

St Mungo's

# New Horizons: Towards a Shared Vision for Mental Health

St Mungo's Response to the Consultation Questions

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## About St Mungo's

St Mungo's is the main provider of services for London's rough sleepers, as well as to other homeless populations. Over the last ten and more years, central government has launched a number of initiatives to reduce rough sleeping. St Mungo's is the only third sector agency to have been involved in each of these programmes.

We run a comprehensive range of housing (shelters, hostels, high-support projects and independent flats), with ancillary services from street outreach to resettlement support, backed up by drugs, alcohol and mental health specialists. Every year we help more than 10,000 homeless and vulnerable people find responsive and integrated solutions for problems with housing, employment, training and health.

A fundamental element of our approach is our *Work and Learning* programme, which is the largest such programme for homeless people in Europe. It consists of an integrated range of a dozen projects stretching from engagement through training to employment. Each year we help roughly 100 people into sustainable jobs – and behind that headline figure are the 2,000 other unemployed men and women whom we help to improve their employability through *Skills for Life* and *Skills for Jobs* training, as well as volunteering and other forms of short-term work placements.

We believe that work is central to human identity, and promote its benefits wherever possible. We have a unique track record stretching back more than 20 years, and the clarity of purpose to project this forward into the future. The particular challenge for us – and, we believe, for government – is how to transform the unemployment rate in our hostels. Twenty years ago 86% of our hostel residents were in some form of paid work. Today that figure is 4%.

This represents a shocking failure of policy. We are encouraged by the tone of the Green paper, which identifies welfare dependency and makes some radical suggestions for tackling it. In some areas we think it does not go far enough in its prescriptions for tackling entrenched unemployment. We are determined to bring down the unemployment rate in our hostels, but we need government help to do so. We hope that the Green Paper can be just the launchpad we all need.

## **Introduction**

We welcome this opportunity to comment on the New Horizons proposals for the future of mental healthcare. We have structured our response with some general comments first, and then responses to the specific questions asked.

We would be very happy to provide further clarification of our views, and the evidence that supports them, or of their practical application.

We recognise the impact the NSF has had on the mental health debate over the last ten years, and directly on mental health services. And we welcome the very significant increase in resources that have been directed to mental health services over the same period. It is a great achievement that the New Horizons document can talk of the role of prevention and of recovery in the way that it does, as a work in progress rather than as completely new directions, as they seemed ten years ago. Similarly, the document does not need to spell out what dual diagnosis or personality disorder actually mean, or why they are included. We have come a long way.

However, we are disappointed with the document's lack of actual targets or commitments, and its apparent lack of recognition of how much needs still to be done for the many people who are still excluded, or experience themselves as excluded, from our mental health services. It is well-documented that people with mental health problems face severe social exclusion; it is also well-documented that even within the population of people with mental health problems, rough sleepers with mental health problems, for example, are among the most excluded of the excluded. There seems little in this document that will drive mental health services in ten years time to be significantly more able to help them than they are now.

Our perspective is that mental health services can still work better for many of the people we work with in homelessness hostels and prisons, if there is clear focus on a few areas. Our hostels, and the prisons we work in, accommodate many people with mental health problems that are not receiving effective – or in some cases any - treatment from current mental health services: this is not acceptable. We believe that changing this situation requires a sharper focus on excluded groups and flexible delivery (which does not necessarily mean more money): we are not convinced that New Horizons as it stands will support this. There are some good points and some serious omissions in this consultation document. But it is hard to see where the drivers for real change are: it will not work without them.

