Public Mental Health
Implementation Centre

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

HEALTH INEQUALITIES BRIEFING PACK

Quick guides to public mental health and health inequalities

Contents

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Introduction

This briefing pack contains a series of quick guides to topics that are relevant to public mental health and health inequalities. It supports the implementation of population-based approaches in healthcare, public health and across sectors.

Public mental health is 'the art and science of improving mental health and wellbeing, and preventing mental illness[a] through the organised efforts and informed choices of society, organisations, public and private, communities and individuals'[1].

Addressing the implementation gap in treatment of mental health conditions, prevention of associated impacts, prevention of mental health problems, and promotion of mental wellbeing and resilience are central to public mental health.

Audience

This briefing pack is aimed at the following audiences:

- integrated care boards (ICBs)[a]
- primary care
- public health
- clinical staff
- leaders in mental health settings.

Each section provides background information plus the actions that ICBs, trusts and clinicians can take to address the impacts of health inequalities on treatment and outcomes, across the health care and public health sectors.

The Public Mental Health Implementation Centre (PMHIC) define public mental health as including five key elements:

1. **population approach**
2. **addressing the implementation gap**
3. **targeting inequalities and higher risk groups**
4. **coordinated approaches**
5. **involvement of people and organisations[2]**

a See the Glossary for definitions of mental illness and ICBs.

Overarching themes

Each topic in this pack was written with the intention that it could be read independently of the other topics. However, there are some overarching themes relevant to all aspects of public mental health.

Using data in a population approach to mental health

A public mental health approach involves considering needs, challenges and solutions at a population level. This differs from traditional clinical ways of working, which tend to focus on individual people. To understand population- or community-level needs and challenges, we need to use data and insights.

Data quality can vary, and it's important to think about the limitations of the data we use and what might be missing. By asking about and using data, we can identify where data quality needs to improve and support this to happen. Quality improvement (QI) and research teams will be vital in trying new approaches. Data should be considered when evaluating any interventions that are put in place. Metrics should be considered and identified at the beginning of any project, to ensure that the required data is collected.

What types of data are there?

The data may be quantitative or qualitative.

Quantitative data is numbers- based, and refers to things which can be counted (for example, the number of people who attend their appointment each month).

Qualitative data is information about people's characteristics or qualities that is not measured with numbers. It can help us understand why or how something happens, and how that affects people (for example, feedback from a community organisation about why some people are unable to attend appointments).

Where can the data be obtained from?

Data are available from a range of sources and at different levels, including national, regional and local. Choose a data source that is appropriate for the question you are trying to answer. Using national data sources can help to avoid duplication on a regional or local level, particularly for quantitative data. It is recommended to use national data sources whenever possible, before considering regional and then local data sources.

Examples of sources of national data are mental health reports from NHS England or NHS Futures, data from the Office for National Statistics (ONS), reports from the Centre for Mental health and data from the Office for Health Improvement and Disparities (OHID) Fingertips.

Examples of regional data sources are NHS Futures' regional pages and ICB data.

Examples of local data include provider data and place-based data. For qualitative data, local insights and place-based information-gathering can add great value.

Targeting inequalities and higher risk groups

Health inequalities are 'unfair and avoidable differences in health across the population, and between different groups within society'[3]. Such differences include how long people are likely to live and for how many years of their life they live in good health.

Socioeconomic inequalities drive health inequalities and increase the risk of mental health conditions. In turn, mental health conditions contribute to deepening socioeconomic inequalities.

Our health and wellbeing, as well as our experiences of health inequalities, are all influenced by the conditions in which we are born, grow, live, work and age, including factors such as housing, employment and education. All these broader influences are referred to as the wider determinants of health (see Figure 1).

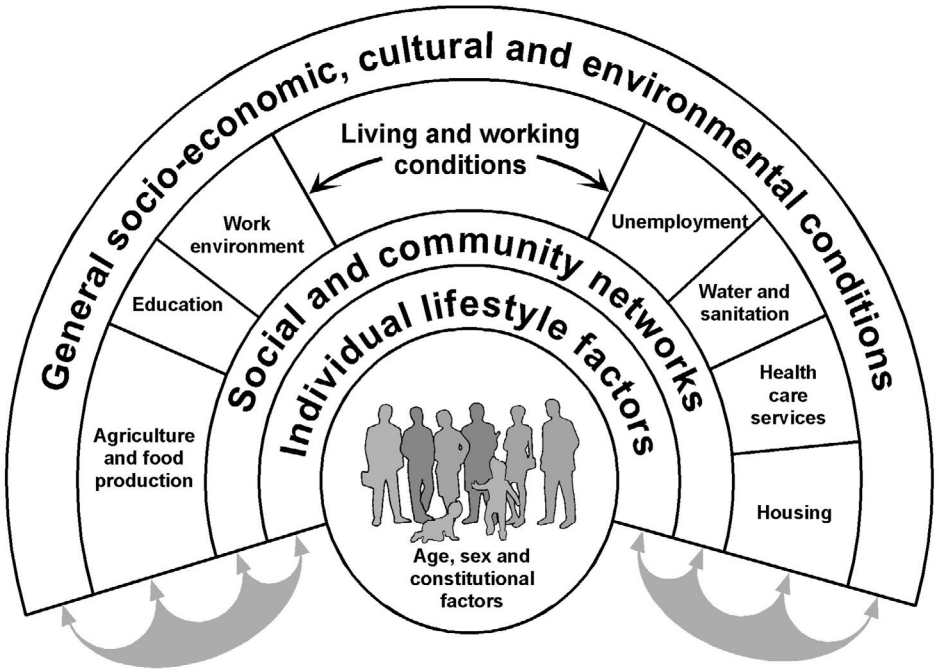


Figure 1: Wider determinants of health. Source: Dahlgren and Whitehead, 1991[4].

Some groups and communities are more likely to experience poor health than others; for example, people living in more deprived areas, those from Black, Asian and minoritised ethnic communities, and those experiencing homelessness. Intersectionality is an approach that helps us to understand that health and health inequalities are shaped by multiple overlapping factors, and that wider determinants are often interlinked. For example, someone experiencing homelessness will find it more difficult to access healthcare and healthy food. When that person is a woman, they will also have a different experience than a man.

Coordinated approaches

We all have a role to play in improving health and taking public mental health actions[5]. In doing so, we must remember that mental health organisations and their staff are part of a wider system. Systems leadership is important, with leaders across the system needing to work together to understand the value of mental health, consider it in all policy decisions and hold each other to account in taking action.

Mental health services and organisations do not bear all the power or responsibility in public mental health. This document sets out what may be within the sphere of control of NHS mental health services and their staff. However, it is important to recognise that many public health actions lie within other sectors, which we may be able to work alongside or support.

Involvement of people and organisations

Compassionate culture in staffing

Compassionate culture in a workplace promotes ***'a sense of collective compassion – by supporting noticing, feeling and acting on the suffering of others at the workplace'***[6]. Such a culture can result in improved staff productivity, performance and job satisfaction.

We know that many staff employed by the NHS are also likely facing a range of inequalities. Therefore, fostering a compassionate culture in the workplace can enable staff to feel supported and acknowledge any problems they may be facing. Also, there are clear links between staff experience and patient outcomes. The higher the levels of satisfaction and commitment that staff report, the higher the levels of satisfaction that patients report.

Positive, supportive environments for staff create caring, supportive environments for patients, and deliver high-quality care. Such leadership cultures encourage staff engagement.

Fostering a compassionate culture is an enabler to undertaking any work relating to tackling healthcare inequalities. There are a range of initiatives that can be undertaken to encourage compassion in the workplace. For example:

- Regularly undertaking a cultural review to understand how to improve working environments so that all staff can thrive[7]:
  - To embed a consistent experience for staff, cultural reviews are best undertaken in collaboration with system partners and peers. This allows a more practical and structured approach to understanding culture, the perspectives of the NHS workforce, patients and partners, and to support targeted and relevant action.

- The NHS Culture and Leadership Programme provides a well-established tool and evidence base that NHS systems can use to conduct cultural reviews.
- Ensuring senior leaders undertake compassionate leadership training.
- Embedding compassionate cultures and compassionate leadership into trusts' vision/objectives/strategies/policies/processes.
- Freedom to speak-up initiatives.
- Regular staff engagement/listening events.
- Adhering to the actions in Our NHS People Promise.

Workforce capacity building

To embed public mental health approaches that impact on health and wellbeing, we need a workforce with the skills, knowledge and capacity to support health and wellbeing. The workforce needs to have confidence in their ability to improve mental and physical health, and be able to apply knowledge, skills and values effectively in practice[8].

The national Mental Health and Wellbeing Plan discussion paper[9] outlines a need for early mental health support with signposting provided in settings where the right staff training and interventions can make a difference. It also outlines the need for better integration between mental health care and wider services including housing and social support[9].

