FAIR DEAL
For mental health
17th October 2008

Our manifesto for a 3 year campaign dedicated to tackling inequality in mental health. Sign up to our campaign at www.fairdeal4.mentalhealth.co.uk

Previous campaigns have involved:
- Defeat Depression
- Every Family in the Land
The core purposes of the Royal College of Psychiatrists are to:

- Set standards and promote excellence in psychiatry and mental healthcare.
- Lead, represent and support psychiatrists
- Work with service users, carers and their organisations.

We are committed to patient centred practice through:

- Professionalism
- Innovation and research
- Lifelong learning
- Fairness and inclusion
- Ethical practice
- Multidisciplinary working
Introduction

Good mental health should be a priority for each and every one of us. Mental Health is the key to Public Health. Mental health services have lagged behind those in physical health.

We must acknowledge that over the last 10 years, investment and progress has been made in relation to

- Social costs of mental health
- Discrimination
- Stigma
- Social exclusion
With the 60th anniversary of the National Health Service (NHS) in 2008 and new planning for mental health in all the countries of the UK it is timely to take an overview of where we need to improve. Informing this campaign over the past year, we asked psychiatrists across the UK what they thought the key challenges and opportunities were for mental health and learning disability services.

Psychiatrists who work with all the different service user groups (in hospitals, communities and prisons), responded.

The service users and carers actively contributed their views.

The common thread that links all responses is a drive for equality.

Our International Divisions are now taking up a similar process because we live in a global society.
FAIR DEAL Campaign

- Funding
- Access to services
- In-patient services
- Recovery & rehabilitation
- Discrimination & stigma
- Engagement with service users and carers
- Availability of psychological therapies
- Linking physical and mental health
FAIR DEAL Campaign

- Achieving a fair deal: awareness
- Achieving a fair deal: action
- Achieving a fair deal: involvement
Why a Fair Deal?

1a

**F**unding of mental health research and services needs to increase. It should more fairly reflect the costs of mental health problems in society and the need for improved knowledge of mental disorders.

2a

**A**ccess to services should be made easier across the lifespan for all people with mental health problems. The most overlooked groups include those in transition from adolescent to adult services, older people, prisoners, people with learning disabilities and those with substance misuse problems.
Why a Fair Deal?

3a

In-patient services should be improved, with sufficient capacity for patients to be admitted locally into an appropriate ward. Improvements in ward conditions and the expansion of child and adolescent and intensive care beds are key.

4a

Recovery and rehabilitation should be integral to mental healthcare and treatment. A coherent policy based on recovery-orientated practice is needed for people experiencing long-term mental health problems.
Why a Fair Deal?

5a

Discrimination and stigma need to be tackled throughout society. The NHS should lead by example in promoting equality and human rights in all of its work as an employer and provider of health services.

6a

Engagement with service users and carers must be meaningful, not tokenistic. People with direct experience of mental health problems or learning disabilities should have a central role in the design and delivery of mental health services.
Why a Fair Deal?

7a

Availability of psychological therapies should be equitably implemented across all ages, patient groups and settings. A particular focus is needed on older people, hospital in-patients and prisoners.

8a

Linking mental health and physical health must be part of every doctor's practice, this will require education, training and collaborative working between mental health and other medical specialties.
1B – What we are calling for Research funding

- Major increase in research funding to improve understanding of mental disorders and lay the foundations for better treatments and services and reduced stigma.

- Continued increases in public expenditure on mental health services to reflect the human and economic costs of mental illnesses in society.

- Development of long-term sustainable funding strategies for mental health service provision at every level (including commissioning and payment by results) to make the delivery of these services realistic.

- The commissioning practice of mental health services to be fairer, more transparent and based on the best evidence available.
1C – Evidence Base

- Recent figures show that mental health research received 6.5% of total research funding compared with 25% for research of cancer and 15% of neurological diseases.

- Unlike other common diseases, there is no disease-specific charity in the UK that funds research into mental disorders.

- 9% of the total National Health Service’s and social service’s spending in Northern Ireland, 11% in Scotland, 12% in England and an estimated 12% in Wales is allocated to mental health services. This is disproportionate to the human and economic costs of mental disorders.