## General Comments

1. We are commenting on aspects of the New Horizons document from the perspective of a voluntary sector agency working with homeless and vulnerable people, many of whom have mental health problems and complex needs, and with offenders, many of whom share this profile. We have not commented on the sections on children/youth or elderly, as these are not our key areas of activity.
2. We welcome the review of mental health services as timely and necessary: mental health problems remain one of the key predictors of homelessness, and levels of up to 85% of homeless people are reported as having mental health problems (cf Happiness Matters 2009; Crisis 2009; Literature Review for DCLG, Maguire 2009)
3. We are disappointed that homelessness is only mentioned once in passing, and that there is not a section on social exclusion/inclusion and health inequalities, with a sub-section on homelessness. Both exclusion and inequalities are markedly and severely poorer for people with mental health problems than the general population, and for homeless people with mental health problems than for even the general population of people with mental health problems. We think specific measures need to be taken to redress this imbalance; current mental health services do not meet this need, and indeed in many cases actually increase social exclusion. An urgent review of the Homeless Mentally Ill Initiative (now 20 years old) would be a good start (such a review is supported by the HMII psychiatrists we have spoken to).
4. We welcome the findings and recommendations of the Bradley Review, to which we contributed at the consultation stage, and also the DH's efforts to engage the third sector in delivering some of these recommendations. We see such a proactive and broad approach as key to providing effective treatment and support services for people with a wide range of mental health problems, and particularly those who are also socially excluded. We believe it would be helpful to include some of the key Bradley recommendations in this document as much of it applies to people other than offenders who have complex mental health problems.
5. We welcome the emphasis on recovery, and the suggestion that there should be more recovery-oriented services and outcomes. We would like to see this taken further, with a requirement for recovery-oriented outcomes to be specified by commissioners, and for all services to be evaluated in terms of their achievements in supporting recovery. We would suggest key recovery outcomes as being in socially-valued occupation, retaining stable accommodation, and having good relationships.
6. The document uses 'time-limited' as if it is a quality. The truth is that sometimes time-limited interventions are effective and sometimes they are not. In general, we would prefer to see more recognition that for some vulnerable people longer term services, when delivered within a recovery ethos, have high value.

7. As (short or medium) time-limited approaches do not meet the needs of some of our clients, they instead spend non-limited time in prisons and hospitals: this is expensive, inefficient and inhumane, and there are better alternatives.
8. We welcome the recognition that many people with mental health problems use drugs and alcohol to a significant degree; we would suggest that it is the majority of people with mental health problems. We would like to see a much clearer statement of what mental health services will do to provide treatment options for these people. At the moment, they are often told to go and detox first, which is unrealistic. In our experience, assertive outreach teams do not work well enough with this client group. We would like to see a requirement on mental health services to provide treatment (mainly psychological therapies) to people who want it, regardless of whether they use drugs and alcohol at the time of assessment. Dual diagnosis services need to work with the effects of mental health problems compounded by drug and alcohol use, not try to separate the two conditions. Our users repeatedly say that mental health problems underlie the substance use (Happiness Matters, 2009); this needs treating with respect, and acting on. Some clinicians say they cannot treat mental health problems while the client uses substances, and do not do so; some say they can, and do do so – commissioners should test the clinical outcomes by real-life research. If they commission people who say they can treat the mental health problems of those who continue to use substances (rather than those who say they can't), then we will soon discover whether or not it works. We would be happy to be commissioned to do this.
9. We welcome the commitment to expanding access to psychological therapies, but we believe that this must not be confused with rolling out the current IAPT programme. IAPT offers little to the majority of our clients, who have psychological disorders often combined with substance use, and with whom many IAPT clinicians are not sufficiently trained to work; indeed, people with substance use problems are specifically excluded in most IAPT sites. We would like to see widely accessible psychological therapy services for people with complex needs. Our own Lifeworks programme, using fully-trained and experienced UKCP-registered psychotherapists, has shown this to be effective, with high attendance rates and high positive outcomes (Lifeworks report, 2009). We can also cite examples of general practice counselling services which work effectively with a far wider range of clients than IAPT services.
10. Currently, there are a large number of people with mental health problems who receive no treatment because they do not have illnesses such as schizophrenia that meet psychiatric criteria, and do not have mild to moderate depression/anxiety so do not fit with IAPT. These people are left in the community to become homeless, commit suicide, commit crime, go to prison, become ill enough to get hospitalised, etc. It would be far more cost-effective to replace IAPT with a psychological therapy service that could work with all-comers (and still meet IAPT targets); this is eminently feasible. We need generally accessible psychological therapy in primary care.