Some initiatives to support the building of workforce capacity include:

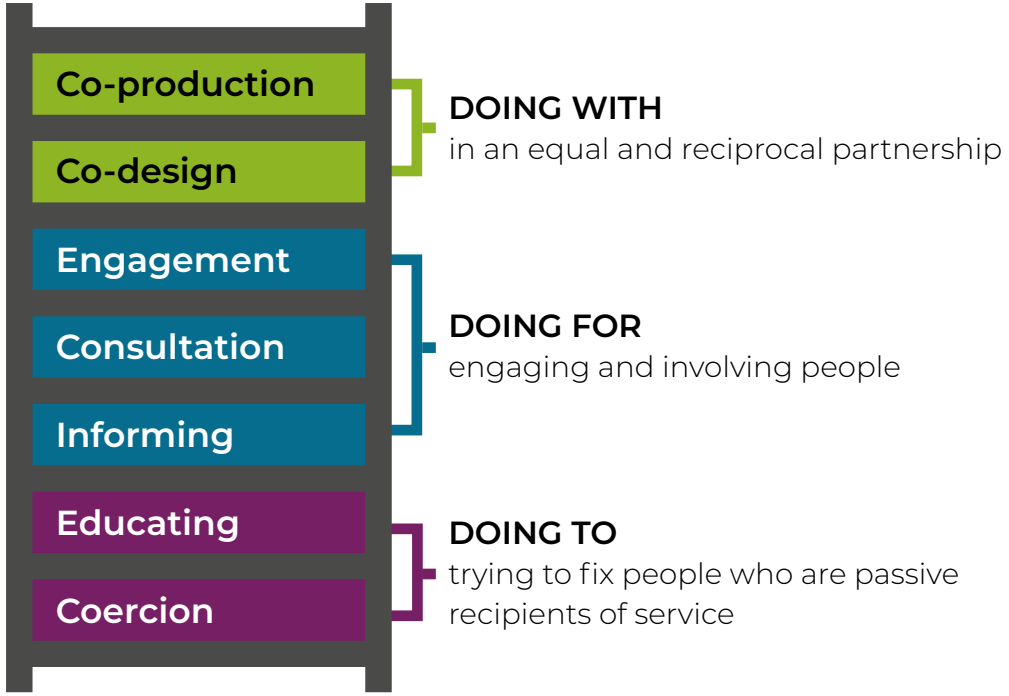
- Senior leadership advocate for the mental health of citizens as a valuable resource for thriving communities and economies[8].
- NHS England's GIRFT (Getting it Right the First Time) programme.
- Embed a MECC (Making Every Contact Count) approach. This Public Health England and NHS England approach uses behavioural science principles to support conversations about health and wellbeing that include information sharing and appropriate signposting.
- Offer placements to temporarily impact on workforce capacity. This might include public health registrars, project management trainees and university students (for example, healthcare courses).

Co-production and engaging with communities

Local Government Association describe co-production as ***'an equal relationship between people who use services and the people responsible for services. They work together, from design to delivery, sharing strategic decision-making about policies as well as decisions about the best way to deliver services'*** [10,b]. It's important to recognise that while approaches such as engagement and co-design can be valuable for gaining people's views and ideas, co-production allows power to be shared more equally and allows patients to have a more active role in the entire process (see Figure 2).

There are a number of benefits to a co-production approach. True co-production helps provide more effective services through better understanding of users' needs. It facilitates a strengths-based approach in which people using services are recognised as assets, and have the opportunity to be heard, involved and valued.

See also the Culture of Care programme's Co-production Guidance for Wards.



Diversity and inclusion in co-production

Co-production must address diversity and inclusion issues

When first bringing together co-production groups, the protected characteristics of members of the groups should be considered

Figure 2: The ladder of co-production. Reproduced with permission from Think Local Act Personal[11].

b See the Glossary for a definition of co-production.

Some possible approaches to facilitate co-production within mental health trusts are:

- To employ a **dedicated co-production lead**.
- **To train staff in co-production**, to embed learning across all aspects of the trust's work, including:
  - QI
  - evaluations of interventions
  - evaluations of services
  - resource development
  - service design, and so on.
- To have a **clear trust-level commitment to co-production**, for example through a co-production strategy or framework, and dedicated reward and recognition policies, to ensure consistent processes when working with people with lived experience[c].

See also the References and useful resources

c See the Glossary for a definition of lived experience.

Anchor institutions

Why do anchor institutions matter?

Anchor institutions are ***'large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have significant influence on the health and wellbeing of communities'***[1].

NHS trusts are often referred to as anchor institutions, but how can they positively influence the social, economic and environmental conditions in the area, to support the health and wellbeing of the local people and communities?

See Figure 3 for an infographic on what makes the NHS an anchor institution.

What are the impacts?

By choosing to invest in and work with local organisations, communities and people, the NHS can further contribute to the reduction in health inequalities. For example, offering apprenticeships to local young people and people with learning disabilities can give them work experience that enables them to apply for other jobs in the NHS.

What can trusts do?

- Offer employment, apprenticeships and work placements to local people.
- Develop a Green Plan which commits to reducing the environmental impact of the organisation.
- Have processes in place to ensure that some estates and facilities can be used by local communities for free or at subsidised rates.
- Build relationships with partners and local communities to understand local needs and to enable collaboration to support areas of need.
- Join the Health Anchors Learning Network[2] for ideas on how to get started as a health anchor institute, and for additional resources and support.

What can ICBs do?

- Adding a social value focus into the procurement process, to support local and more sustainable, ethical procurement and/or encourage other organisations to 'give back' to local communities.
- Provide targeted training for procurement teams, managers and relevant staff on integrating social value, sustainability and health equity into their work.
- Set up an Anchor Group in the trust, with a formal governance structure, to bring together health inequalities, sustainability, procurement and employment opportunities.
- Establish parameters for monitoring and evaluating the outcomes of Anchor Group initiatives, with regular reporting to stakeholders to ensure continuous improvement.
- Pay employees the Real Living Wage[3].

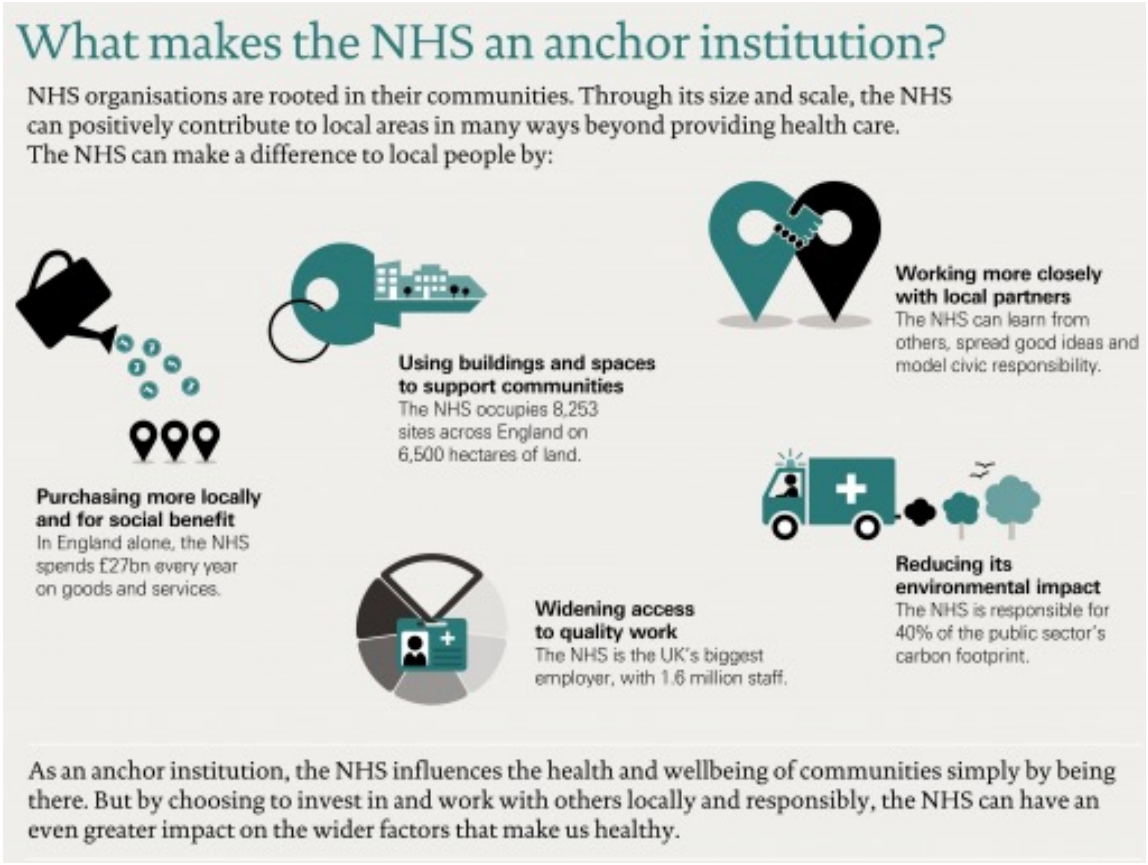


Figure 3: Infographic on what makes the NHS an anchor institution. © 2019 The Health Foundation[1].

See also the References and useful resources

Core20PLUS5 (adults)

Why does Core20PLUS5 matter?

Healthcare inequalities are widening across the UK, and were exacerbated by the coronavirus (COVID-19) pandemic. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level[1,d].

What is Core20PLUS5?

The approach defines a target population – the Core20PLUS.

