Consultation response

The King's Fund response to the New Horizons consultation

15 October 2009

The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

Key points

- The emphasis given in New Horizons to the prevention of mental illness and the promotion of positive mental health is welcome, but this must not be allowed to compromise the availability or quality of acute care.
- Evidence on the cost-effectiveness of proposals is needed, particularly with regard to preventive approaches.
- The broad vision described in New Horizons would be strengthened by the inclusion of a smaller number of specific recommendations to support prioritisation at the local level.
- Stronger proposals are required for improving the quality of inpatient care and services for people with complex needs.
- The barriers to implementing the approach described in New Horizons are considerable, and include challenges in terms of the skills and attitudes of clinicians; commissioning competencies; and multi-agency working. Further detail on the strategies and levers that will be used to overcome these would be beneficial.
- The need for quality improvement in primary mental health care goes well beyond what will be achieved by the Improved Access to Psychological Therapies programme. Attention should be paid to the models of care used in general practice, as well as to the mental health skills, knowledge and attitudes of primary care professionals.

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

The national economic context will have a major impact on mental health and mental health care over the next 10 years. Although the recession is not likely to extend far into this period, the impact on public sector spending is expected to do so. Overall public expenditure is expected to decline in real terms over the period 2011–2017, and the NHS budget is likely to see little or no growth, and possibly a real terms reduction (Appleby *et al* 2009). Mental health currently accounts for a greater proportion of primary care trust spending than any other clinical area (Appleby and Gregory 2008), and these budgets are likely to come under increasing pressure. Outside the health sector, public spending on housing, social welfare and other areas of direct relevance to people with mental health problems may also be reduced.

While public spending may stagnate or decline, mental health needs are expected to rise, in part due to demographic change. Expanding services in their current form to keep pace with

predicted increases in demand would require spending to rise by 45 per cent to £32.6 billion in 2026 (at 2007 prices). This is largely due to the predicted rise in the number of people with dementia (McCrone *et al* 2008). In addition to this, levels of depression, anxiety and other mental health problems are likely to increase as a result of the recession and rising levels of indebtedness and unemployment (Waddell and Burton 2006). These effects can be expected to last for much of the coming decade, long after the recession itself has ended.

The resulting gap between demand and available resources contrasts with the period of growth seen over the past 10 years, and is likely to be the single most important challenge for mental health care over the next decade. The NHS and other partners will need to respond by focusing determinedly on the effectiveness and efficiency of services and interventions.

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

Both promotion/prevention and service development are important, and The King's Fund strongly supports the principle that improvement is needed on both fronts. Mental health is an area that has long eluded the basic principles of public health, despite many calls for the application of such an approach (MHF 2005, Naylor *et al* 2008). Policy and funding have been directed primarily at service development, and specifically service development for those who are most acutely unwell. The New Horizons consultation document makes considerable progress in addressing this. However, the relatively poor performance on meeting Standard One of the National Service Framework (NSF) for Mental Health, which dealt with mental health promotion, demonstrates that implementing a public health approach to mental health will not be easy. If New Horizons is to succeed where the NSF failed, it will need to identify the specific mechanisms and incentives that will be used to guarantee that prevention and promotion are made a higher priority. The following barriers to implementing a successful public mental health approach will also require attention.

- **Evidence base** – If a greater emphasis is to be placed on public health approaches to mental health, it is crucial that this is evidence-based. Commissioners will require evidence on the clinical effectiveness and cost-effectiveness of different approaches. Where this is lacking, preventive and well-being services should be commissioned only as pilots for evaluation, to fill gaps in the evidence base.
- **Workforce development** – A public health approach will involve radically new ways of working, and the training needs that these changes will impose for frontline staff should not be underestimated.
- **Commissioning competencies** – Commissioners will also require new skills and competencies if preventive and well-being services are to be commissioned effectively.
- **Partnership working** – Shifting towards a public health model for mental health will require joint working across a wide range of organisations. As effective partnership working has proved difficult to achieve between the NHS and local authorities, widening this to include other sectors is likely to be an even greater challenge.

It is important that the increase in attention to public mental health approaches should not lead to the needs of those who are severely unwell being eclipsed. In a resource-limited system there will always be a difficult balancing act between the two aims, but the new focus on prevention should not be allowed to compromise the availability or quality of acute care (in particular inpatient care) or care for those with complex needs, for example, people in the criminal justice system or those with a 'dual diagnosis' of both mental health and substance misuse problems.

