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MENTAL HEALTH ANALYSIS PROFILES (MhAPs)
England

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ABSTRACT

As part of a wider project on mental health in OECD countries, a series of descriptive profiles have been prepared, intended to provide descriptive, easily comprehensible, highly informative accounts of the mental health systems of OECD countries. These profiles, entitled 'Mental Health Analysis Profiles' (MHAPs), will be able to inform discussion and reflection and provide an introduction to and a synthesised account of mental health in a given country. Each MHAP follows the same template, and whilst the MHAPs are stand-alone profiles, loose cross-country comparison using the MHAPs is possible and encouraged.

The English mental health care system can be regarded as one of the clearest examples of a "community care" approach to mental illness, with relatively well established links and networks between mental health care providers and social care providers. Strong links between social support services, for example employment and housing services, and appropriate psychological and medical interventions, have been a priority. Recent developments in the system include the introduction of a programme of talking therapies, IAPT, rolled-out nation-wide, a commitment to introduce waiting times standards for mental health services, and early in 2014 a mental health action plan, Closing the gap: priorities for essential change, which sets out 25 areas for urgent action.

RÉSUMÉ

Lancée dans le cadre d'un projet plus vaste consacré à la santé mentale dans les pays de l'OCDE, la série de profils « Santé mentale : profils d'analyse » (Mental Health Analysis Profiles - MHAP) vise à décrire de manière simple et détaillée les systèmes de santé mentale des pays de l'OCDE. Ces profils, qui étayeront les examens et les réflexions qui seront menés, feront le point sur la situation d'un pays donné dans le domaine de la santé mentale. Les profils MHAP sont indépendants les uns des autres mais suivent le même modèle : il est donc possible, et recommandé, de les utiliser pour procéder à des comparaisons entre pays.

Le système de santé mentale anglais peut être vu comme un des exemples typiques de système ayant une approche de "soins communautaires" en ce qui concerne les maladies mentales, avec des liens et réseaux relativement bien établis entre les intervenants de soins de santé mentale et les services sociaux. La priorité a été mise sur la nécessité d'avoir des liens étroits entre les services d'aide sociale, par exemple l'emploi et le logement, et les interventions médicales et psychologiques. De récentes évolutions dans ce système sont à noter, telles que l'introduction d'un programme de thérapie parlante, l'IAPT, déployé sur tout le territoire, un engagement pour l'introduction de limites de temps d'attente pour les services de santé mentale, et, au début de 2014, un plan d'action de santé mentale appelé en anglais *Closing the gap: priorities for essential change,* définissant 25 domaines d'action urgente.

TABLE OF CONTENTS

Tables

Figures

Boxes

Introduction

1.   The English mental health care system can be regarded as one of the clearest examples of a "community care" approach to mental illness, with relatively well established links and networks between mental health care providers and social care providers. The model of "care in the community" for those suffering from mental ill health, as opposed to inpatient treatment or institutionalisation, is one that has also been followed by other OECD countries. Strong links between social support services, for example employment and housing services, and appropriate psychological and medical interventions, have been a priority in the English mental health system. Early in 2014, the Department of Health published a mental health action plan, *Closing the gap: priorities for essential change* which sets out 25 areas for urgent action. The document challenges the health and social care community to move further and faster to transform care and support; the public health community, alongside local government, to give health and wellbeing promotion and prevention the long-overdue attention it needs and deserves; and individuals and communities to shift attitudes towards mental health. There are a number of key mental health developments covered in this action plan, including improving responses to patients in crisis, choice in mental health services, tackling the stigma attached to mental health, reducing suicide and improving access to psychological therapies. In September 2014 the Government announced a new five-year plan for mental health, *Achieving Better Access to Mental Health Services by 2020*, which sets out how services should look over the five years between 2015 and 2020 and the immediate actions expected to take place in 2014 and 2015 to achieve better access and waiting times in mental health services.

1. Mental health history, legislation and human rights

1.1 History and development of the mental health system

2.   In England, there is a 200 year history of policy and legislation specifically related to mental health. During this time the focus of the mental health system has shifted several times, from the dominance of inpatient care in asylums in the 1800s, to a greater focus on mental health disorder rehabilitation and voluntary outpatient treatment (1920s to 1950s), to the community care mental health initiatives of the last 60 years (1950s through to the present day). The prioritisation of community mental health care in the English system is today seen at all levels, from government policy, legislation and the national strategy to finance mechanisms and local service design and delivery. Local mental health services provide varying levels of intervention and support within a community setting, aiming to avoid residential care up until the point at which it is considered to be absolutely necessary and appropriate.

3.   Mental health treatment was shaped significantly by the birth of the NHS in 1948, which became the main health care provider in England. The slow shift from the detention of those with mental disorders to prevention and treatment (which began in the 1920s) continued under the newly formed NHS, as a further shift from institutionalisation to community-based care began. In 1954, the resident population of psychiatric hospital beds peaked at 152 000, and then began to fall with the introduction of welfare benefits and antipsychotic medication, and as part of the wider political and ideological deinstitutionalisation movement that was influential in the United States and Western Europe during the 1950s, '60s and '70s. The influential 1954-57 report of the Royal Commission on the law relating to mental illness and mental deficiency (the Percy report), for example, suggested that most mentally ill patients did not need to be admitted as inpatients, but instead could receive outpatient care from GPs or from community health and welfare services (Percy Commission, 1957). Across the following 30 years, progress towards community-based treatment continued: the 1962 hospital plan for England and Wales stated that large psychiatric hospitals should close and that local authorities should start to develop community services, and in 1975 the White Paper, "Better Services For The Mentally Ill", set out a blueprint for integrating NHS, local

authority and the voluntary sector to provide mental health care based on a vision of community mental health care model.

4.   The 1980s saw major shifts towards local community care and the decentralisation of inpatient beds to district hospitals under the Thatcher government, which then were consolidated in the 1990s: 1986 saw the first complete closure of a psychiatric hospital, and in 1987 the Audit Commission under the Thatcher government published the report "Making a Reality of Community Care", which laid out the advantages of community care for mental health disorders. The 1980s also saw the major expansion of community psychiatric nurses, first introduced in the late 1970s. A focus on health outcomes started in 1992 with the government strategy "Health of the Nation" (Department of Health, 1992a), which built on the earlier WHO document, "Health for All by the Year 2000". Mental illness was included as a key part of this strategy, which set targets to reduce morbidity and mortality due to mental illness, and was followed by implementation strategies in the Mental Illness Key Area Handbooks (Department of Health, 1993; Department of Health, 1994; see also Jenkins, 1994). "Building Bridges" (Department of Health, 1995) set out the vision for inter-sector liaison around mental health and "The Spectrum of Care" (Department of Health, 1996) set out the range of services and interventions envisaged as part of local services for mentally ill people.

5.   In the years following the 1997 election of Tony Blair's Labour Government the NHS underwent a number of major organisational changes, including the introduction of a new results-based payment system for health care providers, the inclusion of public-private partnerships for some services in the NHS (for example, the private finance initiative [PFI] hospital-building scheme and Private Public Partnerships [PPP], started under the Labour government), and the introduction of a series of new performance and outcome guidelines, notably the creation of the National Institute for Health and Clinical Excellence (NICE), an independent national health care standard-setting body (Boyle, 2011). The wider changes within the NHS since 1997 have had significant impacts on mental health care: NICE, which produces clinical guidelines for healthcare providers in England, has produced guidelines on 14 different mental illnesses, including schizophrenia, bipolar disorder, depression and anxiety; "Payment-by-Results" (PbR), the performance-based financing mechanism that was introduced across the NHS from 2004 did not originally include mental health services, but following two pilots is now in the process of being introduced into mental health services (see section 5.2). The Quality Outcomes Framework (QoF) was introduced in 2004 alongside PbR, as a performance management and incentive payment scheme for General Practitioners (GPs) in England, and includes mental health care indicators (see section 5.2).

6.   In addition to changes to health care provision across the NHS, mental health care in England has undergone some important transformations in recent years. "Saving Lives: Our Healthier Nation" (Department of Health, 1999) reconfirmed mental health as a key priority for the NHS, and set a target to reduce suicide and death from undetermined injuries associated with mental ill health by a fifth. The National Service Framework for Mental health in adults of working age published in 1999 was a 10-year strategy, resulting in a significant growth in community mental health provision with the development of early intervention, assertive outreach, crisis intervention and home treatment approaches and community "teams". The 2011 mental health policy for England, "No Health Without Mental Health" described a twin track approach of combating mental ill health whilst also stressing the importance of prevention and individual and population health and well-being (HM Government, 2011) Since then the Government's commitment to parity of esteem was made explicit in legislation (NHS Mandate 2012), and in in 2014, the action plan for mental health *Closing the gap: priorities for essential change* (HM Government 2014) and the five-year plan for mental health, *Achieving Better Access to Mental Health Services by 2020* (HM Government 2014), were published.

1.2 Mental health legislation

7.   Mental health legislation in England sets the conditions under which an individual can be legally detained on mental health grounds and the legal rights of detained mental health patients. The first mental health act in England, the County Asylum Act, was passed in 1808, and was followed by the Lunacy Acts of 1845, 1890 and 1891. The main focus of this legislation was to regulate the development of asylums, to which admission was for the most part involuntary. Since the 1959 Mental Health Act, which switched the decision to compulsorily detain a patient from a judicial one to an administrative one, legislation has focused on balancing the tension between protecting the rights and promoting the safety of patients with mental health problems, and protecting the safety of the communities in which they live, rather than expressly facilitating involuntary incarceration on mental health grounds. Mental health legislation today allows an individual to be detained against their will on the condition that they present a danger to themselves or others, including within the wider community.

8.   The Mental Health Act 1983 offered some further safeguards for the rights of inpatients but was primarily designed to give health professionals powers to detain, assess and treat people with mental disorders. Most involuntary mental health admissions are under the Mental Health Act 1983. Importantly, this Act codified the professional roles of those with the power to apply for the detainment of a patient, specifically those powers held by an Approved Social Worker (ASW), and stipulated specific staff training for any individuals administering the act (Rapaport and Manthorpe, 2009). The Mental Health Act 1995 then gave authorities new powers over those discharged from hospital. Some recently released mental health patients who remained "aftercare users" could be compelled to live at a certain address and to attend certain establishments for treatment, training, occupation or education. These individuals could not, however, be forced to undergo this treatment following their discharge from hospital. The Disability Discrimination Acts of 1995 and 2005, and the Mental Capacity Act of 2005, meanwhile, were focused exclusively on the protection of the rights of people with physical or mental disabilities (rather than the rights or safety of the communities in which they lived, or facilitating ease of treatment, for example), ensuring that services, premises and employment were made accessible wherever reasonable. In addition, the Mental Capacity Act established the important premise that "a person must be assumed to have capacity unless it is established that he lacks it" (Ministry of Justice, 2011).

9.   The Mental Health Act 2007 has returned the focus more directly towards concerns about risks to the public posed by people with a serious mental disorder living in the community (Lawton-Smith, 2008). The main purpose of this legislation was to define the circumstances in which people with mental disorders can be detained and treated. The Act also changed the definition of mental disorder to "any disorder or disability of the mind", and removed "promiscuity" or "other immoral conduct and sexual deviancy" from a list of legitimate reasons to detain someone (it is assumed that promiscuity and immoral conduct will not be used as justification, but despite the removal of "sexual deviancy" the Act still allows the detention of paedophiles provided that their detention fulfils the other conditions for its use). This 2007 Act established the legal principle that a "personality disorder" is a mainstream mental condition, requiring equal consideration for assessment and treatment as other mental disorders (Bradley, 2009), as well as facilitating the detention of a patient even in the case that there is no available treatment likely to aid the patient, so long as the patient is detained and treated with the intention of aiding them (Lawton-Smith, 2008).

10.   Further to these changes the 2007 Mental Health Act broadened the group of people able to apply for the detainment of a patient, and increased the authorities' power over patients in the community with the introduction of supervised community treatment in the form of Community Treatment Orders (CTOs). Supervised community treatment allows people with mental disorders to be compelled to receive outpatient treatment at an early stage rather than waiting until inpatient hospitalisation becomes necessary, but subject to strict conditions.

11.   The rights of patients under the Mental Health Act are further set out in the Mental Health Act Code of Practice 1983, revised in 2008, which is used to inform healthcare and social care professionals' practice, safeguard patients' rights and ensure compliance with the law (Department of Health, 2014a). In July 2014, The Department of Health launched 'Stronger Code: Better Care' an open consultation process on proposed changes to the Code of Practice. (Department of Health, 2014a). The consultation has now closed and comments are being considered.

1.3 Involuntary care and seclusion, rates of control and restraint

Detention under the Mental Health Act

12.   The Health and Social Care Information Centre report *Monthly Mental Health Minimum Data Set (MHMDS) Reports, England - February 2014 summary statistics and related information*, published in May 2014 shows that at the end of February 2014:

- 963,520 people were in contact with secondary mental health services and of these 23,298 were inpatients in a psychiatric hospital (2.4 per cent);

- 15,403 people were subject to the Mental Health Act 1983 and of these 10,985 were detained in hospital (71.3 per cent) and 4,282 were subject to a CTO (27.8 per cent);

- 59.6 per cent of people aged 18-69, who were being treated under the Care Programme Approach, were recorded as being in settled accommodation, while 6.9 per cent were recorded as being employed.

13.   Key facts from the special feature include that, in adult mental health services in 2012-13:

- The rate of detention was 74.8 people per 100,000 of the population, or approximately one person in 1,300 people;

- The rate of short term orders was 40.2 people per 100,000 of the population, or approximately one in 2,500 people;

- The rate of detention was highest for the 75 and over age group at 99.0 people per 100,000 of the population, the highest for any adult age group;

- The rate of short term orders was highest for the 25-34 year age group at 58.1 people per 100,000 of the population;

- The rate of detention for people from the Black and Black British ethnic group, 250.3 people per 100,000 of the population, was around 3 times higher than for the White ethnic group (62.9 per 100,000 of the population);

- 13.4 per cent of people who were subject to a detention were detained more than once in the year;

- 16.8 per cent of people who were subject to a short term order had more than one short term order in the year;

- There were wide variations in the use of short term orders and detentions across CCGs, although these rates are particularly susceptible to variations in the quality of locally submitted data.

Source: *Monthly Mental Health Minimum Data Set (MHMDS) Reports, England - February 2014 summary statistics and related information* - http://www.hscic.gov.uk/catalogue/PUB14125

14.   Decisions to detain a person under the Act are a matter for clinical judgement, and it is agreed that there is no right or wrong overall number. What matters is that each individual decision should be correct at the time that it is taken.