'Core20' refers to the 20% of the national population who are most deprived, as identified by the indices of multiple deprivation (IMD)[2,c].

'PLUS' refers to population groups (locally identified) who experience poorer-than-average health access, experience and/or outcomes, who may not be identified in the Core20 and/or would benefit from a tailored healthcare approach; for example, inclusion health groups such as those experiencing homelessness.

'5' refers to five clinical areas of focus:

1. maternity
2. severe mental illness (SMI) – see section on Core20PLUS5 (adults with SMI)
3. chronic respiratory disease
4. early cancer diagnosis
5. hypertension case finding and optimal management and lipid optimal management.

Also, smoking cessation has been highlighted because it positively impacts all five areas.

d See the Glossary for a definition of the IMD.

What are the impacts?

Core20PLUS target populations have higher rates of mental health problems. People who need access to mental health services are more likely to be from Core20PLUS target populations.

What can ICBs and trusts do?

- Use the Core20PLUS5 framework to guide and prioritise health inequalities work in mental health care and primary care, to support the reduction in health inequalities.
- Develop areas of work that focus on Core20PLUS populations, and consider the five key clinical areas – particularly the impacts on SMI and smoking cessation initiatives.
- Invest at scale in psychological support alongside programmes for long-term conditions.
- Ensure the information we provide on screening, self-care and treatment is fully accessible to the communities that are impacted by the highest levels of inequality.
- Look at waiting lists through an inequalities lens, considering where need is greatest[3].

Actions for ICBs and trusts

- Use data and local intelligence to:
  - identify the Core20PLUS target populations
  - understand what mental health inequalities exist within those target populations.
- Address information governance barriers to linking data across systems to provide a full profile of physical and mental health need to support a population health approach.
- Ensure Core20PLUS5 is referenced in relevant policies and procedures as a framework for reducing health inequalities across all mental health service pathways.

- Educate/train staff on health inequalities so they understand the potential impact these may have on mental health and can advocate for the need to make reasonable adjustments to ensure accessible healthcare.
- Partnership working, considering:
  - in-reach/out-reach multidisciplinary working
  - joint assessment and planning across specialities
  - joint roles.
- Co-production of approaches, with people from Core20PLUS5 populations.

See also the References and useful resources

Core20PLUS5 (adults with SMI)

Why does CorePLUS5 and SMI matter?

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level[1]. See the section Core20PLUS5 (adults) for more information[e].

This section refers to one of the five key clinical areas of focus: SMI. It involves ensuring that annual physical health checks for people with SMI meet at least the nationally set targets.

People with SMI are more likely to have poor physical health[2] and higher premature mortality than the general population, dying on average 15–20 years earlier[3]. It is estimated that for people with SMI, two in three deaths are from physical illnesses that can be prevented[4] (for example, cardiovascular disease, respiratory disease, diabetes and hypertension[5]).

People with SMI die on average

15–20 years earlier

What are the impacts?

Drivers of these inequalities are multifactorial. People living in more deprived areas have a higher prevalence of SMI and people with SMI living in more deprived areas have a higher prevalence of physical health conditions[6]. Deprivation is associated with an increased prevalence of factors that negatively impact health, such as stress and anxiety, obesity, smoking, excess alcohol intake, lack of physical activity and so on.

What can ICBs and trusts do to help?

- Use the Core20PLUS5 framework to guide and prioritise health inequalities work in mental health care and primary care, to support the reduction in health inequalities.

e Also see the Glossary for a definition of the Core20PLUS5.

- Focus on ensuring annual physical health checks for people with SMI to meet at least the nationally set targets, as stated in the Core20PLUS5 framework.
- Adopt a holistic approach to treating both physical and mental health.
- Develop areas of work which focus on physical health of people with SMI including smoking cessation and weight management initiatives.
- Use data and local intelligence to collect data and identify what mental and physical health inequalities exist for people with SMI.
- Address information governance barriers to linking data across systems to provide a full profile of physical and mental health need to support a population health approach.
- Educate/train staff on the physical health inequalities for people with SMI so they understand the potential impact these may have and can advocate for the need to make reasonable adjustments to ensure accessible health care.
    - Ensure staff are educated on their responsibilities for monitoring physical health and their role in supporting good physical health for all patients. Examples include:
        - staff completing the Physical health competency framework for mental health and learning disability settings[7].
        - holistic approaches with integrated physical and mental health care (for example, primary care, general nurses, advanced clinical practitioners and other allied health professionals working with forensic psychiatry units in Humber).
- Provide education and information to patients about the need for physical health monitoring, including how often they should have it and how they can access it.
- Partnership working, considering:
    - in-reach/out-reach multidisciplinary working
    - joint assessment and planning across specialities
    - joint roles
    - in-reach and out-reach provision.

What can clinicians do to help?

- Provide education and information to patients about the need for physical health monitoring, including how often they should have it and how they can access it.
- Encourage patients and their partners/families to increase the self-management of their physical healthcare:
  - Can they access test results and medical appointment times through the NHS England's Patient Knows Best patient healthcare information system?
- Identify barriers to attending for screening:
  - Patients with a history of trauma may need support to attend for some cancer screening due to the nature of these procedures (cervical cancer screening). Clinicians can talk to other clinicians to make these processes work for shared patients.

See also the References and useful resources

Criminal justice

Why does criminal justice matter?

People with mental health problems, learning disabilities and neurodevelopmental conditions are disproportionately involved in the criminal justice system, despite being no more likely to commit a crime. Additionally, these conditions are highly prevalent among individuals within the system, with prevalence of 25–50%, depending on the specific criminal justice setting.

The incidence of self-harm and suicidal thoughts in people in the criminal justice system is also high, with 16% currently experiencing suicidal thoughts and 86% having lifetime experience of self-harm or suicide attempts. This means that people using mental health services may have experience of the criminal justice system.

25–50%

prevalence of mental health problems, learning disabilities and neurodevelopmental conditions in the criminal justice system

What are the impacts?

- Trauma, especially in early childhood[f], can raise the risk that a person engages in activities that will result in arrest and/or imprisonment, including harmful use of alcohol or illicit substances.
- People from minoritised ethnic communities are proportionally more likely to have mental health problems, and also to be in contact with the criminal justice system.

f See also the Glossary definition of ACEs.

- Gender imbalances, with female prisoners far more likely to report a common mental health problem (76% in remand settings) than males (40% in remand settings).
- Physical and mental health are intimately linked, and people linked to the criminal justice system have reduced access to physical health care, which impacts their mental health.
- The wider determinants of health (such as poverty, poor housing, and low levels of education and employment) are drivers for poor mental health and wellbeing, as well as for increased incidence of criminal activity.
- Without proper treatment and support, there is a higher likelihood of reoffending, perpetuating a cycle of involvement in the criminal justice system.
- People with mental health problems in the criminal justice system often experience worse health outcomes due to lack of access to adequate care and prolonged exposure to stressful environments.

What can clinicians do?

- Ensure that your community and crisis teams have strong links with local probation, liaison and diversion, and prison services, to understand local need and enable seamless transitions for people in and out of the criminal justice system.
- Play an active role in your local Right Care Right Person forum(s), and strengthening relationships between mental health, policing, and liaison and diversion services.
- All staff should be aware of the legal powers of policing colleagues, as they relate to mental health.
- Use mechanisms such as street triage services to provide appropriate care for people in crisis who may need intervention from police.
- Take a trauma-informed and neurodivergent-affirming approach to providing care.
- Take a proactive approach to the opportunity to address social determinants of health and wellbeing during a persons' time in prison.

What can ICBs do?

- Implement data collection, sharing and monitoring systems to track outcomes, identify gaps in services and ensure continuous improvement in care and support based on needs (as described under 'What can clinicians do?').
- Create partnerships with police, prison staff and other criminal justice staff to promote appropriate recognition and response to mental health conditions, learning disabilities and neurodevelopmental disorders.
- Ensure there is appropriate training for healthcare staff to implement the actions above (under 'What can clinicians do?').

See also References and useful resources

Elective recovery

The NHS elective recovery plan aims to reduce long waits for elective care by March 2025. The plan also sets out that reducing wait times would be achieved by increasing capacity, focusing more on clinical prioritisation, transforming care and improving transparency for patients.

Why does elective recovery matter?

Elective waiting times have been increasing over time, but the COVID-19 pandemic has further exacerbated this problem. Mental health trusts have waiting time standards that cover:

- talking therapies services (NHS Talking Therapies for anxiety and depression, formerly known as Improving Access to Psychological Therapies [IAPT])
- early intervention in psychosis
- children and young people's eating disorders[1].

However, since the COVID-19 pandemic, some services are facing huge backlogs (>2 years), for example in attention deficit hyperactivity disorder, autism spectrum disorder and eating disorder services.

It's critical that inequalities in access to care and receiving care are considered, and reflected in efforts to reduce wait times.

What are the impacts?

Addressing elective recovery alone without a focus on health inequalities will result in the further widening of health inequalities. Many of the initiatives to drive down elective waiting lists (such as removal from the waiting list after non-attendance at two appointments) discriminates against patients who experience inequalities (for example, those who struggle to take time off work, have caring responsibilities or cannot afford transport to get to the appointment).

By committing to reduce health inequalities, we can also improve productivity, improve patient outcomes and reduce waiting times.