The Care Quality Commission has reported serious lapses of care in inpatient settings and for detained patients with mental health problems and/or learning disabilities (CQC 2009a, 2009b). The decline in NHS provision of inpatient beds has led to increasing numbers of inpatients being cared for by independent health care providers, where monitoring of quality

is made more difficult by poor availability of data (Raleigh *et al* 2008). There is also a danger that further reductions in inpatient provision could simply lead to 'reinstitutionalisation' in prisons and forensic mental health settings (Priebe and Turner 2003). The consultation document is therefore right to suggest that future development in inpatient care should focus on improving quality rather than on reducing bed numbers or admissions. It is important that this message is not lost in a strategy that gives greater emphasis to prevention, health promotion and community-based care.

We are concerned by the limited attention paid in the consultation document to people with dual diagnosis and to people in the criminal justice system with mental health or learning disability problems. The poor quality of services currently provided to both of these groups is well documented (Bradley 2009), and there is a need for New Horizons to propose stronger solutions to these problems. Both issues are also profoundly connected with health inequalities (see Q10).

3. Are the guiding values described in section 1 the right ones? Please explain your view giving examples, if possible.

The guiding values are laudable and should be commended for the emphasis they place on the needs, preferences, aspirations and rights of individual people. There is also a need to place cost-effectiveness firmly among these core values. All services – preventive or curative – need to demonstrate that they represent a cost-effective use of public resources. If resources are invested without proper regard to cost-effectiveness, the ability of the health service and its partners to realise the vision laid out in New Horizons will be compromised. This is made all the more important in the current economic climate.

The recovery model has been strongly advocated by people within the service user movement for a number of years. As with public health approaches, it represents a dramatically different way of working for frontline clinicians. The model challenges basic assumptions about the nature of mental illness and the role of health professionals in tackling it, and the barriers to implementing it across the health service should not be underestimated. It will require development not only of skills but, crucially, of attitudes and values. A concerted attempt to promote the use of this model will include proposals for workforce development at all organisational levels, with resources attached.

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

(i) Personalised primary care

Primary care needs to play a central role in delivering more personalised mental health services. In a major national consultation exercise involving more than 1000 service users, carers and health professionals, primary care emerged as the top priority for making mental health services more patient-centred (Naylor *et al* 2008).

For many people, primary care is the principal provider of mental health care; for example, 90 per cent of people with depression are managed solely in primary care. For many of the large number of people receiving mental health support in primary care, the service provided is far from personalised and can amount to little more than an antidepressant prescription. The Improved Access to Psychological Therapies (IAPT) programme will improve this situation and has much to commend it. However, IAPT will not be the answer for everyone. A large number of people experience mental health problems over the long term, in a chronic or relapsing pattern, but are not acutely ill enough to be referred to specialist services (Simon *et al* 2002; Lloyd 1996; Kupfer 1991). Some of these can be expected to benefit from the time-limited cognitive behavioural therapy programme offered by IAPT, but others will need ongoing support organised on a chronic care model (eg, Collaborative Care) – with systematic follow-up and case management (Boardman and Walters 2009; Scott

2006; Tylee and Walters 2007). There is evidence to suggest that delivering primary care on this model can improve outcomes for people with depression (Gilbody *et al* 2003; Richards *et al* 2008), and the provision of case management should also help to make services more personalised.

Delivering personalised mental health services in primary care will also require GPs to be sensitive to the patient's perception of the cause and nature of the problem and to their preferences about what the focus of intervention should be - eg, ameliorating symptoms, increasing functional ability, or resolving social or cultural difficulties (Dowrick 2009; Gilmore and Hargie 2000). GPs and patients need to be able to construct a shared understanding about the diagnosis and treatment plan (Boardman and Walters 2009; Johnston *et al* 2007).

In addition to being the principal source of support for people with common mental health problems, primary care has a crucial role in attending to the physical health care needs of severely mentally ill people receiving care from specialist mental health services. Models of care allowing closer working between GPs and specialists are required to enable this.

The New Horizons consultation document places much emphasis on the IAPT programme, but there is a need for quality improvement in primary care that goes well beyond this. If services are to be made more personalised, more attention needs to be paid to the models of care used in primary care, as well as to the mental health skills, knowledge and attitudes of primary care professionals.

(ii) Personalised care for the severely ill

Some of the most severely mentally ill people, especially those in inpatient settings, are not currently able to access services that are appropriate, effective and safe (CQC 2009a, 2009b). For example, in a national survey conducted recently by the Care Quality Commission, only 45 per cent of mental health inpatients reported always feeling safe on psychiatric wards, while 39 per cent 'sometimes' felt safe, and 16 per cent did not feel safe at all (CQC 2009c). These basic components of high-quality care should be given priority, on the grounds that no service that is unsafe, inappropriate or ineffective will be able to develop personalised care. However, the work of the Mental Health Task Group demonstrates that even for people in high-care and secure inpatient settings, it is possible to give patients more control over the care provided, for example, by giving choice over sleeping times, meals and activities, and providing advocacy services to support patients in exercising choice (Mental Health Task Group 2003).