Control and restraint

15.   Positive and Proactive Care; reducing the use of restrictive interventions' was published by the Department of Health in April 2014. It includes a requirement for Trust boards or equivalent to develop restraint reduction plans and to record the use of restraint. The NHS Benchmarking Network has been commissioned to capture snapshots of the use of restraint in August 2014 and January 2015. In the longer term the Health and Social Care Information Centre's Mental Health and Learning Disability Minimum Data Set will be amended to accurately record restraint. The Department of Health is reviewing the Mental Health Act Code of Practice. This includes consideration of the authorisation and review requirements for the use of seclusion.

2. Population characteristics

2.1 Prevalence of mental ill health across the population

16.   Mental ill health is the single largest cause of disability in the UK, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease (Prince et al., 2007).

17.   At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time. Almost half of all adults will experience at least one episode of depression during their lifetime.

18.   One in ten children aged between 5 and 16 years has a mental health problem. Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.

19.   A 2012 mental health survey was conducted in Europe by Ipsos to estimate the prevalence of depression in the workplace. The **Impact of Depression in the Workplace in Europe Audit** survey was conducted online (between 30 August and 19 September 2012) across 7065 people aged 16-65 and who had worked in the last 12 months, and France, Germany, Italy, Turkey, Spain, Denmark and the Great Britain participated in the survey. Figures showed that Great Britain had the highest score among the participating countries, with 26% of people having been diagnosed with depression, against an average of 20%. Furthermore, among workers experiencing depression, those in Germany (61%), Denmark (60%), and GB (58%) were most likely to take time off work , compared to an average of 35.5 % (Ipsos, 2012).

2.2 Suicide

20.   Suicide rates in England are low compared to other OECD countries and have steadily reduced, with the lowest number ever recorded in 2007, but with a small rise since then. The three-year average rate for 2010-12 was 8.0 deaths per 100,000 population, 17% lower than in 1998-2000.

21.   Around 4,500 people took their own life in 2012 so suicide continues to be a major public health issue, particularly at a time of economic and employment uncertainty. The latest Office of National Statistics figures show that there were 4,727 suicide deaths in 2013, an increase of 214 compared to the 4,513 deaths in 2012.

22.   The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness indicates that around 75% of people who die by suicide are not in touch with secondary mental health services within the year before their death.

23.   The majority of suicides continue to occur in adult males under 50 years of age. Suicide rates are much lower for females than males. Men are three times more likely to kill themselves than women, but the difference varies by age. The peak difference is in the 20–24 age group where there are five male suicides for each female suicide. The highest rate of suicide for men is in the 35-54 age range although young men under 35 continue to be one of the high risk groups.

24.   The suicide rate for men under the age of 35 has fallen in recent years following a consistent rise over the last three decades of the 20th century. However, it remains a leading cause of death in males aged under 35.

25.   Children and young people have an important place in England's new suicide prevention strategy. The suicide rate among teenagers is below that in the general population. However, half of lifetime mental health problems (excluding dementia) begin to emerge by age 14 and three-quarters by the mid-20s, making this a crucial age group for the early identification of problems and swift and effective intervention.
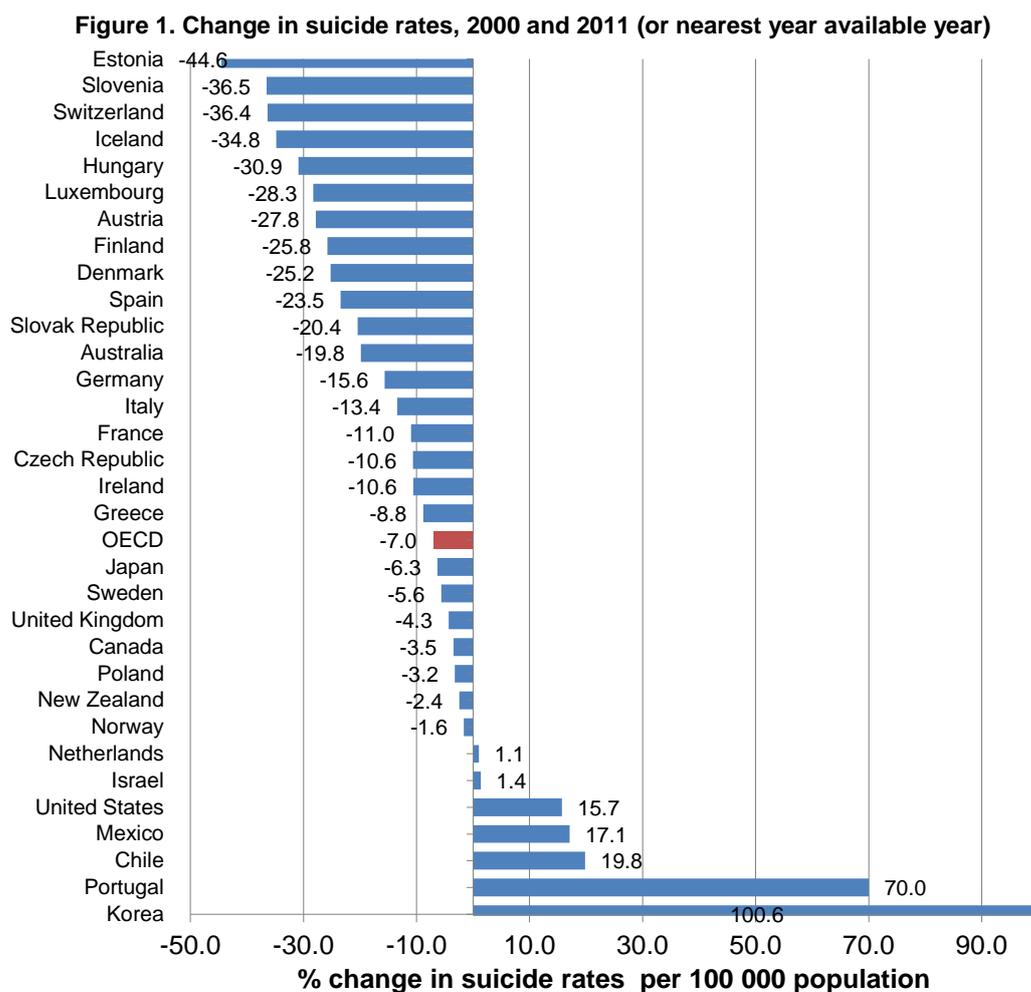
Figure 1. Change in suicide rates, 2000 and 2011 (or nearest year available year)

Source: OECD (2013), *OECD Health Statistics 2013*, OECD Publishing, Paris, www.oecd.org/health/healthdata.

26.   Over the past 10 years, good progress has been made in reducing the suicide rate in England. By 2007, suicide had fallen to the lowest rate in 150 years and there had been a marked fall in suicide in young men.

27.   There have also been substantial improvements in in-patient services. The most recent National Confidential Inquiry into Suicide and Homicide (July 2014) shows that the long-term downward trend in patient suicides continues. From 2002-2011, there was a 50% fall in the number of in-patient suicides. Since 2006, there have been more patient suicides under Crisis Resolution/Home Treatment than in in-patient care. However, the number of suicides under Crisis Resolution/Home Treatment has also fallen since 2009.

Figure 2: Age-standardised suicide rates: by sex, deaths registered in each year from 1981 to 2012 in the United Kingdom
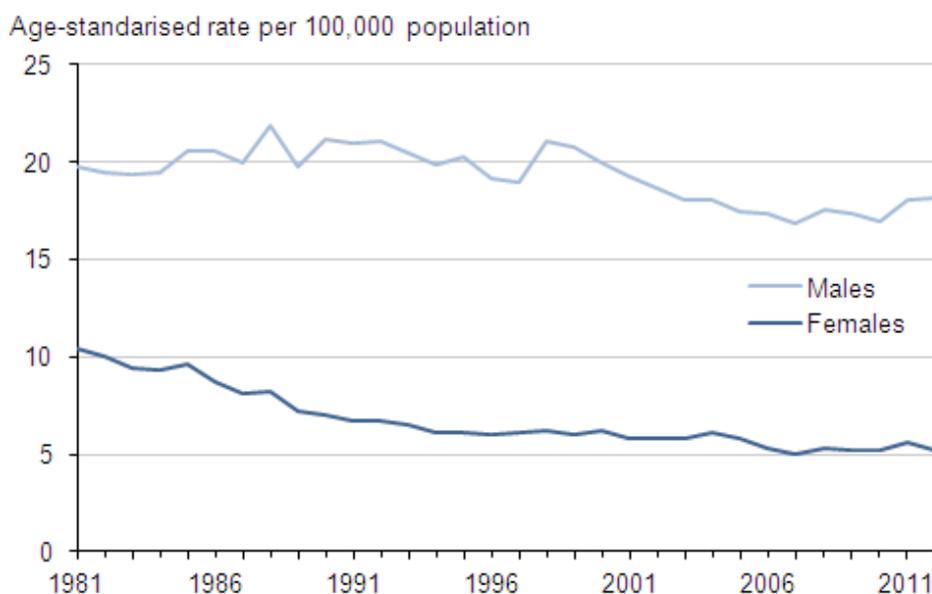
Source : Office for National Statistics (2014), *Suicides in the United Kingdom, 2012 Registrations,* Available at: http://www.ons.gov.uk/ons/dcp171778_351100.pdf, accessed 06.06.2014.

28.   The suicide rate for men under the age of 35 has fallen in recent years following a consistent rise over the last three decades of the 20th century. However, it remains a leading cause of death in males aged under 35.

29.   Data from the Office of National Statistics suggests that since the 1999 government White Paper, "Saving Lives: Our Healthier Nation" (Department of Health, 1999), which set a target of cutting the suicide mortality rate by 20% by 2010, the prevalence of suicide amongst men aged 15 to 44 in England has dropped by 21%, from 20.2 to 15.9 suicides per 100 000 population. The suicide rate has stayed fairly constant amongst women over the last 20 years (around 5 suicides per 100 000 population), with both men and women seeing a slight rise in suicide mortality since 2008, which could be related to the economic crisis (see Figure 2, from ONS Suicide Data, 2011).

30.   There are some specific groups in England that are known to be at above average risk from suicide. The groups at high risk of suicide are:

- young and middle-aged men;

- people in the care of mental health services, including inpatients;

- people with a history of self-harm;

- people in contact with the criminal justice system;

- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

2.3 Other indicators

31.   *Closing the Gap* recognises the wider determinants of mental health and wellbeing, and emphasises the critical importance of addressing inequality in mental health outcomes.

32.   Action on housing, unemployment and poverty are part of the 25 priorities, and focuses on areas where people will see progress in the next few years. For example: On housing, GBP 43 million will be allocated from the Care and Support Specialised Housing (CASSH) to support the construction of a small number of housing projects for people with mental health and learning disabilities;

- Work is underway with Time to Change to address stigma in different communities;

- New liaison and diversion schemes ensure access to mental health services for offenders;

- The Department of Health's Mandate to the NHS sets a clear objective for NHS England to improve waiting times and access and to helping people experiencing mental health to remain in and return to work. Helping people back into employment is a key priority for this Government.

33.   In 2013 the Government commissioned external advice through RAND Europe to develop proposals, which includes looking at how to get health and employment services to work better together on mental health. The report was published on 20 January 2014, and made proposals to potentially improve employment outcomes for people with common mental health conditions.

34.   In October 2013 the Government also introduced a pledge on mental health and wellbeing as part of the Government's responsibility deal with businesses and organisations. The pledge promotes workplace wellbeing for all staff, and aims to improve the provision of work related support for people with experience of mental health issues. It asks employers to promote wellbeing and resilience; support managers to recognise and respond to stress or mental health conditions; and apply practical guidance on making reasonable workplace adjustments for employees with mental illness.

Figure 3. Incidence of absenteeism and presenteeism (in %) and average absence duration (in days), by mental health status, average over 21 European OECD countries in 2010

Panel A. Sickness absence incidence

Percentage of persons who have been absent from work in the past four weeks (apart from holidays)

Panel B. Average duration of sickness absence

Average number of days absent from work in the past four weeks (of those who have been absent)

Panel C. Presenteeism incidence

Percentage of workers *not* absent in the past four weeks but who accomplished less than they would like as a result of an emotional or physical health problem

Source: OECD (2012), Sick on the Job: Myths and Realities About Mental Health and Work, Paris, OECD Publishing.

2.4 Cost to the Economy of Mental Illness

35.   The wider economic costs of mental illness in England have been estimated at GBP 105.2 billion each year. This includes direct costs of services, lost productivity at work and reduced quality of life.The cost of poor mental health to business is just over GBP 1,000 per employee per year, or almost GBP 26 billion across the UK economy (Centre for Mental Health, 2010).

36.   Disorder specific costs include: for conduct disorder, the lifetime costs of a one year cohort of children with conduct disorder (6% of the child population) has been estimated at GBP 5.2 billion; the total annual costs of depression in England in 2007 were GBP 7.5 billion, of which health service costs comprised GBP 1.7 billion and lost earnings GBP 5.8 billion (this does not include informal care or other public service costs; health service costs of anxiety disorders in 2007 were GBP 1.2 billion, and the addition of lost employment brings the total costs to GBP 8.9 billion; the total costs of schizophrenia were approximately GBP 6.7 billion in England in 2004–05.

3. Policy and governance

Note regarding terminology: given the changes that the English health system as a whole has been undergoing, especially with regards to the architecture of governance, funding distribution, and service provision in the NHS, the bodies responsible for commissioning health services will be referred to as "commissioning authorities". For periods preceding 2011, commissioning authorities should be taken to mean Primary Care Trusts, under the authority of Strategic Health Authorities. From 2012, commissioning authorities will primarily be Clinical Commissioning Groups, alongside local government (Local Authorities). For a fuller explanation of governance and commissioning in the health and mental health services, see sections 2.1 and 2.3. A full glossary is included as an annex to this report.

The Health and Social Care Act 2012 which came into effect on 1 April 2013, enacted a series of significant reforms to the NHS, including changes to the commissioning authorities with the aim of putting clinicians at the centre of commissioning. One key change that affected the entire health care system was that under the Health and Social Care Act 2012, most NHS services are commissioned by Clinical Commissioning Groups (CCGs). An autonomous NHS Commissioning Board develops and supports CCGs and holds them to account for improving outcomes for patients and getting the best value for money from the public's investment (OECD Mental Health Questionnaire England, 2012).

