confederation

<http://www.nhsconfed.org>

NHS Evidence

<http://www.evidence.nhs.uk>

NHS Institute

<http://www.institute.nhs.uk/>

Royal College of GPs

www.rcgp.org.uk

Royal College of Psychiatrists

<http://www.rcpsych.ac.uk/>

SCIE

<http://www.scie.org.uk/>

All web addresses in this document were accessed in March 2011.