- Funding of mental health research and services needs to increase. It should more fairly reflect the costs of mental health problems in society and the need for improved knowledge of mental disorders.
2B – What we are calling for better access

- Better access to high-quality physical and mental health services for all age groups and for people with different conditions and needs including people with learning disabilities, addictions, sensory disabilities and personality disorder.

- All health services to ensure 'reasonable adjustments' (as required under the Disability Discrimination Act) are made to facilitate greater access to services by people with mental health problems and learning disabilities.

- Adequate mental health services for convicted and remand prisoners, including for those with substance dependence, of a comparable standard to those provided in the general population.

- The development of policy and services to divert mentally disordered people in the criminal justice system into appropriate healthcare services.

- The transition of young people with mental illness to adult services to be achieved as part of a seamless pathway of care.

- Access to care for older people to be enhanced to meet the level of need.
2C – Evidence Base

- One-in four older people living in the community have symptoms of depression that are severe enough to warrant help, but only half of these are diagnosed and treated.

- In England and Wales 90% of prisoners have at least one diagnosis of mental disorder, but a 2007 HM Inspectorate of Prisons review concluded that there were still too many gaps in provision and too much unmet and sometimes unrecognised need.

- Mental health services frequently fail to identify patients who also have drug use problems, and a third of substance misuse patients with mental health needs do not receive any interventions.

- Access to services should be made easier across the lifespan for all people with mental health problems. The most overlooked groups include those in transition from adolescent to adult services, older people, prisoners, people with learning disabilities, and those with substance misuse problems.
3B – What we are calling for inpatient services

- Bed occupancy levels that are sufficient to enable services to respond to and accommodate emergency admissions and which meet local levels of need.

- The development and adoption of common national standards for effective and efficient in-patient mental health services for adults and young people.

- Robust monitoring by the Care Quality Commission of bed occupancy and conditions for patients detained under the England and Wales Mental Health Act 2007.

- Legislation on delayed transfers of care to local authority housing, extending the scope of the Community Care Act 2003 to include mental health wards, thus removing the disparity between patients with mental and physical conditions.
Although official statistics indicate bed occupancy levels among adult patients of between 85 and 92% in each of the four UK countries, independent surveys find levels ranging from 100 to 140%.

Patients may remain in hospital for months after their need for hospitalisation has ended while they await transfer to local authority accommodation.

In 2008, the Mental Health Act Commission reported that the busy acute wards “appear to be tougher and scarier places than we saw a decade ago”.

In-patient services should be improved, with sufficient capacity for patients to be admitted locally into an appropriate ward. Improvements in ward conditions and the expansion of child and adolescent and intensive-care beds are key.
4B – What we are calling for recovery and rehabilitation

- The formulation of a clear UK rehabilitation policy.

- Recovery to become a better understood and accepted approach across all mental health specialties.

- Clear and practical guidance and standards on how mental health services can be recovery orientated.

- Further research on successful methods of supporting self-management and recovery.
People can, and do, recover from mental health problems. They can take control of building a meaningful life for themselves even while continuing to experience mental health problems' or following a period of poor mental health.

However, mental health services are not good at prompting recovery and professionals are trained in a “recovery-orientated approach”.

Psychiatrists report that specialist rehabilitation services are often not available across the UK, or are under threat, and that a clear strategy for their development is lacking.

Recovery and rehabilitation should be integral to mental healthcare and treatment. A coherent rehabilitation policy based on recovery-orientated practice is needed for people experiencing long-term mental health problems.
5B – What we are calling for tackling discrimination and stigma

- The NHS (as an employer and as a service provider) to take the lead in reducing discrimination against people with mental health problems and learning disabilities, and promoting human rights.

- The health authorities in all parts of the UK to ensure that their disability equality schemes adequately address their disability equality duties in relation to people with mental health problems and learning disabilities.

- The Press Complaints Commission to carry out periodic reports documenting the volume and content of complaints where mental illness was a factor.
5C - Evidence

- When people with mental disorders are asked to name the greatest obstacle to recovery, discrimination and stigma is by far the most common response.