11. We welcome the inclusion of treatment for people with personality disorders. Some 65% of the people we work with meet the clinical criteria for a diagnosis of personality disorder (Maguire, 2007), and we have considerable experience of effectively working with these clients, including successfully providing psychological therapy. At present, many of these clients are not offered any support or treatment by statutory services at all. We would like to see DH recognition of the effective work we do with people with personality disorders, and suggest that we are a model of good practice that could be cost-effectively delivered to people with personality disorders in unstable accommodation before they become homeless, when they are leaving prison etc. We would like to see included in the document a requirement that personality disorder services routinely offer psychological therapies, and that they routinely work with people who also misuse drugs and alcohol.
12. We welcome the promotion of the Recovery Star, which is derived from our Outcomes Star. We note that clients using our psychological therapy service, Lifeworks, increased their scores significantly faster across 100% of the axes than those who did not use the service; evidence that good psychological therapy enhances recovery for people with complex needs (Lifeworks 2009).
13. We welcome the mention of crisis houses as good practice; we would like to see a commitment to the establishment of a network of crisis houses in every borough/town. Similarly, 'c.a.l.m' was cited as good practice – but has to rely on charitable funding to survive. Good practice, even when delivered by the third sector, should be funded from mainstream resources.
14. We would like to see some clear recovery-oriented National Indicators: there are few with any sort of outcomes for people with mental health problems.
15. We would like to see a commitment from the DH to end rough sleeping for people with mental health problems by a fixed time, e.g. 2012.
16. We would like to see a commitment from DH to take responsibility, with accountability at Director level, for homeless people with mental health problems; we would like to see a similar responsibility and accountability in all PCTs (as has been done in Scotland).
17. The document says little or nothing about supported housing. Some people will always require some support to manage independence and long term supported housing must remain an option if we are to give people real choice. A life lived well inter-connected with other people is a far better offer to many vulnerable people than isolating them in the community, and the document could more helpfully acknowledge this.
18. Similarly, there is relatively little on employment: employment is one of the biggest creators of social inclusion, and so getting people with mental health problems back into work must be a key priority. It would also be an effective way of tackling stigma, as familiarity reduces social fear. We suggest targets (perhaps encouraged by reporting to commissioners) for employers with more than, say, 100 employees so that the level of people in their organisation with mental health problems

- 19.** Overall, our experience is that, while good work has been done over the last ten years, there is more still to do than this document suggests. Mental health services still fail a large number of people with mental health problems; suicide rates remain high (they have fallen for young women, who have switched to self-harm, and risen for young men); people have to become severely ill to get treatment; people who use drugs and alcohol are refused treatment; personality disorder services are few and inadequate, and often won't work with people with chaotic lifestyles or who take drugs/alcohol; psychological therapies are still hard to access for those who most need them, and there is a continued obsession with short-term interventions, – and there are still too many people with mental health problems sleeping rough and in prisons.
- 20.** There are effective ways of dealing with this and we urge the DH to promote and replicate more widely some of the inclusive and effective good practice that exists. At a time of limited budgets, we believe that much of this could be funded through efficiencies; we would be happy to meet to discuss how.

## Response to the specific consultation questions

### Question 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?

- **A clear time-framed Government target to ensure that nobody with mental health problems is sleeping rough on the streets.**

Although rough sleeping has been greatly reduced with the success of the Rough Sleepers' Unit, of those who remain on the street the biggest single factor keeping them there is poor mental health. Rough sleepers typically have a range of mental health problems including personality disorders, substance dependency, risk of suicide and self-harm, PTSD, and depression; around 35% have severe psychiatric illnesses as well (CHAIN data).

There is a moral argument that nobody should be sleeping rough because of mental illness, but there are other arguments as to why this should be a top priority: rough sleepers are the most visible of those who currently fall through the gaps in mental health services. To achieve 'nobody with a mental health problems sleeping rough', mental health services would have to be designed so that they provided an effective safety net for everybody with mental health problems. This may seem idealistic, but it is exactly what 'universal healthcare' means, and it is what happens in physical healthcare – people do not end up rough sleeping because of physical health problems (though they often develop significant physical health problems as well as a result of rough sleeping).