(iii) Personal health budgets

Personal health budgets may provide a means of allowing people to choose the package of support they receive from mental health services, social care and related services. Although these have been used by people with mental health issues in relation to their social care needs, at present there is little evidence on the effectiveness of personal budgets for health care. To address this it is important that the use of personal budgets by people with mental health problems is evaluated within the pilot sites chosen by the Department of Health.

(iv) Personalisation through service user involvement

The King's Fund's Enhancing the Healing Environment (EHE) programme demonstrates that involving service users in the design of mental health services can be a powerful means of making services more personalised. Attention must be paid to involving a range of people, including those from hard-to-reach groups. EHE project teams have developed innovative ways of doing this, for example, through the use of 'easy word' literature, consultation workshops, the creation of mood boards and video presentations.

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

As argued above (Q1), value for money is a critical issue. In the context of the expected decline in public expenditure it is imperative that the New Horizons programme constructs a strong argument that its vision and policy recommendations are cost-effective – not just for government and the NHS, but for all the different organisations and interests that will need to be involved in implementing the strategy. If this is not done, there is a clear danger that the proposals will not be implemented fully. The consultation document acknowledges that 'service improvements will need to be self-financing, soundly evidence-based'. Evidence on the cost-effectiveness of interventions is therefore needed (see Q7).

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

The Whole System Demonstrator Action Network (WSDAN), led by The King's Fund on behalf of the Department of Health, includes a database of research on telehealth and telecare for people with long-term conditions. The evidence listed on the database suggests the use of telehealth could improve outcomes for people with depression. Relatively low-tech interventions such as telephone and/or email-based monitoring and support can achieve improved outcomes relative to standard care, particularly in terms of adherence to medication and self-reported depressive symptoms (Fortney *et al* 2007; Dietrich *et al* 2004; Simon *et al* 2004; Tutty *et al* 2000). It is not clear whether these interventions would be any more or less effective if delivered face-to-face, and there is little research addressing cost-effectiveness. The Whole System Demonstrator sites will provide further evidence on the use of such technologies.

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

As indicated above (Q5), the key gap in the evidence base supporting New Horizons concerns cost-effectiveness. This is needed at two levels. First, the case needs to be made as strongly as possible that the overall strategy of investment in public mental health makes economic sense. Second, evidence on the cost-effectiveness of particular interventions is needed to allow commissioners to prioritise. The consultation document frames the role of the Department of Health in terms of 'priority setting (Figure 11, p 100). Given this, it would be beneficial to present evidence on the cost-effectiveness of the interventions recommended in the document, and to supplement the impressively broad vision set out in the document with a smaller number of specific, costed priorities to be implemented nationally.

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

Commissioning skills are a key area of concern. If commissioners are to be the leaders of their local health economy (as required by the world class commissioning competency framework), they may need considerable guidance and support, particularly for commissioning well-being and preventive services. This should include research evidence on the cost-effectiveness of different approaches.

The forthcoming mental health standard contract should provide a lever for commissioners to use to improve quality. However, this does not cover social care or child and adolescent mental health services (CAMHS) services. There is therefore a concern that it will not enable the kind of partnership working that will be so central to achieving the New Horizons vision.

Leadership is also needed at the clinical level. The New Horizons consultation document states that 'clinical/professional leadership is seen as fundamental to driving quality across pathways and empowering frontline staff to improve the quality of services' (p 102), and we

would support this perspective. The King's Fund's Management and Leadership for Clinicians development course is designed to give clinicians the skills and confidence they need to assume leadership roles in a multidisciplinary environment. The Enhancing the Healing Environment (EHE) programme provides a further example of how local clinical leadership skills can be developed through investment in professional development. EHE project teams are involved in a number of developmental activities designed to nurture the skills required to design, manage and implement service improvement projects, with a particular emphasis on the engagement of service users, carers and the public.

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

It is important to emphasise that the kind of broad societal approach advocated in the New Horizons consultation document will require joint working to extend well beyond local authorities and the NHS. Other groups, for example employers, will need to be engaged. As effective partnerships even between statutory services are notoriously difficult to engineer, local NHS organisations will need support in reaching out to these groups. The Department of Health could assist by complementing local action with attempts to engage and influence organisations at the national level, including representative organisations such as trade unions and the CBI – as recommended by Dame Carol Black's review of health in the working age population (Black 2008). This would help create momentum for change and increase the impact of joint working between local NHS organisations and employers. The Department could also assist NHS organisations by developing a strategic framework suggesting what the 5–10 key groups to target might be, and how to go about doing so.