3.1 Governance and organisation of the health system

37.   The governance, organisation and financing of the health service in England underwent significant reform recently. The Health and Social Care Act 2012, which came into effect in 2013, changed the governance and accountability structures at primary, secondary and specialist levels in the health service.

38.   Following changes to the NHS made by the Labour government (1997-2010), health services had been managed through "Strategic Health Authorities" (SHAs) and "Primary Care Trusts" (PCTs). Primary Care Trusts commissioned and governed services for their local jurisdiction, including commissioning the services of NHS Trusts (Acute Trusts, which managed hospitals and some regional or national centres for more specialised care, Mental Health Trusts and Ambulance Trusts), and NHS Foundation Trusts. NHS Foundation Trusts, in contrast to PCTs and NHS Trusts, which were accountable to SHAs, are accountable directly to Parliament, and to the NHS independent regulator of Foundation Trusts, "Monitor". Foundation Trusts are NHS hospitals run by local managers, staff and members of the public, which tailor their services to meet the needs of the local population.

39.   All SHAs and PCTs were abolished on 1 April 2013 as part of the government's reforms of the NHS. Strategic Health Authorities were replaced and their responsibilities have been taken over by clinical commissioning groups (CCGs) and the NHS Trust Development Authority (NHS, 2013).. On April 1 2013, PCTs functions were taken over by clinical commissioning groups (CCGs) and local area teams (LATs) (NHS, 2013). They share the responsibilities of commissioning services for their local communities. CGCs, through the services that they commission, provide health care for the population, including mental health care. NHS commissioning bodies have traditionally been allowed only to commission services from public providers, principally NHS Trusts and NHS Foundation Trusts. Under the recent reforms the majority of commissioning is from public providers, principally NHS Foundation Trusts, but commissioning authorities are allowed to buy services from "Any Qualified Provider", including private and non-governmental providers. "Any Qualified Provider", which was introduced starting from April 2012, gives patients the power to choose from a list of approved service providers – NHS, private and voluntary – for care that would then be paid for by their commissioning authority (for further details see Department of Health, 2011f; Department of Health,, 2011g, NHS, 2013).

40.   There are 12 "Special Health Authorities", which provide a particular health service to the whole of England, for example the NHS Blood and Transport Authority and the National Institute of Clinical Excellence (NICE). These bodies are independent from the NHS governance system. They can be subject to ministerial direction in the same way as other NHS bodies (NHS, 2013).

41.   Some of the Department of Health budget was, under the new reforms, kept in Public Health England rather than being directed towards NHS commissioners, and some of the health budget was directed towards social care services. Public Health England is responsible for public health schemes and concerns, organised locally, for example vaccinations or initiatives to promote population wellness. These local budgets are overseen by Local Authorities (including "Health and Well-being Boards") (Local Government Association, 2013).

Figure 4. Governance, financing and service delivery reforms to the NHS following the Health and Social Care Act 2012
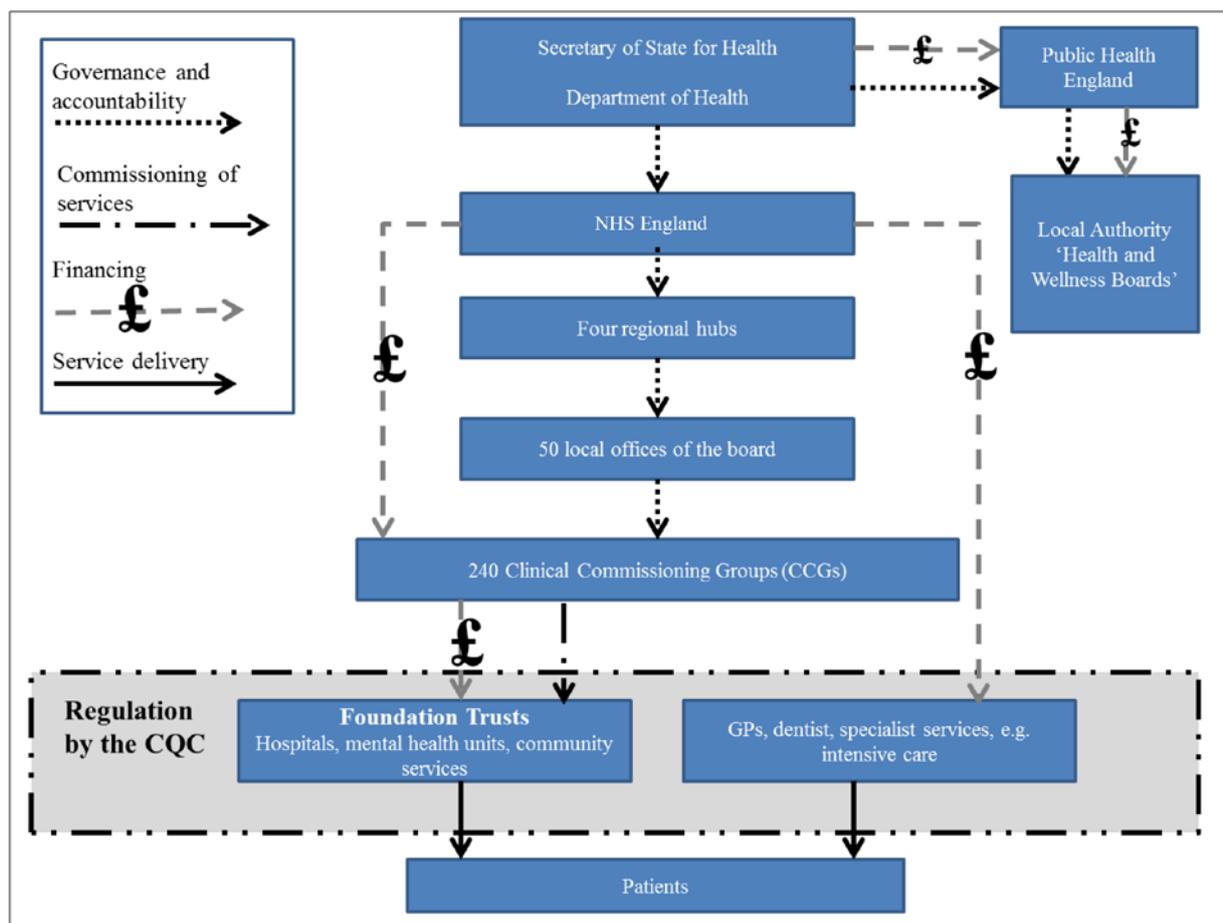
3.2 Governance structure for mental health

42.   Under the new Health and Social Care Act 2012, most NHS services, including primary care, inpatient and outpatient care, are commissioned by CCGs (OECD Mental Health Questionnaire England, 2013).

43.   From April 2013, the NHS England has been provided with funds from the Department of Health following negotiations with the Treasury for the total amount that is to be spent on all health care. NHS England devolves this money to locality-based Clinical Commissioning Groups for purchasing most services to be provided by secondary health care providers, whether in the acute sector or mental health or community services. Based on the reported level of need for mental health services within any area, there is a percentage of the total budget that should be spent on mental health services by each CCG. They are under no obligation to divide their spend according to this formula, but they have to demonstrate that through their commissioning they are achieving certain outcomes.

44. Primary mental health care is mainly provided by General Practitioners under the General Medical Services contract, with additional financial rewards under the QOF for GPs who provide certain services and meet certain targets, some of which are directly relevant to mental health care (see section 5.2). Some specialised mental health services continue to be commissioned nationally through the NHS England (OECD Mental Health Questionnaire England, 2013), including: Specialised Services for Eating Disorders; Secure / Forensic Mental Health Services; Specialised Mental Health Services for the Deaf; Gender Identity Disorder Services; Perinatal Mental Health Services (Mother and Baby Units); Complex and/or Refractory Disorder Services; Specialised Services for Asperger Syndrome and Autism Spectrum Disorder; Tier 4 Severe Personality Disorder Services; Neuropsychiatry Services; and Tier 4 Child and Adolescent Mental Health Services.

45. Secondary mental health services under the NHS are provided primarily by NHS mental health trusts (41 foundation and 17 non-foundation trusts). The Mental Health Trusts may provide services such as counselling and other psychological therapies, specialist medical care and training services for severe mental health problems, community mental health care teams, community mental health care houses and day treatment clinics (NHS, 2013). There are some specialist mental health services, which fall within local NHS or Mental Health Trusts and which provide services nationally, such as the three high-security psychiatric hospitals, Broadmoor (West London Mental Health NHS Trust), Ashworth (Mersey Care NHS Trust) and Rampton (Nottinghamshire Healthcare NHS Trust) (see section 4.5).

Box 1. Organisation and Services at South West London and St George's Mental Health NHS Trust

This Mental Health Trust provides mental health services for residents in south west London, specifically providing comprehensive mental health and social care services to the residents of Kingston, Richmond, Merton, Sutton and Wandsworth boroughs, a population of about one million people. Employing 2500 staff, the Trust has an annual budget of around GBP 170 million. The Trust also provides a number of specialist regional and national services, including services for National Deaf Services, supporting deaf people with mental health needs, a regional Eating Disorders Service, and a Behavioral Cognitive Psychotherapy Unit, which provides treatment and support for people with obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD)

The Trust is responsible for 26 Community Mental Health Teams and a number of other outreach and crisis home teams. At any one time 20 000 people are receiving treatment and care from the Trust (South West London and St George's Mental Health NHS Trust, 2014).

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46. The reforms set out above (section 3.1) affects organisation of the whole of the NHS, including mental health. The key impacts on mental health service provision are, as yet, not fully clear. There are diverse opinions both about the reforms and about their effect on mental health, with some arguments for example suggesting that GPs have considerable experience treating patients with common mental health disorders, and others pointing to widespread concern that GPs are not adequately skilled to commission for people with severe mental health problems (Lawton-Smith, 2011). The Health and Social Care Act 2012 included the involvement of other health professionals in CCGs, including hospital doctors and nurses, with scope for the involvement of NHS managers.

47. There has been renewed focus on "outcomes" under the Health and Social Care Act and the White Paper "Equity and Excellence: Liberating the NHS", specifically upon the NHS Outcome Framework, which will be a tool for management at each level in the NHS. The experience of mental health care in the NHS is included in these outcome measures, which are intended to provide a national level indication of how well the NHS is performing. Specifically, the NHS outcome indicators for mental health in the 2011/12 Outcomes Framework drew on the Community Mental Health Services Survey as an indicator of satisfaction with the mental health service experience (Department of Health, 2012a) and mortality indicators, and indicators using the Mental Health Inpatient Survey may be developed for future

frameworks. There were some minor adjustments to the Outcomes Framework for 2012/13 (Department of Health, 2011a). There were also some adjustments to the Outcomes Framework for 2013/2014 . A new indicator related to psychological therapies was introduced. The new mental health indicator was designed to measure the response to anxiety and depression disorders through the delivery of the Improving Access to Psychological Therapies programme (Department of Health, 2012a). Data are published by Public Health England (PHE) in the Public Health Outcomes Framework Data Tool at http://www.phoutcomes.info. The baseline period for the Framework is 2011, and the first official statistics release took place in November 2012 (updated in February 2013). The Framework includes a number of indicators which aim to measure progress the public health system achieved in improving mental health outcomes at local level.

3.3 Private mental health care

48.   England has a growing private health sector, which individuals can choose to access on a personal basis, perhaps using private medical insurance (OECD Mental Health Questionnaire England, 2012). Following the 2012 NHS reforms, non-NHS mental health care providers can also be commissioned directly by any of the commissioning bodies (usually a CCG or NHS England) or may be sub-contracted by an NHS provider. The Government is also committed to ensuring that patients and service users are able to choose "any qualified provider" in certain community and mental health services. It is for commissioners to decide locally which services are appropriate for this approach, following engagement with patients. Offering the choice of Any Qualified Provider (AQP) is a way of commissioning services that enables patients to choose, where appropriate, any provider, including voluntary and private sector providers, that meets the necessary quality requirements (OECD Mental Health Questionnaire England, 2012).

49.   Non-NHS providers have a strong presence in secure and forensic mental health services, learning disabilities services, and other specialised services such as eating disorders and addictions. They are also called on to provide short-term psychiatric intensive care beds (OECD Mental Health Questionnaire England, 2012).

3.4 Current mental health strategy and recent mental health policy

50.   The new mental health strategy for England, "No Health Without Mental Health", published in 2011, describes a twin track approach of combating mental ill health whilst also stressing the importance of prevention and individual and population health and well-being. This strategy stresses the need for prevention and early recognition of problems in children and their families and the importance of specialised Child and Adolescent Mental Health Services (CAMHS) (HM Government, 2011). In February 2014 the Government published *Closing the gap: priorities for essential change*, which sets out 25 areas for urgent action including:

- extending the legal right of choice to include mental health services;

- stamping out stigma and discrimination around mental health;

- helping people with mental health problems to remain in or move into work; and

- increasing access to psychological therapies.

51.   In September 2014, the Government published *Achieving Better Access to Mental Health Services by 2020*, which sets out an ambition and the immediate actions that should be undertaken during

2014-15 to achieve better access and waiting times in mental health services. GBP 40 million additional spending was identified for 2014/15 which comprises:

- an investment of GBP 7 million to end the practice of young people being admitted to mental health beds far away from where they live, or from being inappropriately admitted to adult wards; and

- an investment of GBP 33 million to support people in mental health crisis, and to boost early intervention services, that help some of the most vulnerable young people in the country to get well and stay well.

52. A further GBP 80m was allocated for 2015/16. For the first time ever this enabled the setting of access and waiting time standards in mental health services. This will include:

- Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks;

- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.

53. GBP 30 million targeted investment will help people in crisis to access effective support in A & E.

54. Starting this year, the Department of Health and NHS England will work together with mental health system partners to develop detailed proposals for the introduction of further access and waiting time standards from 2016 onwards.

Box 2. Closing the Gap

The British Government made a commitment in the Health and Social Care Act 2012 to give mental health equal priority with physical health. The document *Closing the Gap*, the new mental health action plan, sets out our priorities for essential change in mental health: 25 areas where people can expect to see and experience the fastest changes.

The document challenges:the health and social care community to move further and faster to transform care and support;

the public health community, alongside local government, to give health and wellbeing promotion and prevention the long-overdue attention it needs and deserves; and individuals and communities to shift attitudes in mental health.

Closing the Gap aimed to bridge the gap between the Government's long-term ambition and shorter-term action. It shows how changes in local service planning and delivery will make a difference, in the next two or three years to the lives of people with mental health problems.