What can ICBs and trusts do to help?

- Ensure tackling health inequalities is embedded within elective recovery plans/waiting time standards across all mental health service pathways.
- Review rates of people who did not attend appointments/were not brought for appointments, and consider policies related to access with a health inequalities lens.
- Develop 'waiting well' initiatives to target people whose health is at high risk of worsening while waiting for assessment or treatment.
- Consider health inequalities across the whole pathway, including primary care.
- Consider approaches to 're-weight' waiting lists based on clinical need **and** health inequalities (see the HEARTT Tool[2] [Health Equity and the Right to Treatment]).

- Use data to identify broad health inequalities within waiting lists (for example look at disaggregated data for deprivation, ethnicity, age and gender, at a minimum).
- Use local insights, community voices, case studies and so on, to understand why these inequalities exist and explore what can be done to address them.

What can clinicians do to help?

- Understand the elective recovery plan and how this can impact inequalities in care.
- Educate and train staff on health inequalities so they understand the potential impact these may have on mental health waiting times.

See also the References and useful resources

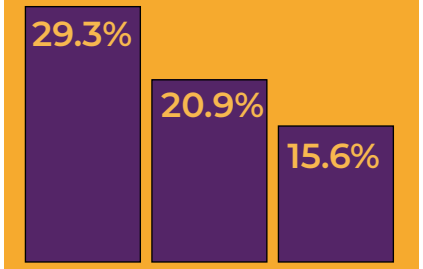
Ethnicity and discrimination

While trauma and discrimination can affect everyone, a disproportionate number of people from Black and South Asian ethnic groups experience mental health problems. Discrimination and racism experienced throughout life, both societally and interpersonally, can make it more difficult for someone to receive care and recover from illness.

The prevalence of common mental health problems varies by ethnic group. For example, the prevalence of common mental health problems is 29.3% among Black British women, 20.9% among White British women and 15.6% among Non-British White women[1].

A report from the charity Mind[2] sets out why ethnic inequalities should be considered when we think about mental health.

Prevalence of common mental health problems in women by ethnicity[1]



Why do ethnicity and discrimination matter?

Racism and discrimination can result in trauma throughout a person's life. Racism and discrimination can also contribute the intergenerational transmission of mental health conditions[3].

Historical trauma is the exposure to systematic oppression faced by multiple generations of families which can be transmitted through physiological, environmental, and social pathways[3,4]

Stigma is also an important factor related to racism that impacts health. A meta-analysis of global data showed that people from minoritised ethnic groups experience more stigma for mental illness compared with people from non-minoritised groups[5].

What are the impacts?

Discrimination, racism and stigma impact a person's mental health. These factors also impact seeking and receiving treatment, and the quality of treatment received.

Stigma, discrimination and racism can contribute to barriers to accessing mental health services, or negative experiences of health services. Stigma has been found to impact people's emotional responses and coping, as well as their knowledge, beliefs and attitudes around mental health problems[6]. Stigma has also been found to cause people from minoritised ethnic groups to conceal their mental health conditions or treatments from their loved ones. This can impact some groups differently than others[6].

What can ICBs and trusts do to help?

- Develop a strategy for addressing racism and discrimination in your organisation.
- Consider the needs of your local communities. For example, work alongside partners to carry out a strategic needs assessment.
- Embed a public health approach to understanding and addressing discrimination:
  - Joint Strategic Needs Assessment (JSNA)[g] can identify the scale of the problem and the existing resources to address it.
  - Create and implement a multi-agency approach to addressing the drivers identified in the JSNA.

What can clinicians do to help?

- Understand how discrimination and stigma can affect a person's health and recovery.
- Aim to understand patient's point of view – perhaps it is different from yours. Consider how stigma may contribute to their position.
- Learn about health inequalities that are due to racism and how they affect mental health.

See also the References and useful resources

Free eLearning for clinicians:

The RCPsych Health Inequalities eLearning module[7] covers this content and is free to access

g See the Glossary for a definition of JSNA.

Health literacy

Why does health literacy matter?

Health literacy refers to people having the skills, ability and confidence to understand and use information to make decisions about their health[1,2]. This includes being able to navigate health and care services[1]. Evidence shows that 4 in 10 people struggle with health information provided for the public[2]. This figure rises to 6 in 10 if numbers or statistics are included[2].

Health literacy is a health inequality, with certain groups more likely to experience low health literacy than others, and therefore more likely to be impacted[1]. Groups include those from lower socioeconomic status, economically disadvantaged groups, migrants, older people, and people with a disability[1,2].

What are the impacts?

- Low health literacy has been linked to:
  - poorer health outcomes
  - increased inequality
  - unhealthy behaviours (such as poor diet, smoking and a lack of physical activity)[1]
  - low use of preventative services (such as vaccinations and screenings)[2]
  - difficulty taking medicines correctly[2]
  - increased use of emergency care (such as accident and emergency department [A&E] attendances and hospital admissions)[1]
  - reduced life expectancy[1].

What can clinicians do?

- Ensure that information is clear and accessible for all.
  - The NHS' Health Literacy Toolkit[3] provides practical tips for communicating in writing and verbally.
- Take opportunities to share health information with patients, including facilitating goal setting. For example, explaining that smoking is harmful and supporting a goal to reduce smoking[1].
- Use visual means and videos to communicate health information. For example, show someone how much of their medication they should take, or use videos to explain cancer screening[4].
  - Tools such as NHS Scotland's Talking Mats can also support engagement.
- Increase education in the local community.
- Use trained community workers and health champions to relay messages[1].

What can ICBs do?

- Increase staff training on improving the provision of clear and accessible information to patients.
- Ensure staff have access to resources and guidance on the production of materials to explain health information.
- Develop and promote user-friendly digital tools to improve digital access and help people understand and manage their health conditions.
- Set up feedback channels for patients, so they can give feedback on the clarity and usefulness of the information they receive.
    - Act on the feedback that is received.

See also the References and useful resources

Housing

Why does housing matter?

One of the fundamental building blocks of good mental health, physical health and emotional wellbeing is having somewhere safe and secure to live. People who experience mental health conditions are:

- 1.5 times more likely to live in rented housing
- 2 times as likely to be unhappy in their home
- 4 times more likely to say that poor housing worsens their health[1].

Housing can also affect people with learning disabilities or neurodivergence, who also often struggle to access good quality housing that meets all their varied needs[2].

Poor mental health can, in extreme cases, reduce economic options to the point that someone becomes homeless[1]. The experience of homelessness can then worsen mental health conditions, keeping people trapped in a vicious cycle.

It costs the NHS £1.4 bn each year to treat people affected by poor housing. When considering other societal impacts, the yearly estimated cost of poor housing is £18.5 bn[3].

NHS trusts have a statutory duty under the Homelessness Reduction Act 2017[4] to refer patients they consider may be homeless or threatened with homelessness to a local housing authority. This applies to accident and emergency services, urgent treatment centres and inpatient treatment facilities.

What are the impacts?

There is often a bidirectional relationship between mental health and housing, with poor housing negatively impacting people's mental health, and poor mental health negatively impacting people's ability to secure good quality housing[5]. Some of the direct and indirect impacts of poor quality housing on mental health include[1]:

- poor sleep
- increased anxiety and depressive symptoms
- poor physical health (linked to cold, damp homes or homes with no access to cooking/washing facilities)
- loneliness
- self-neglect (which may lead to hospital admissions in vulnerable populations such as the elderly and those with a learning disability)
- delayed discharge
- vulnerability to exploitation and 'cuckooing' (where the home of a vulnerable person is taken over by others who use the property for illicit activities or exploit the person, and is more likely to occur for people living in poor quality housing).

What can trusts do?

- Work collaboratively with your local authority housing team to look for innovative options to support people into good quality housing stock.
- Consider employing a housing specialist as part of your multidisciplinary team.
- When writing care and discharge plans, ensure that quality of housing is central, not just availability of housing.
- Use senior leadership capacity to advocate for a more joined-up approach to housing policy at regional and national levels, ensuring that those with mental health conditions are considered.

- Involve family and carers in discharge plans.
- Consider your role as an anchor institution: Can you provide good quality employment, and/or subsidised housing to go with it?
- Support for staff to know where to signpost/refer patients when housing support is needed.
- Provide examples of integrated care models that have successfully addressed the housing needs of mental health patients, such as Housing First initiatives or co-located services. See also Padgett etal. (2020)[6].
- Identify those most at risk of eviction and rent arrears, and provide early intervention.

What can ICBs do?

- Use data that informs you of the local situation with regard to housing and housing options.
- Suggest exploring collaborative funding models, in which healthcare and housing services jointly invest in housing solutions that support mental health recovery.
- Advocate for enhanced data-sharing agreements between healthcare providers and housing authorities to better track and manage the housing needs of mental health patients.
- Emphasise the need for training programs for both healthcare and housing staff on the interconnections between housing and mental health.
- Develop monitoring and evaluation systems to assess the impact of integrated housing and mental health initiatives. This can help ICBs track progress, identify best practices and make data-driven decisions.
- Form strategic partnerships with housing authorities, local councils and non-profit organisations, to enhance housing support for people using mental health services.
- Advocate for sustainable funding mechanisms that support long-term housing solutions for people with mental health conditions, ensuring that housing support is not just a short-term fix but a sustainable aspect of mental health care.