This leads to our second priority:

- **The provision of universal access to mental healthcare in a community setting.**

Mental health and mental illness are parts of a spectrum of wellbeing, as the New Horizons document rightly points out. However, current mental health services are geared to only work with a very small part of that spectrum, mainly those who have psychiatric illnesses. This is excluding, and not universal, healthcare; it also significantly underpins the stigma of mental illness.

1 in 4 people will develop mental health problems of one sort or another during their lifetime. Mental health problems come in all sorts of forms and severities, and they fluctuate. Service-delivery-oriented mental health services (and that must include those stuck in rigid pathways) can therefore always only be an inefficient response to this. Services targeted on particular problems defined as diagnostic categories inevitably alienate and exclude many, with the result that either their mental illness is expressed in antisocial or criminal behaviours, suicide and self-harm, social dysfunction, and/or substance misuse, or it becomes severe enough to merit entry into the psychiatric/hospital system.

The biggest change in mental health services would be the introduction of centres, possibly as part of the new wave of 'super' GP clinics, where anybody with mental/emotional/psychological distress could go and get treatment from a well-qualified professional (as we all can with physical health go and see a GP). This does not need to be (indeed probably should not be, because of cost, limited training, and stigma) a psychiatrist: the people best trained to work with a wide range of presenting issues in mental health are counselling psychologists or

psychotherapists. The objective would be to offer treatment, principally talking therapies supported by some pharmacology; the outcome would be reduced mental illness in the community, lower use of hospitals, reduced harm from substance use, antisocial behaviours, crime, etc, lower use of CMHTs and other (expensive) specialist services, more people remaining in work etc. The cost benefits realisable through IAPT (which is a limited and inefficient version of this) would be multiplied several times over.

The clinics should also have staff competent to offer support and advice on debt, housing, legal problems etc.

They should be bound by a rule of:

- **No exclusions, and a commitment to recovery**

Current mental health services exclude at least as many people as they work with – those who take drugs and alcohol, those with the ‘wrong’ set of symptoms to meet a specific diagnosis/service criteria, those who are too ‘chaotic’, too unwell (for IAPT), not unwell enough (for psychiatric services), and so on. People who fail to attend appointments are discharged, rather than assertively engaged, despite the most common reason for failed attendance being the very mental health problems services are supposed to be working with.

Mental health services should not be allowed to exclude people who are in mental distress. Only by making universal mental healthcare a reality can clinical practice be forced to develop effective ways of working with the full range of mental health problems. While clinicians do not need to see people with complex problems, they can too easily say they are ‘not treatable’. When a clinician says this, they actually mean ‘I do not know how to treat them’: this is different. But there is no stimulus for research or development when clinicians can so easily simply exclude the person from treatment altogether. Again, this does not happen in physical healthcare: there, if clinicians do not understand an illness, they (or someone) will research it and develop an understanding and some form of treatment; they do not simply say, ‘*you are untreatable, go away*’ as mental health services do. The same rigour should apply in mental health.

Put simply, a big part of the reason why there are so many rough sleepers with mental health problems – and so many people in prison with mental health problems – is because mental health services are not obliged to work with them.

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

## **Question 2: Do you support the twin themes of public mental health/prevention and mental health service development?**

Yes

We think there should be more emphasis in the prevention agenda on universal mental healthcare, as above.

It is not our area of work so we will limit our comments on childhood prevention to saying that the majority of chronically homeless people have backgrounds of parental neglect/abuse and often poor experiences of statutory childcare and/or fostering. We believe improvements in support for parents and improvements in statutory childcare would reap significant benefits in prevention terms.