The document is not just aimed at the health and care sector, but everyone with a role in improving mental health at a national and local level: schools identifying mental health problems sooner; employers helping people with mental health problems find employment and stay in work; health and care services commissioning intelligently, increasing access, reducing waiting times.

Closing the Gap is a companion document to the mental health strategy and its implementation framework, intended to translate the strategy's vision into specific actions. It outlines 25 priority areas where people can expect to see, and experience, the fastest changes.

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55.   'Choice' in mental health is a core part of the current mental health policy agenda in England. The Government has extended the legal rights to choice in mental health so people with mental health problems will have the same choice for their mental healthcare as they do for their physical health. From 1 April 2014, patients can choose which mental health provider and consultant-led team or team led by a named mental healthcare professional will be in charge of their care at their first outpatient appointment.

56.   Again pushing for 'parity' between mental health services and other services, the Government set out ambitions around achieving better access to services, and waiting times guarantees for services, as part of 'Achieving Better Access to Mental Health Services by 2020'. GBP 40million additional spending was identified for 2014/15 which comprises:

- An investment of GBP 7 million to end the practice of young people being admitted to mental health beds far away from where they live, or from being inappropriately admitted to adult wards; and

- An investment of GBP 33 million to support people in mental health crisis, and to boost early intervention services, that help some of the most vulnerable young people in the country to get well and stay well.

- A further GBP 80m was allocated for 2015/16, which will include enabling the setting of access and waiting time standards in mental health services. This will include:

- Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks.

- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis.

    GBP 30 million targeted investment will help people in crisis to access effective support in A & E.

57.   Starting in 2015, the Department of Health and NHS England will work together with mental health system partners to develop detailed proposals for the introduction of further access and waiting time standards from 2016 onwards.

3.5 Monitoring and good practice guidelines in the health and mental health services

NHS England

58.   NHS England (formerly the NHS Commissioning Board) is responsible for overseeing Clinical Commissioning Groups following the ongoing NHS reforms, taking on many of the responsibilities held previously by the Department of Health, Strategic Health Authorities and Primary Care Trusts (Department of Health, 2011c). NHS England oversees outcomes and the drive for improvement, whilst working as an independent, statutory body within the NHS. NHS England's key responsibilities are as follows: to provide national leadership for improving outcomes and driving up the quality of care, to oversee the operation of clinical commissioning groups, to allocate resources to clinical commissioning groups and to commission primary care and specialist services.(NHS, 2013).. In 2012/2013, NHS England had a budget of GBP 108.9 billion to deliver its mandate (NHS, 2013) . In 2013/14, it allocated GBP 65.6 billion to local health economy commissioners: that is, CCGs and local authorities (NHS, 2014a).

Monitor

59.   Monitor was established in 2004 with the inception of Foundation Trusts, as the independent regulator of FTs. It works independently, reporting directly to Parliament. It supports NHS trusts (including mental health trusts) in transitioning into FTs by determining when they reach the required standard for authorisation, and ensures they continue to comply with the licence conditions. Monitor's role significantly expanded under the Health and Social Care Act 2012. As well as financial regulation of NHS FTs, Monitor's role now includes the following:

- Regulating prices – designing a new pricing methodology – the National Tariff;

- Enabling integrated care and preventing anti-competitive behaviour;

- Supporting service continuity.

Monitor is sponsored by the Department of Health and is accountable to Parliament and the Department of Health for performance and value for money.

The Care Quality Commission (CQC)

60.   The Care Quality Commission (CQC) is the independent regulator of health and adult social care providers in England. CQC's purpose is to improve care by regulating and monitoring services. Under the Health and Social Care Act 2008 (the 2008 Act) all providers of regulated activities, including NHS and independent providers, have to register with CQC and meet a set of requirements of safety and quality.

61.   The registration requirements reflect the levels of safety and quality of care that people should be able to expect. Taken together, they form a coherent set and are built around the main risks inherent in the provision of health and adult social care services.

62.   The Government developed legislation, currently before parliament, that will put in place new fundamental standards as requirements for registration with the CQC. These standards give a clear indication to providers the level of care patients and service users must receive. Where providers fail to meet these standards CQC will be to use its enforcement powers to protect patients and service users from the risks of poor care – including prosecuting providers where a failure to meet a fundamental standard results in avoidable harm to a patient or service user, or a significant risk of such harm. The fundamental standards will come into force for all providers registered with CQC in April 2015.

63.   These fundamental standards include:

- care and treatment must be appropriate and reflect service users' needs and preferences;

- service users must be treated with dignity and respect;

- care and treatment must be provided in a safe way;

- service users must be protected from abuse and improper treatment;

- service users' nutritional and hydration needs must be met.

64.   CQC is also in the process of introducing a new inspection regime for providers. To get to the heart of peoples experiences of care, the new style inspections ask five questions of every service provider

– are they safe, caring, effective, responsive to their needs, and well led. Professor Sir Mike Richards was appointed as the first Chief Inspector of Hospitals in July 2013 and is the lead for the CQC on the regulation of all NHS Trusts and Foundation Trusts, including Mental Health Trust as well as independent providers of NHS Secondary Care contracts.

65.   The CQC is also responsible for monitoring that the powers under the Mental Health Act are being used correctly. As part of this role the CQC publishes an annual report on the Mental Health Act, including information about involuntary admissions and detentions under the Act, community treatment, patient involvement in treatment, and use of control and constraint on mental health wards.

NICE

66.   The National Institute for Health and Clinical Excellence (NICE) is the independent national organisation responsible for setting clinical guidelines establishing the quality of care that should be provided by the NHS. NICE was established in part in response to complaints that different local commissioners (PCTs) were providing different levels of services, different treatments and varying qualities of care. NICE guidelines establish the expected care, by illness or according to certain medical technologies, which should be followed across England, as well as reviewing and appraising new technology.

67.   Importantly, NICE sets guidelines on care based on calculations of the cost-benefit of a treatment, following the Quality-Adjusted Life Year (QALY) index. The QALY measure aims to assess the potential for a specific treatment according to how many years of life the treatment may provide and the level of improvement that it is expected to make in the quality of life. Based on the QALY score, the "cost per QALY year" is calculated, with NICE guidelines currently suggesting that treatments costing over GBP 30 000 per year when adjusted for QALY should not be routinely prescribed by commissioning groups. All patients across England should be provided care to a standard no lower than that set by NICE guidelines, and should have access to all medical technologies, treatments and medications approved by NICE. Any decision to provide patients with, for example, medication that is not approved by NICE under the QALY framework is currently subject to the discretion of the commissioning authority. NICE will also be responsible for developing quality standards, and has already developed some.

68.   The National Collaborating Centre for Mental Health (NCCMH), one of four collaborating centres set up by NICE, develops guidelines about the appropriate care and treatment of individuals with mental health concerns within the NHS. The guidance prepared by the NCCMH is then subject to assessment and approval by NICE. The guidelines can be used by professionals and in training, as well as by patients and their carers, and are prepared by teams consisting of health and social care professionals, lay representatives and technical experts. To date, guidelines have been published on Anxiety, Bipolar disorder, Depression in Adults and Schizophrenia, amongst other mental health disorders (for a full list of publications to date, NCCMH, 2014).

69.   NICE is furthermore charged with the development of guidance and quality standards for social care on a national scale (NICE (2014). This role, assumed by NICE in April 2013 as part of the implementation of England's Health and Social Care Act, is to be fulfilled by working together with service users and carers, practitioners and organisations involved in social care in order to produce guidance that better promotes integration between health, public health and social care services. The NICE Collaborating Centre for Social Care (NCCSC) has been established in order to develop social care guidance and provide NICE with support for the adoption and dissemination of social care guidance and quality standards. In December 2012, the Social Care Institute for Excellence (SCIE) and its partners were awarded a three-year contract in order to provide research and analysis support to the NCCSC. Amongst

the topics referred to NICE for quality standard development are autism in adults and children and the mental well-being of older people in residential care.

The Health of the Nation Outcome Scale (HoNOS)

70.   The Health of the Nation Outcome Scale (HoNOS), commissioned by the Department of Health and developed by the Royal College of Psychiatrists' Research Unit (CRU), is designed to measure the health and social functioning of people with severe mental illness. HoNOS is another key tool used in England for estimating the treatment outcomes of mental health disorders. This instrument, with 12 items for measuring behavior, impairment, symptoms and social functioning, should be used after routine clinical assessments, and should be able to test mental health care outcomes. The 12 separate items are scales for given behaviors, such as "problems with activities of daily living" and "non-accidental self-injury", and the patient's condition is marked according to their behavior on these scales. Used longitudinally, the HoNOS scales should be able to measure patient outcomes over time. In 2002, the Department of Health found that 61 trusts were using HoNOS in their services, with 5 having implemented the use of HoNOS across the whole service; most recent reports suggest that 21% of Mental Health Minimum Data Set records include HoNOS reporting (The Health and Social Care Information Centre, 2011). The HoNOS tool has also formed the basis of the Mental Health Cluster Tool, which is to be the assessment mechanism for Payment by Results (PbR) in mental health (see section 5.2).

User involvement: activities of consumer associations, family associations and other NGOs

71.   Some user groups and family associations have played important roles in mental health care and service delivery in England. For example, user and carer groups had significant input into the consultation process leading to "No Health Without Mental Health". In the foreword to "NHWMH", it is stated that the voluntary and community sectors have key roles to play, and that the concept of the "Big Society" (pursued actively by the Conservative party in England), under which citizens are to take more control over their lives and communities, is especially relevant to mental health. According to this strategy, the people who use services should be at the heart of the decision-making and governance process.

72.   Patient Voices is an umbrella organisation that brings together a number of patient representative groups across the health sector, and HealthWatch is a new government-sponsored consumer-focussed body that is due to have an increasing influence (OECD Mental Health Questionnaire England, 2012). Some large non-governmental organisations, such as Mind (http://www.mind.org.uk/), the New Savoy Partnership (/www.newsavoypartnership.org/), Mental Health Provider's Forum (http://www.mhpf.org.uk), Mental Health Foundation (http://www.mentalhealth.org.uk), Time to Change (http://www.time-to-change.org.uk) and Rethink Mental Health (http://www.rethink.org/) have been highly influential concerning the mental health agenda in England.

73.   Time to Change is England's programme to tackle the stigma and discrimination experienced by people with mental health problems and their families. The Department of Health has been funding the Time to Change campaign (GBP 16m 2011-15) which works to support and empower people to talk about their mental health problems and to tackle the discrimination they face. It includes for the first time a tailored programme of work for children and young people.

Box 3. Mental health advocacy: Mind

In 1946, the National Association for Mental Health (NAMH) was established by the merging of three mental health organisations, and its establishment coincided with the establishment of the NHS and the beginning of the welfare state. The NAMH's original aims were to foster a wider understanding of mental health throughout the community, to encourage the provision of courses and lectures to the general public, to supply information as to existing facilities, to promote the establishment of treatment and training facilities for mental health, and to provide community care for people suffering from a mental health problem. In 1971, the NAMH launched the Mind campaign to clarify its objectives and its policy. The campaign was so successful that the NAMH adopted the new name MIND – which changed again during the 1990s to become Mind.

With this new name, the Association changed its core objectives: for the first time support for patients' families was indicated as one of its statutory aims, and the principles of the organisation were rewritten to stress its lobbying activities. Many other campaigns followed the original 1971-73 campaign, leading to significant changes both in government policies including the Home from Hospital campaign – which increased information about existing housing projects and provided extra 130 group home places, and the Breakthrough! campaign – which set up Mind's Yellow Card Scheme, giving mental health service users the opportunity to report on the side effects of medications.

The current focus is on improving mental health services and addressing social exclusion, through the implementation of public campaigns such as Crisis care, Mental health at work, Time to Change, Benefits and welfare reform, Access to talking therapies, and the NHS reform (for further information see Mind, 2014) Currently active in England and Wales, today there are 170 local associations affiliated to Mind which are responsible for running housing schemes, day centres and social clubs, and carrying out many other projects both for users and carers. Mind is managed by a Council of Management, composed of 16 people – trustees, who are responsible for ensuring that Mind's activities are in line with its missions. Speaking for a diverse community, the Council of Management should have representatives from Black and minority ethnic communities and at least one representative of Wales. Mind is an independent charity organisation.

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74.   These groups represent important sources of information and support for service users; many organisations also present their own research, for example surveys of service user needs or access. Some non-governmental organisations also provide mental health services, from support group services to more regular care services for mental ill health sufferers or their carers or families.

75.   The Crisis Care Concordat, launched in February 2014, details how the Government plans to improve emergency support for people in mental health crisis across the country. It is part of a far-reaching new agreement between police, mental health trusts and paramedics. The Concordat has been signed by more than 20 national organisations in a bid to drive up standards of care for people experiencing crisis such as suicidal thoughts or significant anxiety. It aims to cut the numbers of people detained inappropriately in police cells by 50 per cent and drive out the variation in standards across the country.

4. Organisation and delivery of services

4.1 Adult mental health

76.   The English mental health care system, which operates predominantly under the National Health Service, but also under Public Health England and alongside government Local Authorities, is made up of primary and specialist care ("secondary care" and "tertiary care"), and social care. Comprehensive mental health care is also likely to include some input from social care services, both services funded and run by Public Health England and local social services run by Local Authorities. Government-funded and state-run mental health care services are sometimes supplemented by voluntary services and by private services paid for by the NHS, especially for medium and low security care (see section 3.2; section 4.3.ii). A range of private services are available to fee-paying patients or patients with private medical insurance.

Following entry into the mental health system, through a variety of routes, but most commonly through primary health care services, patients can be referred to a range of further services according to their needs.