See also the References and useful resources

Neurodivergence and sensory-friendly environments

NEURO DIVERGENCE

Why does being sensory-friendly matter?

Sensory sensitivities (hyper- or hypo-sensitivity as well as sensory seeking, or unusual interest in different aspects of the sensory environment) are well understood in autism and are becoming increasingly well understood in other neurodivergent groups[1,2]. To ensure we are creating inclusive environments, it is imperative to take a sensory-friendly approach to healthcare spaces design[3]. It is crucial that the approach taken by services also includes how people are accommodated within any environment, including how they access and experience care, not just the design of the environment itself.

What are the impacts?

By not taking account of sensory needs in design, we can often unnecessarily aggravate sensory sensitivities, which:

- prevents people from engaging meaningfully with the healthcare they need to access
- makes effective assessments and treatment planning more difficult

- leads to assumptions being made about behaviours that can negatively affect future healthcare decisions
- widens inequalities in healthcare access, experience and outcomes for neurodivergent groups
- potentially increases trauma, because people are more often exposed to violent incidents on wards.

By taking account of sensory needs in design, we not only support those with known sensory sensitivities but also provide an appropriate environment for all.

What can trusts do?

- Implement available guidance when creating new spaces, or update guidance in all areas of the estate, not just specialist services for neurodiversity (see the NHSE Sensory Friendly Resource Pack)[1,4].
- Ensure that considerations about mental and emotional wellbeing adaptations are given equal weight to considerations about physical adaptations.
- Even small changes, such as adding soft furnishings (where clinically appropriate) and bringing in greenery, can make a large difference, particularly where acoustic sensitivities are considered.
- Allow patients to bring in support items from home during elective procedures or inpatient stays, where clinically appropriate, if needed to make the environment less stimulating (for example, ear defenders, fidget toys and comforting items).
- Nominate a ward-based sensory-friendly champion to lead the work and network with other champions.
- Co-produce any changes to local environments or services with patients, carers, families and staff, and work in partnership.
- Provide training to ensure that people understand why this work is important and how to use any new equipment brought in as part of the changes.

What can ICBs do?

- Facilitate partnerships between healthcare providers, educational institutions and local government to promote sensory-friendly environments across community services.
- Support local advocacy groups focused on neurodivergence by providing platforms for them to share their experiences and influence decision-making processes.
- Collect and analyse data on the experiences of neurodivergent patients, to identify gaps in service provision and inform future planning.
- Work with suppliers to ensure that materials and equipment used in healthcare facilities meet sensory-friendly standards.

See also the References and useful resources

Poverty

As described by the King's Fund[1], poverty causes ill health and leads to increased use of health services. Poverty can take many forms, including food poverty (lack of access to nutritious foods), fuel poverty (being unable to adequately heat your home or cook), and even lack of access to Internet or a smartphone (to help with basic necessities such as finding work or managing healthcare appointments).

Why does poverty matter?

Poverty underpins health inequalities. It causes ill health, drives inequality in health outcomes and increases the use of health services. Poverty is increasing in our poorest areas, and the gap between our most deprived and least deprived communities in England is widening. Poverty disproportionally impacts some groups, including minoritised ethnic groups, single-parent households and people with disabilities[2].

What are the impacts?

Poverty has negative impacts on health and it shapes people's ability to make choices about their health. It restricts people's access to basic needs for mental and physical wellbeing, such as warm, safe housing and adequate nutrition. Living in poverty affects people's ability to engage with healthcare services, and creates chronic and potentially toxic stress[h] that puts a physical strain on people's bodies, which can lead to high blood pressure and an impaired immune system.

h See the Glossary for a definition of toxic stress.

Health outcomes are significantly worse for people living in the most deprived areas compared with the least deprived. These inequalities are also mirrored in those who use mental health services, who are also disproportionally impacted by poverty as both a cause and a consequence of mental ill health.

There are clear links between mental health, suicide and debt, with people in problem debt being three times more likely to have considered suicide. Episodes of poor mental health can also make day-to-day financial management more challenging.

What can ICBs and trusts do to help?

Understand the issue

- Use public health data (for example, regional data from OHID Fingertips or data from your NHS trust) and feedback from patients to ensure you understand what poverty looks like for the communities you serve.
  - Ensure that staff know where to access local service data, or where to access national data.
- Staff should be able to find out if a Joint Strategic Needs Assessment has been carried out in their area and know where to get information on this.
- Take systematic approaches to identify and remove barriers to access, experience and outcomes in your service (for example, Poverty Proofing© services).
- Trusts should provide staff with resources for understanding the impacts of socioeconomic disadvantage on mental health:
  - this should include cultural competence and cultural awareness training
  - protect time for reflection on this for staff.

Embed in health services

- Facilitate links between healthcare and social support services across all levels of care.
- Support the implementation of social prescribing across all levels of care.

Make help accessible

- Advertise and ensure easy, stigma-free access to travel reimbursement schemes.
- Ensure behavioural activation is cost-neutral wherever possible (use local assets and partner with your local authority leisure and culture offer).
- Embed financial advice in your service (for example, through commissioning Citizens Advice in-reach, or through Age UK).
- Consider digital exclusion – ensure information is communicated in a way that is suitable for those who need it.
- Build networks between healthcare, public health, local organisations and the social care sector to find ways to provide better mental health support for people with socioeconomic disadvantage.

Be a good employer/purchaser

- Pay the real living wage and pass this through the supply/ commissioning chain.
- Consider local businesses and voluntary, community and social enterprise organisations in procurement of devices and services.

What can clinicians do to help?

- Ensure staff are aware of signposting guidance or local services that can offer support.
  - For example, Making Every Contact Count guidance.
- Adopt a finance prompt in multidisciplinary team discussions or Huddles.
- Collect information on people's financial circumstances, because this can indicate whether they need additional support to engage with treatment and achieve their treatment goals.
  - Access the Mental Health and Money Toolkit.
- Without judgement or stigma, consider poverty as part of formulation, care planning and risk assessment.
- Build in ways to offer flexibility in timing and venues of appointments. Encourage practitioners to consider:
  - Is care close to home?
  - Are there public transport links?
  - Can someone afford to miss work to attend?

See also the References and useful resources

Research

Why does research matter?

Mental health research has an important role in the understanding and addressing of inequalities, especially when considering the impact of inequalities on mental health. However, historically inequalities have not been a priority in mental health research, and there has been a lack of research, including in people of minoritised ethnicities. This has contributed to the widening of inequalities. Prevention and social interventions have also been less well-researched.

More research is needed into:

- **inequalities in mental health**
- **prevention**
- **social interventions**

What are the causes of inequalities in mental health research?

There are a range of factors, including:

1. **Lack of equality, diversity and inclusion in research participation**. By not actively working to gain a diverse range of participants in research, inevitably results in findings are not applicable/generalisable to certain groups. This in turn exacerbates inequalities.
2. **Lack of equality, diversity and inclusion of researchers**. Researchers are often from groups who do not experience health inequalities, meaning that issues relating to inequalities are not comprehensively considered or there is a narrow focus in terms of thinking.
3. **Research funding often has not historically prioritised health inequalities research or equality, diversity and inclusion** in terms of both researchers and research participants. More recently, addressing inequalities has become a public health and healthcare research priority for the National Institute for Health and Care Research (NIHR) and other national funding bodies.

4. **While much research has focused specifically on mental health inequalities or the impact of health inequalities, there is a lack of translation of research into action**. Much of the research conducted actually results in the widening of health inequalities, due to the reasons outlined above. There is also a lack of such research being translated into practice.

What can ICBs and trusts do to help?

- Embed equality, diversity, inclusivity and tackling health inequalities in the research pipeline from design to delivery, through to adoption. When doing this, ensure that diverse groups of patients and members of the public are involved in all aspects of the research cycle and co-producing research wherever possible.
    - The NIHR has guidance and resources on patient and public involvement.
    - See the James Lind Alliance website, which brings patients, carers and clinicians together.
- Ensure that tackling health inequalities is embedded in local Research and Innovation Strategies.
- Develop future research proposals that focus on tackling health inequalities, and promoting equity, equality, diversity and inclusion.
- Review research projects being undertaken in the trust, for any opportunities to focus on health inequalities.
- Educate and train staff on health inequalities, so they understand the potential impact of inequalities on mental health services and research.
- Give staff dedicated time for research.
- Listen and learn from people with relevant lived experience.
- Collaborate with partner organisations, particularly those from voluntary, community and social enterprise, and faith sectors.

See also the References and useful resources

Smoking cessation

Smoking cessation is when someone quits smoking. Often a 12-week quit date is set and cigarette use is cut down over time, but for people with SMI this process can take longer. Nicotine replacement therapy (NRT) is often used to support the process: people with mental health conditions will need two forms of NRT and longer engagement with stop smoking services.

Why does smoking cessation matter?

In the UK, people with a mental health condition are more than twice as likely to smoke as the general population[1]. In those diagnosed with SMI such as schizophrenia or bipolar disorder, around 40% are smokers[1]. Rates of smoking are even higher in inclusion health groups (people who are socially excluded and have multiple risk factors for poor health). These groups also often have increased mental health needs, with up to 80% of homeless people smoking[2] versus just 11.9% of all adults in the UK[3].