- We think the key to mental health service development is outcome-focused (i.e. what helps people to recovery) commissioning, which would lead in turn to outcome-focused, real practice (as opposed to artificial RCTs) clinical research. In some countries, recovery rates from psychosis are above 75%, in others (such as here) they are below 40% (WHO, 1973, 2001). Setting recovery-oriented targets would push clinical practice towards client-focused outcomes. At the moment, it is all too easy for clinicians to avoid responsibility by talking about the client's 'unsuitability' for the treatments they propose.
- We would advocate for successful working with homeless people with mental health problems to be a sort of litmus test of accessibility and openness of mental health services. Our own psychological therapy services for homeless people show that treatment of complex needs, even for people who continue to use drugs and alcohol, is possible and is effective. We have 75% regular attendance and 75% improvement on the CSIP Wellbeing Impact Assessment Measures; using our version of the Recovery Star, we see 100% increased improvement across all axes compared to clients who do not receive our psychotherapeutic treatment (Lifeworks reports, 2009). Our Lifeworks project has been shortlisted for the HSJ Awards in the category of 'Improving Patient Access': it is not difficult to replicate.

## **Question 3: Are the guiding values described in section 1 the right ones?**

We welcome your statement of values, and agree with them; however, we feel that it should include **safety** – immediately after stating the 'guiding values' the document says that 'safety is an important aspect of a high quality service...In some situations, safety may be the overriding consideration'. If this is so, it should be clearly and openly declared as one of the guiding values. It is damaging to have it as a hidden value, where its negative connotations for personal choice are more likely to come to the fore. We believe that mental ill health is frightening for the person who experiences it, and so safety is actually a positive value both for the community and for the patient: a recent survey suggested that over half of patients were frightened by their experience in psychiatric services (HSJ, Sept 09, quoting the CQC report).

We welcome the emphasis on recovery, and the suggestion that there should be more recovery-oriented services and outcomes. We would like to see this taken

further, with **recovery** specifically mentioned as a basic value, backed up by a Government requirement for recovery-oriented outcomes to be specified by commissioners, and for all services to be evaluated in terms of their ability to support recovery and their delivery of recovery-based outcomes.

**Question 4: What should Government do to promote more personalised services for people with mental health problems and their families? What works in your area, and what does not?**

- The provision of open access wellbeing services as described above, enabling people to make informed choices about treatment/actions they could take to improve their mental health and wellbeing.
- The expansion of personal payments. To do this effectively, assessment should be separated from the provider and the budget-holder function. Assessment should be in the preserve of broadly-trained clinicians.
- The role of adult mental health social services/CMHTs should be reviewed, starting with a fundamental question of ‘are they needed at all?’ It is possible to envisage all that they do, once the assessment role is removed, being done as well or better, and cheaper, by other agents/agencies. If the client or a carer is the coordinator of the personalised care and support package, what is the role of a Care Coordinator? (See Social Care Institute for Excellence’s publication on Personalisation, 2009, for a fuller discussion of this).

**Question 5: In your view, which are the most important areas in mental health services where value for money could be improved?**

**IAPT** By using fully qualified counselling psychologists or psychotherapists instead of people with limited training, the IAPT programme could easily be broadened out so that it provided a first point of treatment for a whole range of mental health problems that people face. It could achieve more than twice as much for the same cost. Such a service would meet the existing IAPT targets but also treat a much wider range of presenting problems, reducing use of CMHTs, secondary mental health services, specialist referrals, psychiatric admissions, and the costs consequent on untreated psychological disorders. It would mark a real step forward at no extra cost; in fact, there would likely be a direct saving, as currently IAPT services are being parachuted in on top of existing services. Provision of a truly professional counselling/psychotherapy service in primary care (or polyclinics, one-stop shops, community centres etc) is a very cost-effective way of treating mental health problems as they are presented in the general population. By broadening the user base and accessibility, it would also reduce stigma.

**Dual Diagnosis/PD Work.** Our experience of dual diagnosis services in London and elsewhere are that many are poor and ineffective. Similarly, there are few or no resources for people with personality disorders who are substance dependent (in our experience, the majority); hospital accommodation projects do not admit people with substance use problems and are very expensive. We provide effective services at a much lower cost both for people with personality disorders and for people with dual diagnosis. Our dual diagnosis projects have achieved improved rates of positive and sustained resettlement, higher levels of engagement with employment/training, and an astonishing zero re-hospitalisations over two and a

half years compared with the previous service provider; but they do not cost any more, we simply reconfigured the staffing.