Figure 5. Common Mental Health Care Pathway for Adults in England

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┌──────────────────────────────────────────────────────────────────────────────────┐
│                  Common Mental Health Care Pathway for Adults in England           │
│                     Psychological, social and medical interventions                │
│                                                                                    │
│          ┌──────────────────────────────┐          ┌──────────────────────┐        │
│          │       Adult Population        │◄─────────│                      │        │
│          ├──────────────────────────────┤          │      Prevention      │        │
│          │        At-Risk Groups         │◄─────────│                      │        │
│          └──────────────────────────────┘          └──────────────────────┘        │
│                                                                                    │
│  ┌───────────────┐  ┌──────────────────────────────┐  ┌──────────────────────┐     │
│  │ Primary Care  │  │    Adult Population with      │  │   Secondary Care     │     │
│  │ GP-provided   │◄─│ Emerging Symptoms and Distress│  │     Assessment       │     │
│  │ care          │  │ Referral by GP, social        │  │   - CMHT, CRHT -     │     │
│  │ IAPT          │  │ services, police, courts,     │  │  Early Intervention  │     │
│  │ Voluntary     │  │ prison service, A&E, self-    │  │      - EIPT -        │     │
│  │ Groups        │◄►│ referral to IAPT              │  │       IAPT           │     │
│  │ Social        │  ├──────────────────────────────┤──►│  Inpatient Care     │     │
│  │ Intervention  │  │    Adult Population with      │  └──────────────────────┘     │
│  │               │  │ Further Serious Distress or   │  ┌──────────────────────┐     │
│  │               │  │ Acute Symptoms                │  │   Secondary Care     │     │
│  │               │  │ Referral by GP, social        │  │  Support and         │     │
│  │               │  │ services, police, courts,     │  │  Recovery            │     │
│  │               │  │ prison service, A&E, referral │  │  Assertive Outreach  │     │
│  │               │  │ by IAPT                       │  │  Inpatient Care      │     │
│  ├───────────────┤  ├──────────────────────────────┤  │  Acute/Intensive Care│     │
│  │ Tertiary Care │  │    Adult Population with      │──►│  Supported          │     │
│  │ Specialist    │  │ Long-term (Chronic) Illness   │  │  Accommodation       │     │
│  │ Inpatient     │  ├──────────────────────────────┤  └──────────────────────┘     │
│  │ Care,         │  │    Adult Population with      │                               │
│  │ Specialist    │◄─│ Longer-term Illness +         │                               │
│  │ Services in   │  │ Long-term Risk                │                               │
│  │ the Community,│  └──────────────────────────────┘                               │
│  │ Forensic      │                                                                  │
│  │ Services      │                                                                  │
│  └───────────────┘                                                                  │
│  ┌──────────────────────────────────────────────────────────────────────────┐      │
│  │                              Recovery                                      │      │
│  │                Defined by the individual on all dimensions                 │      │
│  └──────────────────────────────────────────────────────────────────────────┘      │
└──────────────────────────────────────────────────────────────────────────────────┘
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Source: Author based on consultation and interviews with national experts.

77.   Whilst the services provided to patients typically change with a worsening of symptoms, or with the severity of their disorder (see Figure 5), the patient path through the English mental health system is not necessarily linear: primary, specialist and social services are expected to coordinate their care provision in order to ensure a comprehensive response to patients' needs. Coordination between GPs and Community Care Teams, for example, is actively encouraged, and when this coordination is working as designed this approach can be highly effective. The integration of "social" care services, for example supported housing or employment services, with "medical" mental health services, is one of the priorities, and one of the particular strengths, of the strategy set out in *No Health Without Mental Health*, *Closing the Gap* and *Achieving Better Access to Mental Health Services by 2020*.

4.2 Primary care

78.   There are multiple routes that an individual living in England might take into the mental health care system, including through the accident and emergency department of a general hospital (A&E), through the courts, prison service or the police, or via children and young person's services. The most frequent pathway, however, is through the patient's General Practitioner (GP). Furthermore, of the 29% of the population with a CMD who had used some kind of health service for a mental or emotional problem, GP services were the most commonly used (38%) (APMS, 2007). Looking at the population with other mental health disorders, and especially psychoses, GPs are still one of the most commonly used health service. Of adults with a psychotic disorder, for example, two-thirds (67%) had spoken with their GP about a mental or emotional problem in the year preceding the most recent APMS (2007). Emergency departments are also used in the case of mental health emergencies, for example people who have harmed themselves and need urgent physical healthcare, and others who have immediate mental health needs. People who have barriers to other healthcare, such as homeless people and vulnerable migrants, are more likely to go to A&E departments. Many, but not all, emergency departments have psychiatric liaison services to assess mental health needs, provide short-term treatment and support and link people into longer-term care if needed (Mind, 2011).

79.   The treatment of mental health problems in primary care varies considerably across the country (OECD Mental Health Questionnaire England, 2012). Even within a particular locality there are wide variations in the willingness of primary care practitioners to engage in the treatment of mental health. Where a commissioner has made the decision that care for those with mild to moderate mental health problems should be managed in primary care, they will have to ensure that General Practitioners are properly trained to deal with this group of patients, as psychiatry is not a compulsory part of GP training. There are also particular issues around prescribing some of the anti-psychotic drugs with guidance from the National Institute of Health and Clinical Excellence (NICE) stating that GPs should not prescribe antipsychotics for generalised anxiety disorder (Rethink Mental Illness, 2012).

80.   Depression and anxiety disorders especially, but also other mental illnesses such as eating disorders, are frequently treated by General Practitioners at a Primary Care level. In a significant number of cases where an individual contacts their GP with a mental or emotional health concern, in particular a CMD, the problem is addressed directly by the GP. An individual seeking help from their GP, for example, may be given advice or prescribed medication directly by their GP. Similarly, a GP could refer a patient to an NHS counselling service or an IAPT service (see below) or place the patient on a waiting list for an NHS counselling service. It is hoped that as IAPT becomes more established that GPs will look to refer more people on for treatment and as IAPT shows that depression and anxiety can be effectively treated that more people will come forward for treatment. In many regions, depending on the services locally and on the demands of the local population, there is a greater demand for counselling services for CMDs . The Department and NHS England's recently published five-year plan for mental health, Achieving Better Access to Mental Health Services by 2020, sets out the immediate actions this year and next to achieve better access and waiting times in mental health services. For the first time national standards for waiting times in mental health services will be set. These will include treatment within six weeks for seventy- five per cent of people referred to the Improving Access to Psychological Therapies programme, with the aim of ninety-five per cent of people being treated within eighteen weeks. However, if local government provision for counselling services is weak, a patient may be advised to contact a local private or voluntary organisation that may provide care appropriate to their needs more rapidly. Typically, a GP will refer a patient to a secondary mental health service if they consider the patient's problems to be too complex, or too serious, to be handled by themselves and counselling services alone.

81.   Even when a patient is receiving treatment or care from secondary services the GP should stay involved with the patient's mental health pathway, frequently acting as a Care Coordinator between

services, especially for patients with a "Care Programme Approach", and assuming responsibility for ongoing contact and "check-ups" for patients with severe mental health disorders (see section 4.3). Included in GP practices' quality of care objectives and incentives, as set out under the Quality Outcome Framework (QOF; see section 5.2) is the need to follow up patients with psychoses who do not attend the GP's practice for their annual review, and to present evidence that patients with psychoses have participated in routine health promotion and prevention advice appropriate to their age and health status, as well as "reward points" attributed for the number of patients who have been given, and had reviewed, their "Care Programme Approach". The QOF for GPs is being used by NICE and the NHS to define other primary care objectives for mental health and to try to influence and shape the outcomes and quality of care through this pay for performance scheme. Of the QOF indicators used by GPs in 2013/14, 10 were in the mental health domain. These indicators include, for example, the ability to register people with schizophrenia, bipolar disorder and other psychoses and a range of screenings (BMI, alcohol consumption, blood glucose) for patients with schizophrenia, bipolar disorder and other psychoses. There is also a QOF indicator for "The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate" (BMA (2014). For a full list of QoF indicators 2013/14 see BMA, 2014). For further discussion of the QOF see section 5.2.

4.3 Psychological services: Talking Therapies

82.   Over GBP 400 million is being invested over the current Government's term period to make a choice of psychological therapies available for those who need them in all parts of England. Investment will also improve provision for children and young people, older people and carers, people from Black and Minority Ethnic (BME) groups, people with long-term physical health problems and those with severe mental illness.

83.   The Department of Health's 2014-15 Mandate to NHS England makes clear that 'everyone who needs it should have timely access to evidence based services'. The Mandate sets a clear objective for NHS England to deliver the key objectives of the Improving Access to Psychological Therapies (IAPT) programme – providing access to therapies to 15% of those eligible (around 900,000 people) per year by 2015, with a recovery rate of 50%.

84.   The Outcomes Framework for the NHS in England clearly states that the NHS should carry on expanding access to psychological services as part of the IAPT programme. Since 2008 a new service has been created – which is now rolled out to every CCG. A new workforce has been trained, with 4,934 professionals trained in the first five academic years. Over 2.4 million people have entered treatment, and over 1.4 million have completed treatment. Over 1 million patients have reached recovery – and the current recovery rate is 44.8% (Quarter 4: 2013/14). Between October 2008 and March 2014, 86,723 have moved off of sick pay and benefits.

85.   The IAPT commitment is that, by end of 2014/15, IAPT services should be providing timely access to treatment for at least 15% (of those who could benefit estimated 900,000 people per annum) with a recovery rate of at least 50%. Data from quarter four 2013/14 shows a recovery rate of 44.8%, close to the intended recovery rate of 50%.

86.   Since 2008, the IAPT programme has made good progress in expanding coverage, from 3% in 2009/10 to 9.8% in 2012/13. Latest data shows that the expansion in access has slowed over the complex transition to the new health system.

Box 4. Evidence-based psychological therapies – England's experience with IAPT

The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. The programme was first targeted at people of working age but in 2010 was opened to adults of all ages.

From 2011, the programme's focus has broadened, following publication of Talking Therapies: a four-year plan of action, one of a suite of documents supporting No health without mental health, the cross-Government mental health strategy for people of all ages.

In the four years to April 2015:

- the nationwide roll-out of psychological therapy services for adults will be completed,

- a stand-alone programme for children and young people will be initiated, and

- models of care for people with long-term physical conditions, medically unexplained symptoms and severe mental illness will be developed.

Evidence shows this approach can save the NHS up to GBP 272million and the wider public sector will benefit by more than GBP 700 million.

By 31 March 2011:

- 142 of the 151 Primary Care Trusts in England had a service from this programme in at least part of their area and just over 50 per cent of the adult population had access,

- 3,660 new cognitive behavioural therapy workers had been trained, and

- over 600,000 people started treatment, over 350,000 completed it, over 120,000 moved to recovery and over 23,000 came off sick pay or benefits (between October 2008 and 31 March 2011).

The programme began in 2006 with Demonstration sites in Doncaster and Newham focusing on improving access to psychological therapies services for adults of working age. In 2007, 11 IAPT Pathfinders began to explore the specific benefits of services to vulnerable groups. The original Implementation Plan of 2008 and related documents can be view on the Department of Health website. Two important published 'stock takes' on progress were Realising the Benefits (2010), and `IAPT: 3 Year report; the First Million Patients` (2012).

Source: IAPT Programme website: http://www.iapt.nhs.uk/iapt/

4.4 Secondary care

87.   The expectation is that treatment and care for patients will be provided in the most appropriate and therapeutic environment for the patient and that acute beds should be available for those who need them (OECD Mental Health Questionnaire, 2012). Timely care and treatment is increasingly offered in the least restrictive environment and includes the provision of alternatives to psychiatric admission.

Figure 6. Numbers of patients using NHS mental health services have increased over the last decade, as rates of admitted care have fallen
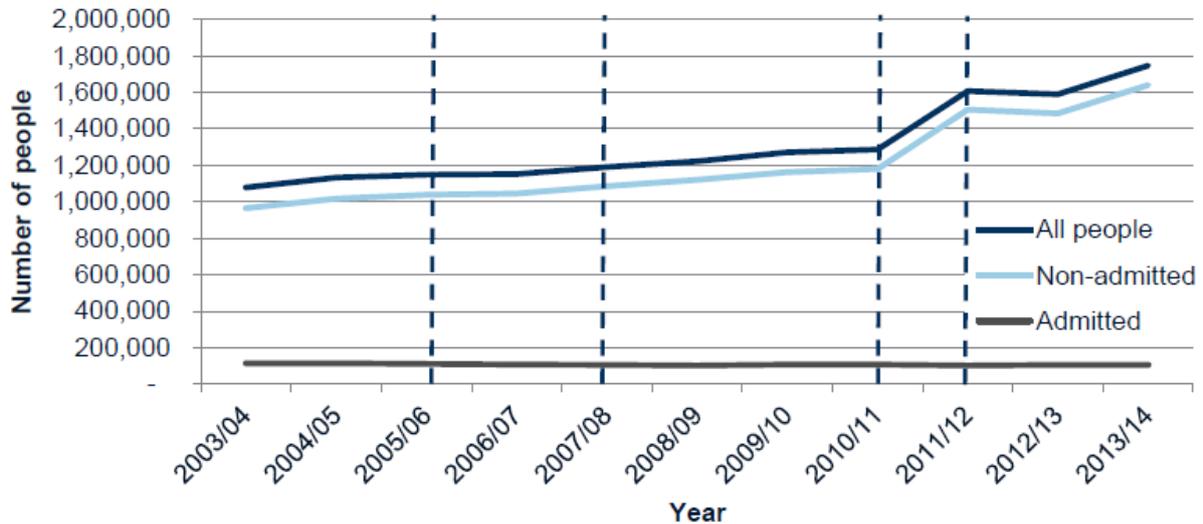

Note: "Admitted" covers patients who spent at least one day as an admitted inpatient, but who may also have received outpatient care, but are not counted in any other categories; "Only non-admitted" includes people who have had contact with outpatient or community services or a day hospital, but who did not spend any time in hospital as an inpatient; "No care" covers people who had a record with a care provider during the given year, but for whom there is no record of any care being delivered.

Source: The Health and Social Care Information Centre (2014), Annual Report from MHMDS Returns 2013-14. Available at: www.hscic.gov.uk.

4.5 Outpatient and community-based secondary care

88.   The last decade of mental health policy has emphasised improvements in community mental health care: the implementation of the NSFMH goal to improve community-based mental health care demanded considerable improvements to existing community-based services. The main aim has been to continue to keep hospital inpatient numbers to a minimum and to maximise the health system's ability to care for adult mental illness within the community. Secondary treatments that would have traditionally been delivered in a hospital or similar inpatient setting are therefore delivered in an outpatient setting.