Most people who smoke start before the age of 20[4]. People with SMI start smoking earlier, compared with the general population[5]. Intervening early in young people who smoke and have a mental health condition is therefore crucial[6]. Furthermore, people who use mental health services and smoke are generally motivated to quit, and quitting can help their recovery from mental illness[7].

Healthcare staff can play a critical role in supporting patients to quit smoking. However, staff sometimes underestimate the importance of quitting, and their patients' willingness to quit[5].

People with mental health problems are twice as likely to smoke

What are the impacts?

Smoking is causally linked to significant long-term physical health issues (such as cancers, heart disease and diabetes), and evidence points towards smoking causing poor mental health[8]. For people with SMI, smoking also contributes to shorter life expectancy. This contributes to the health inequalities faced by people with SMI.

Smoking can compound issues related to poverty and financial distress (for example, tobacco poverty[i]), meaning that people can get stuck in a cycle of fear of poverty, and use coping strategies such as smoking[9].

What can ICBs do to help?

- Support a joined-up approach across mental health and public health to reduce smoking among people with mental health conditions.
  - See the PMHIC's Framework for Action on smoking and mental health[10].
- Consistent implementation of smoke-free trust policies for staff and patients.
- Use the levers in the NHS Long Term Plan to support patients to quit effectively.
  - For example, inpatient tobacco treatment and referral to pharmacies.
- Providing NRT and/or vapes as an aid to quitting, and explore ways to procure these sustainably.
    - For example in partnership with other trusts, or moving away from single-use products.
- Consider offering or sourcing financial support for patients to access NRT or vapes if costs are a barrier to access.
  - Work with peers who are members of the RCPsych QuITT (QI in Tobacco Treatment) programme, or use their resources.

i See the Glossary for a definition of tobacco poverty.

- To better support people with SMI to quit, encourage staff to consider the guidance and recommendations in the National Collaborating Centre for Mental Health (NCCMH) evaluation of NHS early implementer sites of tobacco dependency community-based services[11].
- Build confidence in your staff by supporting them to receive VBA+ (Very Brief Advice on Smoking) training.
    - And increase awareness of relevant services for referral or signposting as part of providing advice.

What can clinicians do to help?

- Understand what smoking cessation resources and support are available to your patients.
- Talk to your patients about smoking cessation support.
    - For example, the medication varenicline reduces nicotine cravings and achieves higher quit rates in a 12-week prescription.
- Work with local partners as part of a tobacco-control partnership, ensuring that people using any mental health services can access support to quit.
- Make sure your data is up to date:
    - Ensure that there is routine recording of smoking status, cessation status, quit attempts and outcomes.

Visit the Action on Smoking and Health (ASH) Local Toolkit for the latest data in your area: Resources – ASH

See also the References and useful resources

Substance misuse

Why does substance misuse matter?

Substance misuse is a patterned use of a drugs in which the user takes the substance in quantities or ways that are damaging to themselves or others[1].

During 2022–2023, there were just over 290,000 adults in contact with drug and alcohol services in England. Most people in treatment for alcohol and drug misuse experience mental health problems (86% and 70%, respectively)[2].

Among children and young people, high levels of self-harm, domestic violence and sexual exploitation are shown in the drug treatment data[2], with low referral rates from mental health treatment into alcohol and drug treatment.

People living in deprived areas are at higher risk of harm from substance misuse[3]; with the UK seeing the highest rates of alcohol- and drug-related deaths in its most deprived neighbourhoods.

Substance misuse can be common in socially marginalised communities (for example, those involved in the criminal justice system), further adding to difficulties they have engaging with traditional services.

What are the impacts?[2]

Substance misuse has a wide range of health-related impacts. This includes mental health problems, lung damage, cardiovascular diseases, liver damage, blood-borne viruses, unhealthy behaviours and premature mortality[4]. Moreover, death by suicide is common in those with a history of alcohol or drug use, and substance misuse is recorded in 54% of all suicides in people experiencing mental health problems. We also know that despite the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with co-occurring conditions are often excluded from services

Health impacts of substance abuse include:

- mental health problems
- lung damage
- cardiovascular diseases
- liver damage
- blood-borne viruses
- unhealthy behaviours
- premature mortality
- suicide

What can clinicians and trusts do?

- Take a 'no wrong door' and anti-stigma approach to support people with substance misuse who present needing help.
- Form networks of expertise in dual diagnosis across the trust that include lived experience and peer roles.
- Actively participate in/take on shared leadership of local substance misuse networks, linking with key stakeholders at place-level.
- Ensure that community hubs incorporate easy access to substance misuse services through partnership, co-created at place level.
- Educate staff in core skills in substance misuse, use of the dual diagnosis pathways and appropriate interventions (for example, motivational interviewing and harm minimisation).
- Have access to dedicated workers (including substance misuse peer workers) in hospitals, in single-point-of-contact roles to help navigate multiple services, and as part of crisis response.
- Develop and embrace harm-minimisation and harm-reduction practices, such as making naloxone available to those at risk of opioid overdose.
- Ensure dual diagnosis-related duties are specified in job descriptions and regularly reviewed during appraisal, underpinned by accessible training and development.
- Develop a clear dual diagnosis policy and a clinical pathway built around the principles of no wrong door, anti-stigma approaches and collaborative care.
- Improve identification of dual diagnosis need as part of routine data collection.
- Formalise routes to continuous learning implementation from drug-related deaths and incidents.
- Ensure that alcohol and drug recovery and community engagement, in all forms, are assertively promoted across all mental health services.

What can ICBs do?

- Partner with local charities, healthcare and community organisations to create a local coordinated approach to substance misuse prevention and treatment.
- Use national and local data (National Drug Treatment Monitoring System and Fingertips Alcohol Profile, respectively) to monitor trends in substance misuse within the population, identify high-risk areas and adjust strategies accordingly to target interventions more effectively.

See also the References and useful resources

Suicide prevention

Preventing suicide requires coordinated action across many areas of policy (for example, in health and education). See more in the House of Commons research briefing, Suicide Prevention: Policy and strategy[1].

Why does suicide matter?

Suicide represents a tragic loss of life for an individual, the people who love them, the wider community and society as a whole.

Suicide is multifactorial, but some associated factors may include:

- bereavement by suicide (for example, of a family member or close friend)
- history of self-harm
- loneliness and social isolation
- history of mental health conditions
- chronic physical health issues especially chronic pain
- gambling and debt
- financial difficulty and economic adversity
- alcohol and drug misuse
- domestic abuse
- history of trauma.

Death by suicide may be linked to acute mental illness but may also occur where someone has no diagnosable mental health condition but is still in crisis. Of all people in 2011–2021 who died by suicide, 26% had recent contact with mental health services[4].

What are the impacts

The impact of suicide is devastating. It can ripple across communities and wider societies, with lasting impacts for those who knew and loved the individual, and beyond.

Groups recommended for tailored, targeted support in the UK 2023 national suicide prevention strategy[2] include:

- **children and young people**
- **middle-aged men**
- **people who have self-harmed**
- **people in contact with mental health services**
- **people in contact with the justice system**
- **autistic people**
- **pregnant women and new mothers**

What can ICBs and trusts do to help?

- See the National Confidential Inquiry into Suicide and Safety in Mental Health's annual report, UK patient and general population data 2011–2021[4], which is a comprehensive source of evidence and recommendations for practice in mental health care. The link leads to the latest full report and summary guides.
- See the policy paper Suicide prevention in England, 5-year cross-sector strategy[5], which presents evidence for wider action, including partnership and community activity.
- Stay up to date with the latest evidence (for example, through the National Confidential Inquiry into Suicide and Safety in Mental Health's annual report[4] and conferences), and systematically consider how the evidence relates to your population and service offer.
- The NCCMH's Self-harm and Suicide Prevention Competence Frameworks[4] can be used to build knowledge and capacity across staff, ensuring all have access to suicide awareness training and meet the relevant competences.
- Ensure your trust is represented in your local authority and ICB suicide prevention partnerships, and support wider partnership work on issues including access to high-risk locations.

What can clinicians do to help?

- Understand the data – get involved in local suicide surveillance, audit and learning work, and use data from the ONS to understand your local picture.
- Provide bereavement support to those affected by suicide.
- Refer patients in need to effective crisis support. Discuss and document crisis planning.
  - What are the telephone lines that patients in crisis can call? Provide details about local, NHS 111 (medical health) and 111 +2 (mental health), and national lines (such as the Samaritans).
  - Where else can support be accessed during a crisis that meets the needs of groups recommended for tailored, targeted support?

See also the References and useful resources

Sustainability and the climate emergency

Why does sustainability matter?

Climate change and adverse weather events directly and indirectly affect human health, including mental health. We are seeing the substantial impacts of climate change now, and projections suggest they will worsen unless action is taken.

Globally, around 5% of carbon emissions are from the health sector[1]. Health services contribute to climate change through their carbon footprint, such as single-use items, travel impact of staff and patients, medication production and procurement. Medication and medical equipment have enormous costs to the NHS and account for most of healthcare's carbon footprint.