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

Mental health problems are central to wider health and social inequalities, and it is to be hoped that the forthcoming Marmot Review gives a high profile to mental health. The evidence suggests that prioritising the following areas would have the biggest impact on mental health inequalities.

(i) Childhood mental health problems

Childhood mental health problems are both a cause and a consequence of social inequalities. There is a strong social gradient in prevalence (Green *et al* 2005), and studies demonstrate they have profound consequences for life trajectories, with adverse effects on health and social outcomes later in life (Fergusson *et al* 2005; Stewart-Brown 2004; Scott *et al* 2001). Cost-effective interventions for both prevention and cure of childhood mental health problems exist (NICE 2005, 2007, 2008; Waddell *et al* 2007; Fonagy *et al* 2002), but availability of these is poor (Meltzer *et al* 2003; BMA, 2006). Both preventive and curative action on childhood mental health problems could reduce inter-generational transmission of inequalities. CAMHS will therefore need to play a key role in tackling inequalities, and the separation of the National CAMHS Review from the New Horizons programme is a cause for concern.

(ii) Employment and mental health

There is strong evidence that mental ill health and unemployment are mutually reinforcing (Waddell and Burton 2006). Action on this self-perpetuating mechanism through the use of evidence-based models such as Individual Placement and Support (Bond *et al* 2008) provides an important way of reducing mental health inequalities. It is also important more generally to create workplaces that promote mental health.

(iii) The interaction between physical and mental health

People with mental health problems are more likely than the general population to suffer from physical health problems such as obesity, diabetes, stroke and cardiovascular disease – and vice versa (Atlantis *et al* 2009; Prince *et al* 2007; Osborn *et al* 2007). Co-morbid mental health problems can lead to poorer quality care for physical conditions (Kisely *et al*

2007; Noel *et al* 2005; Nuyen *et al* 2008) and substantially poorer outcomes (Chapman *et al* 2005; Evans *et al* 2005; McVeigh *et al* 2006). Psychological therapies can improve patients' ability to manage long-term physical conditions such as diabetes, heart disease and COPD (Helsop and Foley 2009, Morley *et al* 1999). A strategy to reduce inequalities should therefore include a focus both on the psychological component of physical health problems and on the physical health needs of people with mental health problems.

(iv) Mental health in the criminal justice system

Mental health problems and learning disabilities are highly prevalent among those in the criminal justice system and have a profound impact not only on those affected, but on their families and carers, and society beyond. Improving the quality of mental health care and related services for these people should be an important component of action on mental health inequalities. We would support a stronger line being taken in favour of implementing the recommendations of the Bradley report.

(v) Substance misuse / dual diagnosis

Integrated services for people with substance misuse problems alongside mental health problems are still poor quality or not available in some areas. Given the higher prevalence of substance misuse problems among people with mental health problems, those in the criminal justice system, and people from lower socioeconomic groups, a strategy to reduce mental health inequalities needs to give prominent attention to this issue.

11. How can we best improve a) the transition from child and adolescent mental health services to adult services, and b) the interface between services for younger and older adults?

For patients' experiences of transitions between different parts of the mental health system to be improved, policy drivers applying to all parts of the system must be aligned. As CAMHS are not included in New Horizons, it is important that the programme draws explicit connections between its proposals and those made in the National CAMHS Review.

12. In your view, what more should the Government do to combat stigma?

Stigma is a huge challenge, but given the extent to which it impacts on the lives of people with mental health problems (Time to Change 2008), it is also one that it is important to tackle. Evidence suggests that while public information campaigns have a role to play, on their own these mass educational techniques will not be sufficient. A major review found that direct personal contact between people with and people without mental health problems is a potent means of changing attitudes (Thornicroft 2006). One approach is to organise educational sessions run by mental health service users targeted at young people, key decision-makers, opinion-shapers and those whose work has a direct bearing on people with mental health problems, such as journalists, employers and the police. A second approach is to focus on enabling more people with mental health problems to remain in the workplace, the effect being to raise the visibility of and 'normalise' mental illness. Legal changes focusing on removing the barriers that lead to discriminatory treatment and exclusion from the workplace may be necessary as part of this strategy.

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This note responds to the xxxx [add in line referencing consulting organisation and name of consultation].