Figure 7. Coordination of patients' care by clinical teams
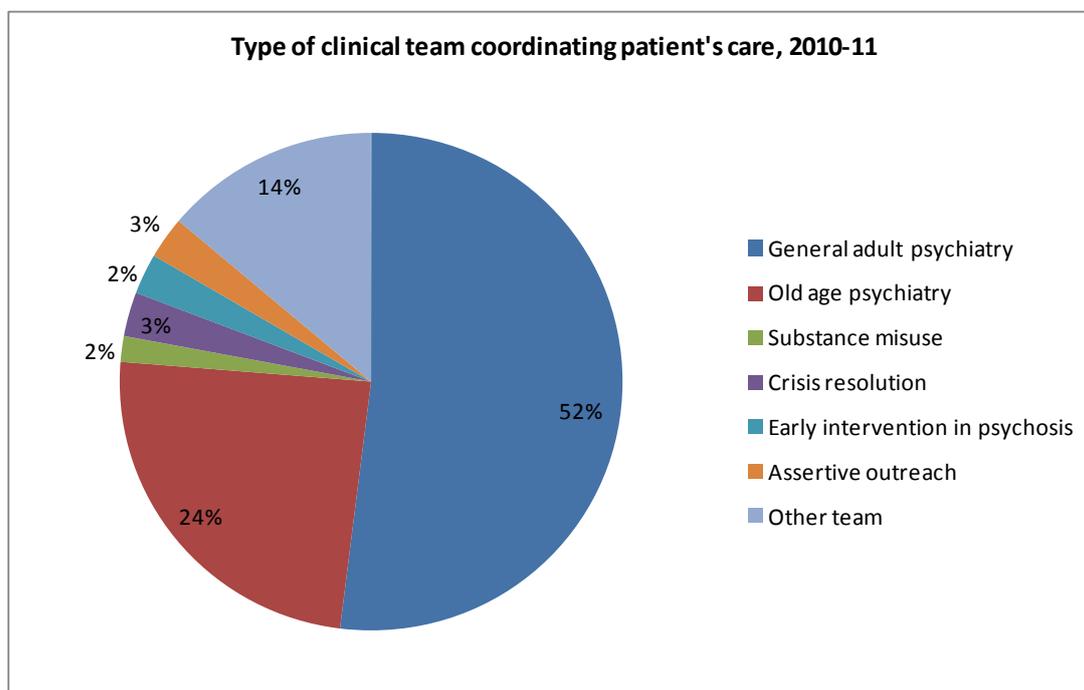
Note: General adult psychiatry services are provided though multidisciplinary teams to adults living in a certain area, often linked to the person's GP practice. The team provides a range of different treatment approaches but there is an emphasis on work in community settings, including visiting patients' homes.

Source: The Health and Social Care Information Centre (2011), MHMDS: Mental Health Minimum Dataset - Online Statistics 2003-11,

4.6 Crisis Care Concordat

89.   The mental health Crisis Care Concordat was agreed between over 20 national organisations from health and policing and launched in February. It aims to improve the responses that people in mental health crisis situations receive from services, and in particular, to keep people in mental distress, who have committed no crime, out of police cells.

90.   Since February 2014 there have been a number of achievements:

- Health, policing and local authority colleagues working together in every locality in England to develop their joint **Local Crisis Declarations**. The amount of activity from local leads on mental health and policing is unprecedented, and people are set on finding local solutions and agreements through joint action planning.

- The use of **police cells** as places of safety for people detained under the Mental Health Act reduce by 24%. (There were 7,881 cases in 2012/13, down to 6,028 cases in 2013/14) The Department is working closely with the Police to monitor further progress this year.

- **Ambulance Trusts** accept a new protocol for rapid response to people in mental health crisis. Previously, some Trusts did not treat these cases as emergencies, now all have signed up to provide initial clinical assessments within 30 minutes.

- The **Care Quality Commission** undertake a survey and mapping exercise of all hospital based places of safety, and begin to inspect mental health crisis services against many of the service standards set out in the Concordat.

- DH funded **street triage** schemes show that nurses advising police officers on people in mental health crisis can reduce detentions (data to August showed a reduction of s136 detentions of 25%) and keep these people out of police cells. The nine DH funded schemes have been joined by around 15 schemes funded by police, NHS and local authorities this year.

- The **Royal College of Psychiatrists** survey the provision of liaison psychiatry services in Emergency Departments and NHS England use this information as the basis for GBP 30m investment to be targeted in 2015/16 on the development of effective models of liaison mental health services in acute hospitals.

### 4.7 Day treatment and outpatient clinics

91.   As well as the services provided by community mental health teams, key mental health services in England are provided by outpatient clinics, community clinics and day care facilities, community mental health centre, and day clinics that operate from local hospitals or some larger GP surgeries.

4.8 Secondary inpatient care

92.   National health systems that choose to treat people in the community, such as the English mental health system aims to do, frequently commission services (such as community mental health teams) that can engage with serious mental health crises in an outpatient setting. As such, these health systems should not need to commission as many psychiatric beds as systems that choose to treat people in hospitals. Where inpatient care is considered necessary, and cannot be avoided through community care interventions, services are delivered not by stand-alone psychiatric institutions but by psychiatric wards in general hospitals and specialist acute inpatient units. Some inpatient care is provided in residential units or supported housing, and for some patients living in such a unit is an obligation under a Community Treatment Order.

93.   According to OECD data, in 2010 the United Kingdom commissioned 0.54 psychiatric beds per 1 000 people (33 803 in total), which is close to the OECD average of 0.72.

Figure 8. Number of psychiatric beds per 1 000 across the OECD, 2000 and 2011 (or nearest available year)
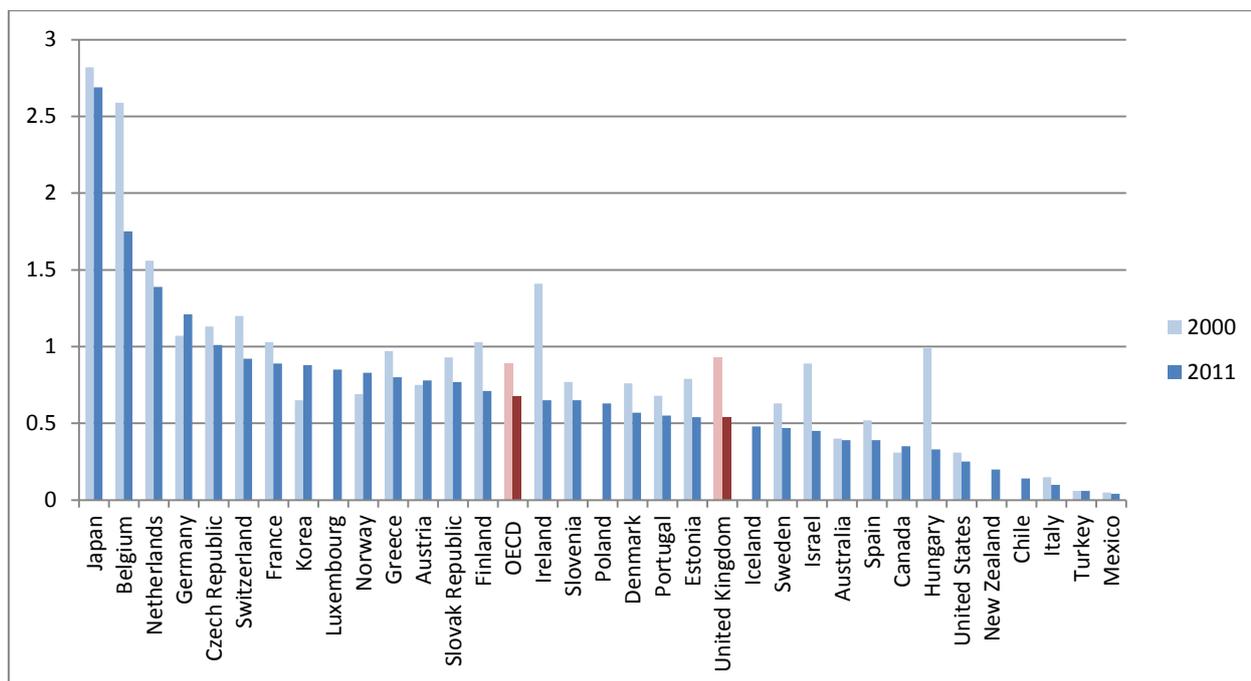
Source: OECD (2013), *OECD Health Statistics 2013*, OECD Publishing, Paris, www.oecd.org/health/healthdata.

94.   There has been significant investment in inpatient environments, with over GBP 2 billion invested in new and refurbished mental health facilities since 2001. It means that timely care and treatment is increasingly offered in the most suitable and least restrictive environment.

95.   Inpatient mental health care that is provided by the independent sector and funded by the NHS has become quite significant. It is difficult to be clear on the total number of independent beds, although Glover (2007) reports 31 940 independent sector psychiatric beds in 2001. In 2011/12, independent providers funded by the NHS provided a quite significant amount of secondary mental health care (see Table 1).

Table 1. Independent sector provision of secondary mental health services, funded by the NHS

Total number of people	Total			Admitted			Other		
	All providers of NHS funded care	*of which:* NHS providers only	*of which:* Independent providers only	All providers of NHS funded care	*of which:* NHS providers only	*of which:* Independent providers only	All providers of NHS funded care	*of which:* NHS providers only	*of which:* Independent providers only
Male	699,333	693,584	5,749	53,159	51,806	1,353	646,174	641,778	4,396
Female	878,832	872,435	6,397	47,631	46,661	970	831,201	825,774	5,427

Source: Adapted from The Health and Social Care Information Centre (2011) Mental Health Minimum Dataset (MHMDS) 2011/12 quarterly returns, available at: http://www.mhmdsonline.ic.nhs.uk, accessed 4 March 2014.

4.9 Social care co-ordination

96.   The coordination of social care, social needs, social policy and health care needs and policy is central to the current health and mental health strategies in England. Health, wellness and mental health are seen as cross-sector problems, and the integration of mental health care services with social care and support is prioritised. "No Health Without Mental Health" (HM Government, 2011) further confirms and consolidates this approach. The Health and Well-being Boards are an opportunity for joint planning between health services and social care services for individuals with complex needs, including individuals with complex mental health needs. Individuals in England with mental ill health who also need social care, for example supported housing, education programmes, training or back-to-work initiatives, will normally receive these services from their Local government Authority (LA). By far the most common accommodation services for people with mental health needs, for example, are Local Authority and registered residential care homes, and supported housing (together accounting for 82% of the provision of long-term accommodation beds for people suffering from mental illnesses), both of which are generally provided by voluntary or private organisations, but paid for by the NHS (Boyle, 2011). Accommodation needs, job-seeking approaches and employment goals, where appropriate, should form part of the Care Programme Approach. The LAs and NHS should collaborate when providing comprehensive care for those individuals who need it.

97.   The Care Programme Approach (CPA), which has been in place since 1991, should be coordinated by the patient's GP and involve relevant mental health professionals working for the social services, and should be subject to regular review. A Care Programme Approach should typically, for example, assess the adequacy of the individual's existing housing situation, and then enable appropriate coordination and information sharing, facilitated by the Care Coordinator, with the Local Authority housing service. Educational, training or employment needs should also be addressed under a CPA, as should the social care needs of any dependent children of the individual (Department of Health, 2008b). Social workers working as part of a clinical team are one of the most frequent contact points for individuals receiving mental health services in the community (see Figure 9).

98.   Some recent policies have aimed to address the employment needs of people with mental ill health (see **section 6.2.ii; see also section 4.1.i on IAPTs**), and some initiatives aim to provide social support for carers of mentally ill people in England (see section 3.5).

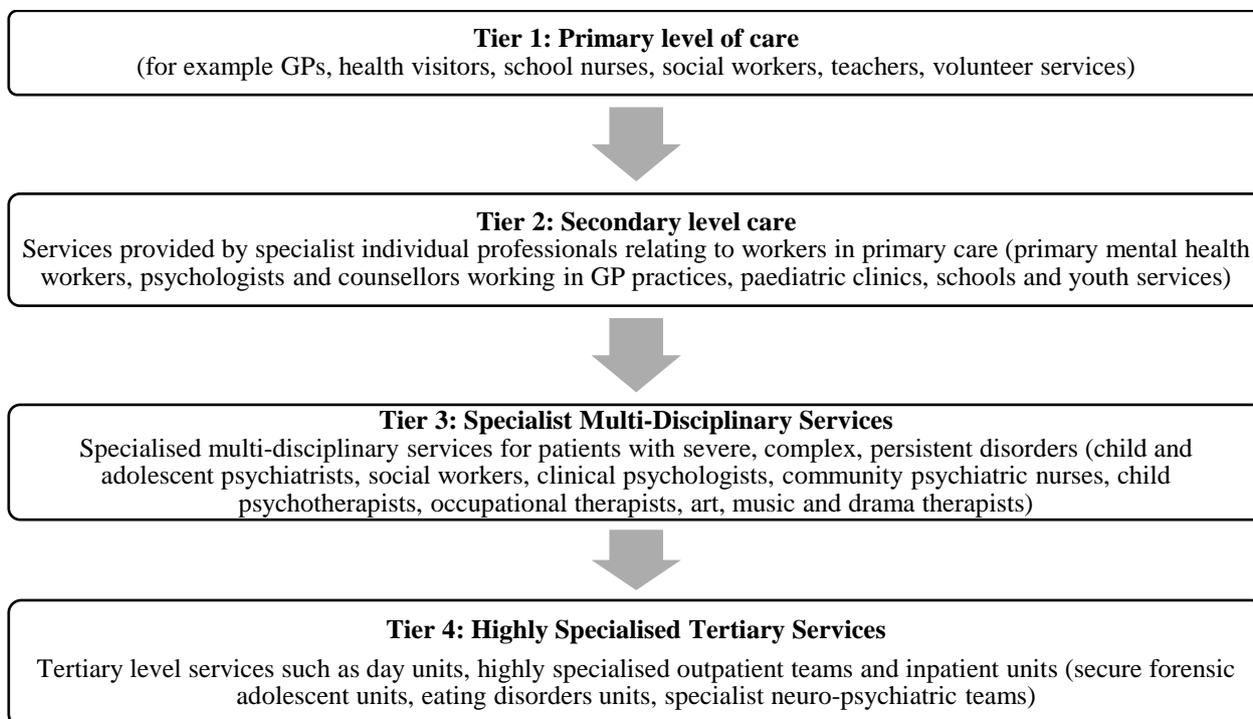*4.10 Children, adolescents and young people*

99.   The government strategy, *No Health Without Mental Health* (2010), stresses the importance of the prevention of mental ill health, and points out that nearly 50% of lifetime mental ill health, excluding dementia, is evident by age 14. Early intervention, including intervention at preschool and school age, has therefore been placed at the forefront of the current government approach to mental health.

100.   It is estimated that 9.6% of children under the age of 16 in Great Britain suffer from some mental disorder – just over 11% of boys and just fewer than 8% of girls, the majority of whom suffer from conduct disorders and anxiety disorders (ONS, Child and Adolescent Mental Health Data, 2004). The most common referral of children and adolescents into mental health services is, as for adults, through a GP (primary health care), although education services, social services and child health services also play an important role in referral and as care providers for children and adolescents. Child and Adolescent Mental Health Services (CAMHS) provide mental health care for young people under the age of 18 in England. Since 1 April 2013, NHS funded Child and Adolescent Mental Health Services are mandated to collect and submit the CAMHS Data set, including information on targeted needs, referrals to CAMHS, presenting problems and diagnoses, contacts, care planning, interventions, outcome measures and inpatient stays (The Health and Social Care Information Centre, 2014).