What are the impacts?

People using mental health services may be more vulnerable to climate-related health challenges due to pre-existing health inequalities. For example, those using certain antipsychotic medication and people with a learning disability are more vulnerable to the effects of heatwaves. Heatwaves and flooding can increase anxiety, depression and trauma symptoms and result in an increase in mental health-related admissions and A&E attendance[2]. These environmental stressors may disproportionately impact on people with mental health vulnerability. There is also an association between increased suicide rates and heatwaves. Indirect impacts such as migration and trauma related to conflict, even loss of income, have mental health impacts.

Significant events resulting from climate change, such as extreme weather, floods and wildfires, can result in damage to and loss of home with resulting impacts on mental health such as increased rates of substance misuse, post-traumatic stress disorder and depression.

Witnessing the impacts of climate change through the media can create a sense of fear, worry or tension, sometimes referred to as 'eco-distress'. While these responses are normal, young people and those experiencing mental health problems may be especially vulnerable.

What can ICBs and trusts do to help?

The number one way to improve sustainability in mental health care is by preventing mental health problems from arising. A joined-up approach, with public health, social care and government, is essential for improving the implementation of population-based approaches to preventing mental health problems from arising and reducing the associated impacts. An overview of the public mental health implementation gap is provided in the PMHIC briefing paper[3].

The Health and Social Care Act 2022 requires that all commissioners and providers of NHS services address net zero emissions targets. As part of this requirement, each trust must have a Green Plan and a board-level lead for this sustainability[4].

The RCPsych's 2021 report on sustainability[2] describes the importance of careful prescribing behaviour and sustainable use of medication

More sustainable mental health care offers an optimised version, a 'green' standard. This can improve on the traditional gold standard care by also providing:

- social prescribing
- nature-based care
- thoughtful prescribing
- more focus on prevention and early intervention.

Actions for ICBs to consider

- Public health and healthcare must work together to prioritise prevention of mental health problems (at primary, secondary and tertiary levels). Prevention is the best way to reduce carbon intensive hospital admissions where possible.
    - Population-level prevention requires a joined-up approach across healthcare, public health, government and other sectors to implementation.
        - This includes evidence-based interventions to prevent mental health problems, treat mental health conditions early on and support mental health recovery.
- Embed a Sustainable Quality Improvement (SusQI) approach into all QI projects[5].
- Transform green space at places of work to promote health, including improving biodiversity and reducing carbon via planting[6].
- Embed sustainable models of care, including providing care closer to home, considering use of digital technologies and focusing on getting the right care, for the right person, at the right time.
- Consider outdoor activities as part of routine care, including social prescribing, walking groups and gardening groups.
- Consider medication use, ensuring the lowest appropriate dose is used and provide psychoeducation on the effects of extreme weather events (such as heatwaves) while taking certain medications, including antipsychotics.

The NCCMH have developed guidance for providing net zero mental health care that can support embedding sustainability[5]

- Support knowledge and capacity building by providing staff training around sustainability and climate change, and consider the ways that sustainable practices can be taken up in hospital settings, for example offering clean tap water rather than sugar-sweetened beverages.
- Support trusts to develop an organisation Green Plan with clear objectives.
- Ensure representation at place-based or system-level meetings around sustainability.

What can clinicians do to help?

- Psychiatrists should aim to prescribe medication at the lowest effective dose, monitor medication use and discuss adherence.
- Stop unnecessary prescribing, as appropriate, in collaboration with patients.
- Follow the Choosing Wisely UK initiative that is aimed at improving conversations between healthcare professionals and patients. This can improve decisions on care and avoid tests or treatments that are unlikely to be beneficial.

See also the References and useful resources

Trauma

Why does trauma matter?

Trauma refers to distressing events that are so extreme or intense that they overwhelm a person's ability to cope. When these events occur during childhood, they are often referred to as adverse childhood experiences (ACEs)[j].

Both trauma and ACEs are strongly associated with poorer mental and physical health outcomes. ACEs are not rare. It is estimated 9% of people in England have experienced four or more ACEs, with this proportion being higher in more deprived areas. Intergenerational trauma is more common in minoritised ethnic groups, and in refugees and asylum seekers.

The ten original ACEs are:

1. **physical abuse**
2. **sexual abuse**
3. **psychological abuse**
4. **physical neglect**
5. **psychological neglect**
6. **witnessing domestic abuse**
7. **having a close family member who misused drugs or alcohol**
8. **having a close family member with mental health problems**
9. **having a close family member who served time in prison**
10. **parental separation or divorce on account of relationship breakdown**

Case study: A survey in Blackburn with Darwen Borough found that 47% of adults in the borough had experienced at least one ACE in their life – the survey also showed that the number of ACEs experienced increased the risk of harmful behaviours and poor health outcomes in adulthood

j See the Glossary for a definition of ACEs.

What are the impacts?

Exposure to trauma and ACEs results in significantly greater future risk of:

- physical illnesses, such as:
  - heart disease
  - stroke
  - cancer
  - chronic obstructive pulmonary disease
  - diabetes
- mental health conditions, such as:
  - depression
  - self-harm and suicide
  - psychosis
  - eating disorders
  - substance misuse.

It has been estimated that for each ACE experienced, the odds of having a psychiatric disorder increase by about 52%[1].

Trauma affects a person's ability to engage with care and support, often making relationships, school, work and self-care challenging[2]. It also impacts staff, which should be considered in all actions.

What can ICBs and trusts do to help?

Trauma-informed practice is required by the NHS Long Term Plan. Taking a trauma-informed approach[2] involves:

- taking a trauma lens (that is, to recognise that people may have experienced trauma which can impact how they feel, think and behave, and to respond accordingly)
- preventing further re-traumatisation
- ensuring safety
- building trust
- providing choice, including shared decision-making and goal-setting
- collaborating with and empowering patients
- taking into account cultural considerations.

Trauma-informed practice can be embedded by **applying the Roots framework**[3] to benchmark and improve practice across seven evidence-based domains:

Domain	How to apply the domain
Safety	Promote worth and a sense of belonging, validate experiences and opinions, ensure safety from physical harm from others.
Language	Ensure that the language used in the organisation promotes equality and inclusive discussion.
Social	Be aware of how people under stress may be triggered, based on their previous relationships. Offer support to them from people with lived experience.
Interventions	Offer interventions that are trauma-informed, and ensure support is delivered in a way that appreciates the impact of trauma and minimises further harm.
Empowerment	Empower staff to own their efforts towards change.
Whole system	Offer an easily accessible range of therapies that are designed to treat trauma.
Compassionate leadership	Adopt a leadership style that facilitates trust, transparency, empowerment and respect.

This will be supported by:

- Staying informed about the latest evidence on trauma-informed approaches, which is crucial. National organisations often release the most recent evidence[4].
- Establishing networks in different levels of health services, from frontline staff to ICBs, to develop a coordinated population-based approach that can improve the implementation of mental health strategies.
- Promoting the conducting of JSNAs and needs assessments, to determine the local prevalence of ACEs, the proportion of individuals receiving interventions to prevent ACEs and to identify necessary actions to address gaps.

- Building understanding capacity and capability across all staff groups on trauma-informed approaches.
- Understanding of the implications of the legislative context for trauma-informed approaches.
  - Contact the appropriate lead within your service to find out more.
  - Legislative context includes the Children Act 1989, Care Act 2014 and Mental Health Act 1983, and the NHS Long Term Plan.
- Reviewing local policies and procedures (including human resources) to ensure they adhere to the principles of trauma-informed practice.
- Ensuring a robust offer for staff wellbeing and critical incident response.

What can clinicians do to help?

- Participate in evaluations and research.
- Use a trauma-informed self-assessment toolkit to embed ACEs awareness[5]. and trauma-informed approaches.
- Review your service environment to ensure that services are psychologically informed and feel safe to patients.
- Apply the Roots framework[3].

See also the References and useful resources

Unemployment

Why does unemployment matter?

People with long-term physical or mental health conditions or disabilities are less likely to be in employment than those without long-term conditions or disabilities. Rates of employment for people with SMI are lower than for any other group of health conditions[1]. In January 2021 a Health Foundation report[2] showed that 43% of unemployed people had poor mental health. This was greater than for people in employment (27%) and for people who were on furlough (34%)[2].

What are the impacts?

Unemployment increases the risk of:

- early death
- long-term health conditions
- cardiovascular disease
- poor mental health and suicide
- health-harming behaviours.

What can ICBs and trusts do to help?

- Ensure representation at place-based or system-level meetings around employment.
- Identify opportunities for public health and healthcare to develop local action plans for suicide prevention (as recommended by OHID) that target unemployed people.
- Build staff knowledge about local employment support services.
    - Ensure they know how to access or refer to them. This may include an IPS (Individual Placement and Support) offer.

- Build staff confidence in asking about employment and its relationship with their health.
- Support public health and healthcare to carry out duties in workplace wellbeing initiatives:
  - ensuring staff represent the communities served by the organisation
  - considering equality, diversity and inclusion in recruitment, retention and progression practices.
- Provide active support and paid placements for a variety of people, including those with learning disabilities.
- Maximise the apprenticeship levy to open up employment and training to underserved populations.
- Take a joined-up approach between healthcare and public health to implement interventions and programmes to prevent mental health problems due to unemployment.