The model is easily replicable and could be rolled out to anywhere that has supported accommodation: it costs relatively little to transform an ordinary accommodation project into one which can provide an effective therapeutic process for people with complex needs, whether dual diagnosis or personality disorder (our frontline hostels see levels of up to 70% of their clients meeting the criteria for a diagnosis of personality disorder, usually compounded by polysubstance use – but we have a more than 60% overall positive resettlement rate).

As people with these conditions, poorly treated, cost so much in terms of hospitalisation, incarceration, antisocial behaviour and crime, the cost savings could be very high.

**Social services/CMHTs.** Scrapping most of adult social services would save a lot of money. The role of Adult Social Services in mental health has changed over the years, and with personalisation becomes even less clear. Currently, much of what they do can be seen as gatekeeping: they assess people so as to exclude them, to protect budgets and limited-capacity services. This is not good for people with mental health problems in general. Assessment should be clinical, by psychologists, and should be freed from budgetary overtones, which distorts the assessment. If a need is assessed, but there is no resource, that should be transparent; what happens now is that the need is denied because of resource pressure (e.g. budgetary, lack of bedspaces, lack of capacity to take on new cases).

Most of the support that social workers provide (eg with benefits, debt, housing etc) could be done cheaper and more effectively by staff from the third sector; the assessment should be done by clinicians; care coordination, in line with personalisation, should be done by the patient, with the support of a carer/friend/relative/support worker.

Similarly, much of what CMHTs do could be done more effectively or more cheaply, or both, by others: medication could be the responsibility of primary care practices; psychological therapies likewise (see above on improving IAPT); social work functions could be divided up as above; the input of psychologists or psychotherapists, advising GPs, could replace the costly requirement of a psychiatrist in every team. Doing this would not only save a lot of money, it would broaden accessibility to people with conditions that CMHTs as currently structured cannot work with effectively.

In many cases, good quality supported housing would be more effective, more therapeutic and more cost-effective than the current system.

We suggest a complete review of community-based adult mental health services, and piloting other approaches in a couple of areas, perhaps as part of the 'Total Places' approach.

**Question 6: Which areas can you identify where innovative technology can help people with mental health problems, and their families?**

Having a mobile phone, combined with the 'Voicemail 4 All' initiative, has proved extremely useful for homeless people in keeping in touch, and in attending regular appointments (mobiles have alarms, and clinicians can text clients to remind them).

**Question 7: What are the current gaps in research evidence supporting the development of New Horizons?**

- There are major gaps in the research evidence about what works (i.e. enhances recovery, reduces psychopathology) in real practice. Much of the accepted evidence is derived from RCTs conducted in very artificial conditions, and which should be treated with a considerable amount of caution; other research methodologies, especially those based in clinical practice, should be given more weight (See an academic analysis of current research on psychological therapies by Michael King, 2008, for a fuller discussion of this). Mental health research should use the same recovery yardstick as commissioning should, and should be based on real life services/situations.
- There should be funding support for innovative mental health practice to continue for long enough for independent clinical research to be undertaken; and funding should support this research where initial evidence suggests effectiveness. For example, our Lifeworks project enhances change on the Outcome Star (a forerunner of the Recovery Star) across all axes, and enhances wellbeing on the CSIP measures: it now needs rigorous clinical evaluation, but there is no obvious channel for funding clinical research into innovative practices.
- There is a wealth of evidence, both clinical and neurological, for the role of attachment in disturbed development and disturbed adult behaviours. Much as recovery can provide a coherent ethos for service design and commissioning, so attachment theory can provide a theoretical coherence and drive clinical innovation. More research into the relationships between attachment disorders, defences against those disorders, and particular behaviours (for example, chronic homelessness, transient engagement, substance dependency) would provide a stronger basis for predictive and preventative work as well as for ongoing clinical and social care practice. (There is so much literature on this it is hard to cite one source; attachment is probably the best evidenced behaviour of all. However, it is rarely taken into account).
- More research into the relationship between attachment and developmental disorders and brain physiology would help to clarify treatment routes for e.g. people with suspected learning difficulties or some aspects of autistic spectrum disorder, older people with suspected dementia, or alcohol-dependent people with suspected brain damage.
- On the other side of the scale, more research into the impact of positive social engagements, such as work, on psychological morbidity would be welcome also. It is widely accepted that people with mental health problems do better if they are socially included, and this is often seen as why people with psychotic episodes in some third world countries have better prognoses than in ours, but there is little rigorous research about exactly