101.   Education services and social services play a particularly important role in detecting mental ill health in children, and later in delivering and coordinating the care provided by the CAMHS. Given young people's high levels of contact with education services, schools can be a primary point of mental health detection and care delivery. The ONS Child and Adolescent Health Data (ONS, 2004), for example, is drawn from surveys of parents, teachers and children and young people. Schools are also expected to promote good mental health for students, and remain alert to mental health concerns; NICE Public Health recommendation 12 (NICE, 2008), for example, offers guidelines on social and emotional well-being in primary education, stating that "schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed". The Targeted Mental Health in Schools (TaMHS) initiative, which ran between 2008 and 2011, was backed with GBP 60 million of funding from the Department for Children, Schools and Families. The programme aimed to tackle emotional and mental health support delivery in schools for children aged 5 to 13, and was found to have had mixed results at the end of the three-year programme. TaMHS provision was found to have led to a decrease in the onset of problems in primary aged children (aged 5-11), but not at secondary level, or for pupils who had emotional and behavioural difficulties prior to the establishment of the scheme. For further information see "Guidance on commissioning targeted mental health and emotional well-being services in schools" (Department for Education, 2010a) and "Me and My School" (Department for Education, 2010b).

102.   The mental health pathway for children and adolescent – under 18s – is broadly similar to the working age adult pathway; since the 1995 NHS Health Advisory Service's thematic review of CAMHS, it has become common to describe these services with the following four-tier framework (Wistow and Barnes, 2007):

Figure 9. Child mental health pathway

Tier 1: Primary level of care
(for example GPs, health visitors, school nurses, social workers, teachers, volunteer services)

↓

Tier 2: Secondary level care
Services provided by specialist individual professionals relating to workers in primary care (primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services)

↓

Tier 3: Specialist Multi-Disciplinary Services
Specialised multi-disciplinary services for patients with severe, complex, persistent disorders (child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists)

↓

Tier 4: Highly Specialised Tertiary Services
Tertiary level services such as day units, highly specialised outpatient teams and inpatient units (secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams)

Source: adapted by authors.

103.   Should a child or young person be referred to a specialist CAMHS service, individual cases will then be taken on by a CAMHS coordinating team. CAHMS teams are typically not mapped onto the CAMHS four-tier service provision system, but are rather categorised as Generic, Targeted, Dedicated and Tier 4 teams. The 4-tier system describes the services that should be available at different levels of need, responding to different complexities of demand, but both the affected child or adolescent and the CAMHS teams should be able to move between these tiers so that the most appropriate services are accessed and delivered.

4.11 Early Intervention

104.   Early intervention teams treat and support people between 14 and 35 years old, who are experiencing psychosis for the first time. Support from an early intervention team is for a limited amount of time, usually three years. The National Institute for Health and Care Excellence (NICE) recommends that everyone experiencing psychosis for the first time is offered early intervention services.

105.   An early intervention team comprises staff from a variety of backgrounds to meet need. Most staff will come from health or social care backgrounds and include psychiatrists, social workers, nurses, and psychologists.

106.   Access to an early intervention team usually comes through a referral.   Early intervention teams accept referrals from GPs and other mental health teams in the community. Sometimes local early intervention teams will also accept self-referrals or referrals from friends and family.

107.   People with complex needs requiring ongoing support may be placed under the Care Programme Approach (CPA). They should then receive a care plan and regular reviews. They should also get a care co-ordinator who will be responsible for overseeing their care and support.

108.   After the allotted time, if the individual sill requires mental health support , the early intervention team can refer to the local Community Mental Health Team (CMHT). Discharge may happen sooner if the person is able to manage without their support. If this happens the person will usually be discharged back to their GP.

109.   Early intervention in psychosis services produce better clinical outcomes than generic teams and are also cost-effective. Clinical gains made within such services are robust as long as the interventions are actively provided. Longer-term data show that some of these gains are lost when care is transferred back to generic teams.

4.12 Forensic services

110.   The NHS has commissioned health care for all prisoners since 2006. Prior to 2006 the Home Office commissioned prison health services. Since April 2013, NHS England has commissioned health services for all prisoners in England. Following two challenges under the Human Rights Act in 2006 and 2010, prisoners are entitled to receive the same NHS healthcare treatments as non-prisoners – known as "equivalence of care".

111.   Improving mental health outcomes for offenders is a cross-government area of work under the leadership of the Health and Justice Partnership Board. NHS England is currently rolling out the key liaison and diversion programme nationally, in police custody and at courts, identifying individuals with mental health problems, learning disabilities, PD and drug or alcohol problems.

112.   Until April 2013, Primary Care Trusts (PCTs) commissioned primary healthcare, mental health and substance misuse services in public sector prisons and in four contracted prisons with DH-allocated

funding to PCTs to commission offender healthcare services. The Health and Social Care Act 2012 abolished PCTs and transferred offender health budgets to NHS England from the beginning of April 2013.

113.   Prior to this change, healthcare in some secure accommodation was commissioned by other government bodies: NOMS for some contracted prisons; the UK Borders Agency for Immigration Removal Centres; the Youth Justice Board for Secure Children's Homes and Secure Training Centres and Police Authorities for Police Custody Suites and Sexual Assault Referral Centres). All prison and secure estate healthcare is now NHS England-commissioned, although the transfer of healthcare commissioning in police custody and in Secure Children's Homes with Welfare-Only Beds to NHS England is still in progress.

114.   As of 5 September 2014, there were 85,385 prisoners in England and Wales (male and female, all ages including young offenders aged 15-17 held in Young Offender Institutions). The Department of Health has not surveyed the incidence of prisoner mental health but considers the Office of National Statistics (ONS) 1998 survey Psychiatric Morbidity among Prisoners in England and Wales to be the most reliable data currently available. ONS reported that around 90% of adult prisoners had one or more of five mental health-related disorders - personality disorder, psychosis, neurosis, alcohol misuse and drug dependence. However, this is aggregate and self-reported data and does not identify the incidence of mental illness.

115.   The prison population contains a high proportion of very vulnerable individuals, often with underlying health problems, and many of whom have experienced negative life events such as drug/alcohol abuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

116.   *Prison Service Instruction (PSI) 74/2011 Early days in custody (PSI 74/2011)* requires that reception screening is provided before the prisoner's first night. Screening should detect immediate physical health and mental health problems and significant drug or alcohol abuse. PSI 74/2011 requires that reception screening should assess a prisoner's risk of self-harm and suicide, risk of harm to others, or risk harm from others. People with a severe mental health problem, or vulnerable to suicide, may be referred for a further mental health assessment.

117.   All prisons have on-site primary health care teams who can treat most health problems. When treatment cannot be provided in a particular prison, a prisoner may need to be transferred to another prison, or be escorted to hospital on an inpatient or outpatient basis. NHS prison mental health services are provided through 102 in-reach teams, accessible to all prisons.

118.   If a prisoner requires inpatient treatment for severe mental disorder, and meets the criteria for detention under Sections 47 and 48 of the Mental Health Act, an application is made to the Justice Secretary to authorise a transfer to secure mental health services. There are around 900 S47/48 transfers a year. Prisoners eligible for transfer to NHS psychiatric units should be moved out of prison as quickly as possible. DH issued good practice guidance to the NHS in 2011 which explains how transfers can be completed within 14 days between prison and hospital, where there is clinical need. Delays in transferring prisoners can occur e.g. when there are disagreements between clinicians about the level of care that can be provided in prisons (and the subsequent need for transfers) and the complexity of the prisoner's condition.

119.   Some offenders have mental health problems which are best managed outside the criminal justice system. In 2009, when Lord Bradley's Report into people with mental health problems or learning disabilities in the criminal justice system was published, the whole Report was accepted by the previous Government. The current Government also accepted the main thrust of the Bradley Report, which was taken forward through the Liaison and Diversion programme (led by NHS England since April 2014).

120.	The Department of Health audited progress on the Bradley Reort (Jan 2013) and reviewed all 83 recommendations. It found that some recommendations had been fully implemented, others were in progress and others were no longer policy objectives. The Bradley Report from 2009 continues to inform policy discussions between Ministers and officials from the Department and across Government, and with NHS England and stakeholder members of the Bradley Report Group. The Department of Health will consider the reports of progress and further recommendations in the 2014 The Bradley Report five years on and consider with the Ministry of Justice, Home Office and NHS England any implications for future policy development.

121.	Improving mental health outcomes for offenders being taken forward through the cross-government Health and Justice Partnerships Board and Liaison and Diversion Programme Board (LDPB). Under its Terms of Reference, the LDPB is accountable for delivery of the liaison and diversion programme and for overseeing progress across all of its component sub-programmes and projects, although NHS England commissions liaison and diversion services and has been responsible for roll-out since April 2014.

122.	Following the approval of the outline business case by HM Treasury in December 2013, NHS England has rolled out a new national Liaison and Diversion standard service specification and operating model to 10 trial schemes, serving 22% of the English population. These trial schemes will be evaluated by 2015 with an additional wave rolled out by 2015/16 which will extend coverage to 50% of the population. Following the evaluation, a full business case will be submitted to HM Treasury in autumn 2015, to obtain full approval for the roll out to cover 100% coverage of the population by 2017/18.

123.	Liaison and Diversion services operate by referring people suspecting of committing a criminal offence who are identified with having mental health, learning disabilities, substance misuse or other vulnerabilities to age-appropriate treatment and support services. Liaison and Diversion services help to join up police and courts with mental health and other services so that people in the criminal justice system with mental health problems, learning disabilities and substance misuse problems receive the treatment they need at the earliest possible stage. Liaison and diversion assessments will help magistrates and judges ensure that offenders are diverted to the most appropriate place of treatment when sentenced, including those for whom treatment in the community is clinically appropriate.

124.	The Government has committed GBP 25 million to introduce a new standard service specification of liaison and diversion services in England to identify and assess the health issues and vulnerabilities of all offenders when they first enter the criminal justice system. The 10 pilot liaison and diversion services went live on 1 April 2014 with coverage in 50 police custody suites. If the pilots are successful, the aim is to have 100% coverage by 2017.

4.13 Minority and excluded groups

Older population

125.	Conservative estimates of mental health problems in older people suggest they are widespread, occurring in about 40% of people visiting their GP, 50% of general hospital inpatients and 60% of people who live in care homes. Depression is present in about 12 to 15% of people aged over 65. It is more common in people with long-term medical conditions and can worsen outcome in a range of physical disorders. Depression can usually be treated. Dementia affects one person in 20 aged over 65 and one person in five over 80. In the next 10 years, the number of people aged over 65 will increase by 15% and the number of people aged over 85 will increase by 27%.In cost of illness studies, the direct costs of Alzheimer's disease alone exceed the combined cost of stroke, cancer and heart disease.

126.   There is much that can be done to improve the quality of life of older people with mental health problems and their carers. Health and social care service commissioners are encouraged to recognise the potential savings that can be made by taking better account of the mental health needs of older people, and how outcomes can be improved.

Minority ethnic groups

127.   The 2014-15 mandate to NHS England makes clear that everyone should have timely access to the mental health services they need.

128.   The Government's commitments to tackling inequality are set out in the mental health action plan *Closing the Gap*, as one of 25 key priorities for change in mental health, published in 2014. *Closing the Gap* recognises that people from BME communities are less likely to access psychological therapies. Work between the Government, the Department of Health, and the Mental Health Providers Forum and the Race Equality Foundation is ongoing, as part of efforts to understand these inequalities, and develop strategies to tackle them. The Government's mental health strategy *No health without mental health* underscores the importance of ensuring services meet the needs of black and minority ethnic (BME) communities.

129.   The implementation framework for the mental health strategy (July 2012) sets out clear roles and responsibilities for a range of organisations to improve mental health and well-being. This includes the Department of Health's role in tackling health inequalities and ensuring equality in mental health services.

130.   Improving Access to Psychological Therapies (IAPT) is working with a number of BME groups to promote wider access of the service to all sections of the community. A grant scheme will be shortly launched to encourage community-based interventions to increase uptake of talking therapies, including from BME groups.

131.   Part of the GBP 400 million pledged to improve access to psychological therapies will specifically help people from communities that find it difficult to access these services. NHS England is working with BME community leaders to encourage more people to use psychological therapies.

132.   In 2012/13 Time to Change, the Department of Health funded mental health anti-stigma and discrimination programme focused on working with African and Caribbean communities, ring-fencing 25% of the grants fund for work with BME communities, and build partnerships with BME organisations.

133.   The Crisis Care Concordat, launched in February 2014, details how the Government plans to improve emergency support for people in mental health crisis across the country. It is part of a far-reaching new agreement between police, mental health trusts and paramedics. The Concordat acknowledges that there are particular difficulties to achieving better mental health outcomes for people in black and minority ethnic (BME) communities.

4.14 Mental health strategic initiatives

Suicide

134.   *Preventing suicide in England: A cross-government outcomes strategy to save lives* was published on 10 September 2012 to coincide with the International Association for Suicide Prevention's World Suicide Prevention Day.

135.   The first annual report on England's cross-government suicide prevention strategy, *Preventing Suicide in England: One year On*, was published on 17 January 2014. It highlights a new agreement designed to promote greater sharing of information with friends and family of people at risk of suicide.

136.   The Mental Health Action Plan, Closing the Gap: Priorities for Essential Change in Mental Health (January 2014), sets out 25 of the most important changes that should be implemented in NHS and social care to make in the next few years to improve the lives of people with mental health problems and help reduce health inequalities.

137.   The Crisis Care Concordat, launched in February 2014, details how the Government plans to improve emergency support for people in mental health crisis across the country. It is part of a far-reaching new agreement between police, mental health trusts and paramedics. The Concordat has been signed by more than 20 national organisations in a bid to drive up standards of care for people experiencing crisis such as suicidal thoughts or significant anxiety. It aims to cut the numbers of people detained inappropriately in police cells by 50 per cent and drive out the variation in standards across the country.

138.   Over the past 10 years, good progress has been made in reducing the suicide rate in England. By 2007, suicide had fallen to the lowest rate in 150 years and there had been a marked fall in suicide in young men.