See also the References and useful resources

Glossary

Terms

Term	Definition
Adverse childhood experiences (ACEs)	ACEs are stressful events which occur in childhood. They include: ■ Being the victim of abuse (physical, sexual and/or emotional). ■ Being the victim of neglect (physical and emotional). ■ Parental abandonment through separation or divorce. ■ A member of the household being in prison. ■ Growing up in a household in which there are adults experiencing alcohol and drug use problems. ■ Growing up in a household where a parent has a mental health condition. ■ Witnessing or experiencing domestic violence. ACEs are common. Evidence in England published in BMC Medicine showed that almost 50% of people experienced one ACE and over 8% experienced four or more.
Co-production	'*Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.*' – Surrey and Borders Partnership NHS Foundation Trust, via NHS England

Core20PLUS5	The core 20% most deprived (by the IMD) of the national population, plus populations experiencing poor health access, and five clinical areas of focus
Indices of multiple deprivation (IMD)	IMD is an official measure of deprivation for small areas called LSOAs (Lower-layer Super Output Areas). Each LSOA is a standard statistical geography, designed to be of similar population sizes, with an average of 1,500 residents or 650 households in each LSOA. IMD ranks all LSOAs from most (ranked 1) to least deprived (ranked 32,844). This ranking is based on several domains including income, employment, education, health, crime, barriers to housing and services and living environment. IMD is often described in quintiles or deciles (placing the ranked areas into 5 or 10 groups, respectively).
Integrated care board (ICB)	ICBs oversee clinical commissioning in local areas. They replaced clinical commissioning groups in 2022.
Joint Strategic Needs Assessment (JSNA)	JSNAs are a continuous (rather than one-off) locally owned process in which a population's health and social care needs are assessed, and used to plan and improve health and wellbeing. JSNAs are a statutory requirement, carried out by local authorities, public sector partners and the NHS. They form the basis of strategy and priorities when commissioning services. See the Department of Health's statutory guidance on JSNAs.

Lived experience	Lived experience is the knowledge and understanding you get when you have personally lived through something. In mental health services, a person with lived experience is often someone with personal experience of mental health problems. However, it may include people with lived experience of poverty, racial trauma, marginalisation and other forms of prejudice or discrimination which may affect mental health.
Mental health conditions (mental disorders)	*'The definition in the Mental Health Act 1983 is "any disorder or disability of the mind." This includes diagnoses of mental illnesses (for example, anxiety, depression, schizophrenia) as well as personality disorders, eating disorders and alcohol/drug dependency. A full list can be found in the International Classification of Diseases Eleventh Revision (ICD-11).'* **Note:** Feedback from experts with lived experience indicated that their preferred terminology (and which is used in the [Public Mental Health Leadership Certification] course) is **mental health problems and/or mental health conditions** (where diagnosed). '*These terms also encompass conditions that do not meet the diagnostic threshold to be counted as an illness. Additionally, the term "condition" encompasses a diagnosis such as neurodivergence from a strengths-based approach*.' – RCPsych Public Mental Health Leadership Certification course, under 'List of Terminology' (course supplement, source of definition).

Mental illness	*'Often used in a psychiatric context and defined by "a group of signs and symptoms that represent a change in an individual's prior mental state and lead to the experience of distress and/or a decline in function."'* This may refer, for example, to depression and anxiety (common mental disorder) or schizophrenia and bipolar disorder (severe mental illness). **Note:** Preferred terminology is **mental health problems and/or mental health conditions** (where diagnosed) and reasons for this preference are outlined under 'Mental disorder' – Public Mental Health Leadership Certification course, under 'List of Terminology' (course supplement, source of definition).
Tobacco poverty	Tobacco poverty is when money needed for living is spent on tobacco and smoking products: '*Tobacco use contributes to poverty by diverting household spending from basic needs such as food and shelter to tobacco. This spending behaviour is difficult to curb because tobacco is so addictive.*' – WHO Fact Sheet on Tobacco
Toxic stress	Toxic stress is strong, frequent, and/or prolonged adversity (often in a childhood). Such adversity may include emotional abuse, neglect, accumulated burdens of family economic hardship and so on. This adversity generally occurs without adequate support, particularly parental support in children and young people, to buffer the effects. This kind of prolonged activation of the stress response systems can cause lasting impacts on brain and organ system development, increasing the risk of stress-related disease.

Abbreviations

A&E	Accident and emergency department
ACE	Adverse childhood experience
ASH	Action on Smoking and Health
Core20PLUS5	A target population of the core 20% most deprived, plus populations experiencing poor health access, and five clinical areas of focus
COVID-19	Coronavirus disease 2019
ICB	Integrated care board
IMD	Indices of multiple deprivation
IPS	Individual Placement and Support
LSOA	Layer Super Output Areas
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NRT	Nicotine replacement therapy
OHID	Office for Health Improvement and Disparities
PMHIC	Public Mental Health Implementation Centre
QI	Quality improvement
SMI	Severe mental illness
SusQI	Sustainable Quality Improvement

References and useful resources

Introduction

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Useful resources

- https://www.kingsfund.org.uk/insight-and-analysis/projects/improving-nhs-culture – Web page on improving NHS culture from the King's Fund.
- https://thinklocalactpersonal.org.uk/our-hubs/co-production/what-is-co-production/ – Co-production in commissioning tool, an online resource from Think Local Act Personal, hosted by the Social Care Institute for Excellence

Anchor institutions

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Criminal justice and mental health

Useful resources

- https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person – Home Office/Department of Health and Social Care policy paper, National Partnership Agreement: Right Care, Right Person.
- https://www.justiceinspectorates.gov.uk/cjji/media/press-releases/2021/11/mentalhealth2021/ – Criminal Justice Joint Inspection press release on how the criminal justice system is failing people with mental health issues.
- https://www.nice.org.uk/guidance/ng66/ – National Institute for Health and Care Excellence (NICE) guidance: Mental Health of Adults in Contact with the Criminal Justice System: Identification and management of mental health problems and integration of care for adults in contact with the criminal justice system (NG66). London: NICE; 2017.
- https://www.cambridge.org/core/journals/bjpsych-open/article/prevalence-of-mental-disorders-in-defendants-at-criminal-court/0EA21DA05D8DBE64A78D14697C3234F9 – Prevalence of mental disorders in defendants at criminal court.

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- https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/ – NHS' 2023 delivery plan for tackling the COVID-19 backlog of elective care, and associated documents.

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Useful resources

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- https://moneyandpensionsservice.org.uk/improve-financial-wellbeing-for-your-patients/ – Financial wellbeing in health and social care.
- https://www.moneysavingexpert.com/credit-cards/mental-health-guide/ – MoneySavingExpert's Mental Health and Debt booklet.

Research

Useful resources

- https://mentalhealthresearchmatters.org.uk/what-good-mental-health-research-look-like/inclusive-antiracist-research/ – Mental Health Research Matters, about inclusive research that tackles inequalities.
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Useful resources

- https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf – Public Health England's guide for commissioners and service providers, Better Care for People with Co-occurring Mental Health and Alcohol/Drug Use Conditions.
- https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives – Government policy paper, From harm to hope: A 10-year drugs plan to cut crime and save lives. See Chapter 3: Delivering a world-class treatment and recovery system.

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Useful resources

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- https://www.iow.gov.uk/keep-the-island-safe/public-health/joint-strategic-needs-assessment-jsna/jsna-inclusion-health-groups/ – JSNA Inclusion Health Groups, via the Isle of Wight Council's web page.
- https://pmc.ncbi.nlm.nih.gov/articles/PMC7525592/ – BJPsych Bulletin article by Salt and Osborne on mental health, smoking and poverty: the benefits of supporting smokers to quit.
- https://www.nice.org.uk/guidance/ng209 – National Institute for Health and Care Excellence (NICE) guideline on tobacco: preventing uptake, promoting quitting and treating dependence.
- https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/eip-2024/ncap-lester-tool-intervention-framework.pdf – Lester UK Adaptation tool: Positive Cardiometabolic Health Resource: An intervention framework for people experiencing psychosis and schizophrenia.
- https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete – The Khan review: Independent review on making smoking obsolete.
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Useful resources

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Useful resources

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- https://www.medrxiv.org/content/10.1101/2022.04.13.22273691v1 – Article preprint, 'The co-production of the Roots Framework: A reflective framework for mapping the implementation journey of trauma-informed care.' (Thirkle SA, Kennedy A, Sice P, Patel P; medRxiv, 2022).

- https://www.trgm.co.uk/manchester – Trauma Responsive Greater Manchester, the Population Health team at Manchester City Council.
- http://pielink.net/introducing-the-pie-approach/ – Psychologically Informed environments.
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- https://www.centreformentalhealth.org.uk/what-ips/ – What is IPS? – from the Centre for Mental Health.
- https://www.gov.uk/government/publications/supported-internships-for-young-people-with-learning-difficulties/supported-internships – Department for Education guidance on supported internships for 16–24 year olds with special educational needs or disability.
- https://www.health.org.uk/publications/long-reads/unemployment-and-mental-health – Unemployment and mental health, by The Health Foundation.

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