what aspects of social inclusion matter, and how they impact on mental wellbeing. Better research would enable more refined social programmes.

**Question 8: How can we support local leadership in building mental wellbeing and mental healthcare services?**

- The key would be to adopt a problem-solving approach, rather than separating people out into services targeted at diagnostic categories (that can never quite fit the range of experienced disorders). Resolving problems is something that can involve clinicians, social care, families, the clients themselves, and local communities. It is something that everyone can identify with, and so lends itself to leadership and galvanises community participation in a way that treatment for, say, forensic psychopathology never can. Again, it also reduces stigma.
- Delivering joint leadership training programmes for clinicians, social care staff and client organisations jointly: these should include representatives from health services, the local authority and the third sector as well as carers/users. Our Director of Programmes is on a leadership course funded by the DH and it is very valuable and effective – more such courses with a mixed group of students, and more locally based courses (e.g. ‘Leadership for wellbeing in Lambeth’) would be even more effective.

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

- Joint commissioning between health and local authority commissioners should be required, not optional.
- Joint outcomes, based on recovery, should be agreed.
- There should be a National Indicator on recovery, with clear targets that both NHS and Local Authorities could aspire to achieve, focused on people with mental health problems including dual diagnosis and complex needs (even with no diagnoses).
- There should be a client-centred problem-solving approach, involving carers/users and the third sector as well as the statutory services. Currently, joint working often breaks down into the ‘silo mentality’ because of role demarcations (which frequently merely reflect service frameworks rather than real ethical dilemmas); the primary task in client-centred work is to support recovery, who and how is secondary. Again, perhaps this is one for ‘Total Places’.
- There needs to be greater transparency in the JSNA process, and particularly about how needs are identified, and how very local needs are met (currently, there is a natural tendency to focus on big population needs, but this will always mitigate against minorities and increase health inequalities)

**Question 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?**

- Focus on rough sleepers and the chronically homeless: they are among the most excluded of the excluded, and suffer from some of the worst health inequalities. What works for them could act as a blueprint for other excluded groups; and challenging mental health services to work effectively with people with very complex and chronic needs would catalyse clinical development. They are also very expensive across a range of statutory services, with a large amount of wasted inputs, so would act as a barometer of the efficacy, and cost-effectiveness, of mental health services. It also (re)affirms a principle of inclusion: nobody should lose their home or remain homeless (let alone on the streets) because of their mental ill health.
- 2, Provide universal easy access to problem-solving oriented mental health services, including psychological therapies. This would contain many problems early on, would enable better wellbeing across communities, would make mental health services more accessible to minorities and other excluded groups, would reduce the numbers falling into unemployment because of stress etc, would reduce demands on CMHTs, hospitals, psychiatrists and other expensive alternatives, reduce crime, and would reduce stigma because of generalised accessibility.
- Develop measures to increase the levels of employment among people with mental health problems. Employment improves mental health, reduces dependency, increases social inclusion, enables personal choice and reduces stigma: that is a pretty impressive set of reasons that few clinical interventions can match. The road to employment is also the road to recovery.

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

Continuity of support, and person-centred support: the client should choose the transition time.

**Question 12: What in your view could the government do to combat stigma?**

1. Promote the spectrum model of mental health, rather than the discrete illness model.
2. Create general access mental health services with a problem-solving approach that work with anyone in distress, situated in primary care or the community.
3. Set requirements of employers with over, say, 100 employees to have and retain in employment 5-10% of people with mental health problems; employment is key to reducing stigma and social exclusion (which to some extent go hand in hand).

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