- People with a mental illness (however mild or long ago) can be denied entry into some professions as 'not fit to practise' even though they meet all the competencies for the profession.

- In the media, reporting of mental illness is unbalanced, contributing to distorted and inaccurate perceptions of the violence caused by people with mental health problems.

- Discrimination and stigma need to be tackled throughout society. The NHS should lead by example in promoting equality and human rights in all of its work as an employer and provider of health services.
6 – Our pledge to work in partnership with users and carers

- The College will continue to integrate service users and carers into their main areas of work (including research, training and quality improvement) and will develop and share best practice with other medical Colleges.

- We will audit and promote the involvement of service users and carers in the training and education of all junior psychiatrists.

- We will develop an assessment tool for measuring the well-being of carers.

- With other partners we will further best practice between psychiatrist and the patient on the use of and withdrawal from medication.

- We will work to support the physical and emotional well-being of carers of people with learning disabilities who present challenging behaviour.
6B – What we are calling for Engagement with service users and carers

- Mental health trusts to involve patients and carers in the design, commissioning and delivery of mental health services, staff training and research or audit programmes.

- Trusts to engage service users in evaluating the service users' involvement in their trust and in taking steps to remedy barriers revealed.

- Trusts to ensure that a champion of patient involvement is a member of the trust's board.
6C - Evidence

- While person-centred care and service user involvement is promoted in the NHS, in practice it often remains tokenistic and service users are not adequately supported, trained or paid for their time.

- Involving service users in the delivery of health services is beneficial. Research shows that service users who work with health services have fewer hospital admissions and better quality of life.

- Engagement with service users and carers must be meaningful, not tokenistic. People with direct experience of mental health problems or a learning disability should have a central role in the design and delivery of mental health services.
7B – What we are calling for psychological therapy

- Strategic planning to ensure that service users in secondary care, older people, people with severe and enduring mental illnesses, those with dual diagnoses, learning disabilities or in custody and people from Black and minority ethnic communities, can gain timely access to effective treatments.

- Organisations providing psychological therapies should promote the development of psychological mindedness and therapeutic skills among all staff, preferably through the appointment of a champion at a high level within the organisation.

- The training of all general practitioners to include delivering effective therapeutic and supportive interventions and shared training with trainee psychiatrists where possible.

- Support for research into frequently used and promising psychological interventions is required.
Psychological therapies are increasingly recognised as being effective in the treatment of a range of mental disorders.

Only 9% of those with common mental health problems received any counselling or therapy.

Government initiatives, however welcome, are unlikely to overcome the lack of provision for some groups (older people, children and adolescents, prisoners, people with learning disabilities and in-patients).

Availability of psychological therapies should be equitably implemented across all ages, patient groups and settings. A particular focus is needed on older people, hospital in-patients and prisoners.
8B – What we are calling for linking physical and mental health

- All health professionals to have training in mental health.
- The curricula of all doctors in training and the continuing professional development of qualified doctors to reflect the relationship between mental and physical health, both in general and in specific conditions.
- National guidelines - including those issued by the NICE and SignHealth - about conditions treated in general hospitals to cover the mental health of individuals with these conditions.
- Patients in acute hospitals to have the same level of access to a consultant psychiatrist as they would have from a consultant specialising in physical health problems.
- All care pathways for delivering physical healthcare to have a mental health component and pathways for commissioning practice to ensure the services to deliver them.
- Education to be provided for service users, carers and the public to develop community awareness of the psychological aspects of physical conditions.
- People with learning disabilities and people with severe mental illness to receive an annual physical health check.
Mental and physical health are inextricably linked and we need to, develop a 'whole person' approach to integrate rather than separate them.

People with certain physical illnesses (such as cancer on diabetes) often report high levels of mental health problems and, while mental illness is associated with poor physical health, people with a mental illness report that healthcare professionals can dismiss their physical symptoms as being unreliable.

Around 150,000-170,000 individuals who self-harm report to accident and emergency departments in the UK each year, but staffing and staff training are often not adequate to provide necessary mental healthcare.

Linking mental and physical health must be part of every doctor's practice. This will require education, training and collaborative working between mental health and other medical specialties.