139.   There have also been substantial improvements in in-patient services. The most recent National Confidential Inquiry into Suicide and Homicide (July 2014) shows that the long-term downward trend in patient suicides continues. From 2002-2011, there was a 50% fall in the number of in-patient suicides. Since 2006, there have been more patient suicides under Crisis Resolution/Home Treatment than in in-patient care. However, the number of suicides under Crisis Resolution/Home Treatment has also fallen since 2009.

140.   Sadly, since 2007 there have been signs that the suicide rate has risen in England. 4,513 people took their own life in 2012 so suicide continues to be a major public health issue, particularly at a time of economic and employment uncertainty.

4.15 Outcomes and quality indicators

141.   Outcome and quality indicators have been integrated in many of the health and mental health strategies in England. With "recovery" and "outcomes" established as key priorities of the most recent mental health strategy, "No Health Without Mental Health", indicators and outcome measures remain important. Quality monitoring is the responsibility of the groups detailed in section 3.4, many of which produce qualitative or quantitative data.

142.   The key source of outcome and quality indicators for the NHS is the NHS Outcomes Framework, the latest version of which was published in November 2012. The current (2012) NHS Outcomes Framework establishes "increased life expectancy" and "reduced differences in life expectancy and healthy life expectancy between communities" as two high-level outcomes to be achieved across the health system.

143.   Supporting indicators will inform an understanding of progress between years, and are grouped into four domains:

- Improving the wider determinants of health;

- Health improvement;

- Health protection;

- Healthcare, public health and preventing premature mortality.

144.   Mental health is explicitly included in domains 1 and 4. A substantial change to the latest review of the NHSoutcomes framework is a more important emphasis on mental health. A new indicator related to psychological therapies was introduced. The new mental health indicator was designed to measure the response to anxiety and depression disorders through the delivery of the improving access to psychological therapies programme (NHS Outcomes Framework 2013/2014).

4.16 Mental health and work

145.   Spending on disability benefits represents a significant economic burden on the public finances of many OECD countries. On average, spending on disability benefits is equal to 2% of GDP in all OECD countries, with spending as a percentage of GDP as high as 4-5% in Norway, the Netherlands and Sweden (OECD, 2010). In the UK, mental health problems are the most common reason given for incapacity benefit claims, the primary condition in 43% of long-term health-related benefit claims (Sainsbury's Centre for Mental Health, 2007). Additionally, unemployment has been recognised as being one of the main factors contributing to the social exclusion of mentally ill people (Social Exclusion Unit, 2004), and one of the biggest reasons for people receiving sick pay and benefits (see section 2). Addressing the frequently mutually reinforcing relationship between unemployment and mental ill health is therefore seen as a financial, as well as social, priority for the current English government.

146.   The "Pathways to Work" scheme, which is available to all claimants of incapacity benefit and has the aim of helping claimants return to work, was introduced in 2004 by the previous government, under the Labour Party. This scheme established teams of personal advisers who focused solely on incapacity benefit recipients, as well as mandatory monthly work-focused meetings, a voluntary choices project that included Condition Management Programmes (cognitive education programmes to help clients manage their conditions in a working environment) and financial incentives. By 2008, the programme, which was provided by a mixture of private and voluntary providers (60%) and Jobcentre Plus (40%), covered all of England. However, this programme was closed in March and April 2011 (Dept of Work and Pensions, 2011). Despite the closure, the current Coalition Government has maintained the commitment to address the links between mental ill health and unemployment, which are set out in "No Health Without Mental Health" (2011). The Department for Work and Pensions is reforming the benefits system, and part of this will include an integrated Work Programme for benefit recipients. There are a series of people, including Work Choice, Access to Work and the pilot scheme Fit for Work Service, which are aimed at helping people with health problems or disabilities to return to work (for more details see NHWMH 2011, p. 43).

147.   The wider economic costs of mental illness in England have been estimated at GBP 105.2 billion each year. This includes direct costs of services, lost productivity at work and reduced quality of life.

148.   The cost of poor mental health to business is just over GBP 1,000 per employee per year, or almost GBP 26 billion across the UK economy. Lifetime costs of a one year cohort of children with conduct disorder (6% of the child population) has been estimated at GBP 5.2 billion. Total annual costs for depression in England in 2007 were GBP 7.5 billion, of which health service costs comprised GBP 1.7 billion and lost earnings GBP 5.8 billion. This does not include informal care or other public service costs. Health service costs of anxiety disorders in 2007 were GBP 1.2 billion. The addition of lost employment brings the total costs to GBP 8.9 billion. Schizophrenia costs were approximately GBP 6.7 billion in England in 2004–05.

149.   The expansion of talking therapies in particular the national roll-out of IAPT, is a cornerstone of the government's attempts to improve the employment rates for individuals with mental health disorders by encouraging and supporting people with mental illnesses to remain in work or return to work. For more details on IAPT, see section 4.1.

5. Organisation and delivery of financing

5.1 Financing of mental health services

150.   The NHS budget, funded by national level taxation and national insurance contributions, is set annually by the Treasury for the Department of Health, and then divided between local health care commissioning authorities, who are responsible for making the detailed decisions about spending, and commissioning the services that they judge their local population to need (Glover, 2007). NHS expenditure has risen significantly over the last 30 years: in 1980, NHS expenditure accounted for 5.6% of GDP; by 2010, expenditure had grown to 8.9% of GDP in the United Kingdom, just above the OECD average of 9.5% (OECD Health data 2012). The vast majority of mental health care and other health services, with the exception of fixed co-payments on prescriptions, is received free at the point of use and paid for by either the NHS or Local Authorities. The independent English health charity The King's Fund has estimated the direct costs of mental illness across the population in England at GBP 22.5 billion a year (McCrone *et al.*, 2008).

151.   However, direct costs underestimate the actual cost of mental illness within England. Evidence shows that approximately 30% of people living with a long-term physical health condition also have co-morbid mental health problems (Cimpean and Drake 2011). International studies suggest that co-morbid mental health problems increase the cost of care for long-term conditions by at least 45% (OECD, 2014) and go uncounted in the estimation of the NHS mental health spending. A study from the King's Fund and the Centre for Mental Health (Naylor *et al.*, 2012) suggests that, in England, between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is due to poor mental health, representing between GBP 8 and GBP 13 billion each year. Mental illness is responsible for 23% of England's total burden of disease, but receives only 13% of NHS health expenditures (Centre for Economic Performance, 2012).

152.   The NHS budget is allocated between commissioning authorities, responsible for purchasing local health services, using a set of formulae designed to split the overall budget according to population needs. These regional commissioning bodies were PCTs, but have been replaced by Clinical Commissioning Groups as part of the NHS reforms detailed in section 3.1. Following the current NHS reforms, a percentage of the health care budget is to be directed towards Public Health England, to be used by Local Authorities to commission public health services.

5.2 Provider payment mechanisms

153.   Commissioning authorities, to whom roughly 70% of NHS funding is currently directed, sign contracts with providers of health services, some of which is based on block contracts where prices are negotiated locally, and providers are paid a given amount of money regardless of the quality, quantity or variety of work they carry out (Boyle, 2011; NHS England, 2013). These block contracts were commonplace across the whole of the NHS a decade ago, but have been reformed in the last 10 years as they came to be considered poor incentivisers of efficiency, quality and case mix. Two new payment schemes, the Quality Outcomes Framework for primary care and Payment by Results for secondary care, have been introduced in the NHS in the last decade. Both these provider payment mechanisms aim to reward performance, quality of care, efficiency and good outcomes.

5.3 Primary Care - The Quality and Outcomes Framework

154.   Prior to the introduction of the Quality Outcomes Framework, GPs were paid by capitation for basic services, a payment mechanism that the government felt did not reward those who took on extra work or made their services more responsive and accessible or who successfully relieved pressures on hospitals. The Quality and Outcomes Framework (QOF) was introduced in 2004 to address these problems

(Cashin, 2014), and takes the form of an annual contract, giving bonuses to GPs and practices that meet certain outcome and quality targets.

155.   The QOF is an annual contract that provides financial bonuses to GPs who meet certain outcome and quality targets. In 2013/2014, there were a maximum of 900 points available to practices for meeting set targets; their attribution was weighted for different indicators, with practices paid an average of GBP . GBP 156.92 per point (BMA, 2013). Although uptake of the QOF contracts is voluntary for general practices, virtually all practices in England are represented by QOF contracts. For more information on QOF indicators, see section 4.1.i.

156.   From 2008, NICE, in association with several other bodies including the British Medical Association, the Department of Health and the General Practitioners Committee, has been responsible for managing the process to develop the clinical and health improvement indicators for the QOF. A potential path should be able to be traced from government policy setting, for example from "No Health Without Mental Health", which influences NICE Quality Standards, which in turn and in time can help to define QOF indicators. Mental health policy should, additionally, influence the NHS Outcomes outcomes targets and indicators set at a local level between commissioning groups and secondary and other care providers.

157.   Given that there has not actually been a comprehensive time series established, nor a control group evaluation of the QOF, it is hard to tell conclusively what effect this scheme has had on GP activity (Cashin., 2014). One observation that can be drawn from reports on the QOF is that, of the cases that GPs are allowed to exclude from their performance results data under certain conditions (see The NHS Information Centre, 2010), effective exception rates indicate that GPs are excluding a higher proportion of mental health patients than other major health groups (the effective exception rate for patients with mental health needs was 10.4 in 2010/11, compared to rates of 1.6, 5.5 and 6.5 for cancer, asthma and diabetes patients, NHS Information Centre 2011). This could suggest that the high level of points attributed to GPs for mental health services successfully rendered encourages patient selection and the deliberate exclusion of more difficult cases from the data. Concerns have also been expressed that GPs are directing attention away from activity not rewarded by the QOF, and as such care delivery quality is declining in some areas (Cashin, 2014).

158.   In June 2011, there were concerns raised about the depression indicators and their incentive to improve diagnoses of depression: the QOF indicators included incentives to follow up assessments and depression checks following diagnoses, and to perform depression screening for patients on the diabetes register, but they offer no incentives for increasing or improving depression screening across patients. It could be argued, therefore, that the QOF indicators as they stand present GPs with a perverse incentive to not increase screening or depression diagnoses, as this would increase the follow-up and the severity assessments and screening required to meet the QOF targets. In 2013/2014, there are two indicators for depression - the percentage of adult patients with a new diagnosis of depression that have had a bio-psychosocial assessment by the point of diagnosis (DEP001) and the percentage of patients with depression reviewed patients between 10-35 days after initial diagnosis (DEP002). For a list of the 2013/2014 indicators, see (BMA, 2014).

5.4 Payment by Results (PbR)

159.   Payment by Results (PbR) has been used since 2004 as a key provider payment mechanism in secondary care. Across the UK, hospitals are reimbursed for activity undertaken according to nationally set averages. Reimbursement for treatment and diagnoses is set according to different pricing clusters, and service providers negotiate contracts with their local commissioning authority, and then are paid by the services they go on to deliver. The tariffs for PbR vary according to the complexity of the treatment and are also adjusted for the relative cost, depending on the location (in London where the cost of labour is

higher, for example, PbR payments are increased from the national tariff), and are published every year. For the 2010-2011 tariffs, see "Payment by Results Guidance for 2010-11" (Department of Health, 2010); for the 2011-12 tariffs, see "Payment by Results Guidance for 2011-12" (Department of Health, 2011e); for the 2012-13 tariffs, see "Payment by Results Guidance for 2012-2013" (Department of Health, 2012b), for the 2013-2014 tariffs, see "Payment by Results in the NHS : Tariff for 2013-2014" (Department of Health, 2013a).

160.   PbR was designed to "unbundle" secondary treatments and give patients a greater choice of service provider: rather than receiving all of their treatment and care from a single provider, payment by procedure or by different treatment stages under PbR means that patients should be able to receive different treatments from different providers. Although not the only source of income for service providers, PbR represents over 50% of income for the average acute hospital. For an in-depth introduction to Payment by Results, see "A simple guide to Payment by Results" (Department of Health, 2010a).

161.   Implementing a national payment system for mental health is understood to be a key enabler to achieving parity of esteem between mental and physical health, and is expected to help drive up the quality of mental health services. A national payment system for mental health would enable better commissioning and more efficient services by incentivising the provision of services that achieve the best outcomes for patients. A national payment system for mental health would ensure the best services, that deliver the highest quality with best outcomes, receive the most funding.

162.   A new national payment system for mental health began to be introduced from 2012. Many adults receiving care are allocated to a mental health cluster based on their need; services are then tailored according to the needs of the people they treat. In some local health economies, clusters are also used as the basis of payment replacing a system of block payment arrangements, based on historical funding rather than current service provision.

163.   There are 21 clusters, each describing a group of people with similar characteristics. Patients are assessed periodically to monitor their changing needs and re-allocated to a cluster if required. *Closing the Gap: Priorities for essential change in mental health* includes a commitment to continue to develop a national payment system for mental health. NHS England and Monitor are responsible for setting the national tariff arrangements for acute and non-acute .

6. Discussion, innovative practices and conclusion

164.   England, and the United Kingdom, have for some time been at the forefront of evolution and change in the organisation of mental health systems, and ways of delivering mental health care. England was one of the first countries to begin the process of closing psychiatric asylums, and centring mental health care around care in the community. While this process has not been without its own challenges, the mental health system in England today seeks to offer a comprehensive range of services – from primary through to specialist tertiary care, for adults and children – which are delivered in community settings.

165.   Nonetheless, concerns about access to services, availability, and quality for mental health remain a real challenge in England, and demand innovative thinking, political commitment, and commitment of appropriate resources.

166.   England has continued to be an innovator in the field of mental health, and there are several dimensions of mental health care provision discussed in this paper which merit being highlighted for attention by other OECD countries:

- The introduction of measures of outcome and quality for mental health, under the NHS Outcomes Framework, which aims to inform an understanding of progress year-on-year;

- The Improving Access to Psychological Therapies (IAPT) programme, which has made a standardised, evidence-based model of talking therapy available nationally;

- Developing new payment systems for mental health services to encourage quality gains and value-for-money, using 'care clusters' as an adapted form of the PbR tariffs.

167.   The ambitious mental health action plan, *Closing the gap: priorities for essential change,* and the five-year plan *Achieving Better Access to Mental Health Services by 2020*, should set the system on a course towards improving choice, access to services, coordination of care, and tackling stigma. The pledge, announced in 2014, to introduce waiting times standards for mental health services, is an extremely interesting development, both for professionals and service users in England, and in an international context. If political commitment to mental health care improvement continues, and so long as tight resources across the public sector in England do not squeeze spending on mental health too hard, England can be expected to continue as a mental health system from which other OECD countries can learn.

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