Inverclyde council

AGENDA ITEM NO: 22

Report To:	**Policy & Resources Committee**	**Date**: **22 September 2009**
Report By:	**Robert Murphy** **Acting Director Social Care**	**Report No:** **SW/22/09/BY/AM**
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Subject:	**Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011**	

1.0 PURPOSE

1.1 The purpose of the paper is to advise the Policy and Strategy Committee of the Scottish Government's *"Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011",* published May 2009.

1.2 This action plan sets out the Scottish Government's ongoing commitments to working to improve Scotland's mental health and builds upon the work of the National Programme to Improve Mental Health & Well-being.

2.0 SUMMARY

2.1 The Scottish Government has made a commitment to create a more successful Scotland with a thriving society, which offers everyone the opportunity to reach their full potential. They recognise through promoting good mental wellbeing, reducing the occurrence of mental illness and improving the quality of life of those experiencing mental illness is vital to deliver its commitment.

2.2 The Government want to ensure at national, local and individual levels community initiatives and Government policy support people in looking after their own wellbeing. This is explicitly linked to work on tackling poverty and inequalities, supporting economic regeneration and education and the early years.

2.3 Inverclyde Council and its partners are working collectively to address the themes of *Towards a Mentally Flourishing Scotland*. Paragraph four of this paper notes progress and sets out considerations for future direction.

3.0 RECOMMENDATION

3.1 It is recommended that the Committee:

a. bring *"Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011"* to the attention of the Inverclyde Alliance Board and into the local community planning structures

b. recognise the importance of the links to the wider remits and approaches through equality, diversity, human rights, social inclusion etc. and the linkages to the delivery of all the local outcomes of the Single Outcome Agreement (SOA) and particularly in the areas of Health Inequalities, Alcohol Misuse/Problematic Drinking & Tackling Childhood Poverty

c. endorse the local strategic approach outlined in this paper and are also asked to ensure mental health improvement developments are given continuing focus as part of the overall Council work programmes.

d. committee members are asked to support and take part in an event to locally launch *Towards a Mentally Flourishing Scotland* being planned for late autumn 2009.

Barbara Billings
Head of Community Care and Strategy

4.0 BACKGROUND

4.1 *"Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011"* sets out the Scottish Government's commitment to working to improve the mental health of Scotland's people through ensuring that appropriate services are in place, but also by working through social policy and health improvement activity to reduce the burden of mental health problems and mental illness and to promote good mental wellbeing.

4.2 The Policy and Action Plan deals with mental wellbeing as well as mental illness and mental health problems. Mental health improvement refers to activity to promote good mental wellbeing in the general population; to reduce the prevalence of common mental health problems; and to improve the quality of life for those experiencing mental health problems or mental illness.

4.3 The Council and the wider Inverclyde Alliance partners have a role to play in promoting good mental health and wellbeing, particularly as the Scottish Government's approach is public health evidenced informed. This model recognises our mental state is shaped by our social, economic, physical and cultural environment, including people's personal strengths and vulnerabilities, their lifestyles and health related behaviours, and economic, social and environmental factors.

4.4 The six strategic priorities selected by the Scottish Government and set out in the document are:

Priority 1 - Mentally Healthy Infants, Children and Young People
Priority 2 - Mentally Healthy Later Life
Priority 3 - Mentally Healthy Communities
Priority 4 - Mentally Healthy Employment and Working Life
Priority 5 - Reducing the prevalence of Suicide, Self Harm & Common Mental Health Problems
Priority 6 - Improving the Quality of Life of Those Experiencing Mental Health Problems

The delivery of each of these priority areas will assist in the delivery of each of the local outcomes set out in the Single Outcome Agreement (SOA), and good mental health is an underpinning requirement for the delivery of the vision for Inverclyde as set out in the Community Plan, the SOA and the Council's Corporate Plan.

4.5 Inverclyde Council and its many key partners welcome the launch of *Towards a Mentally Flourishing Scotland* and have given a commitment to progress the priority themes of the plan. There is already a significant amount of high quality activity underway in our local area and a range of dynamic partnerships progressing the work.

5.0 PROPOSALS

5.1 Agree for the writing and implementation of a local mental health improvement plan to take into consideration of the suggested local delivery.

5.2 To accept the recommendations of this paper to further strengthen Inverclyde Council's responsibilities to promote better mental health and wellbeing. This in turn for a paper to Inverclyde Alliance Board with the recommendation for each of the lead officers and outcome delivery groups to consider how they will assist in the delivery of the priorities, and where appropriate, reflect this in the detail sitting within or below their outcome delivery plans.

5.3 Agree to accept regular updates from the action and delivery plans in 5.2 from home committees and the SOA programme board.

6.0 IMPLICATIONS

6.1 Legal:

There are no legal implications.

6.2 Finance:

It is anticipated the activity supporting in the local articulation of this national policy will be contained with local budgets.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel:

There is a range of personnel involved in the local delivery of this policy.

6.4 Equalities:

Equal Opportunities processes and procedures are embedded within the operational practices of organisations involved and each organisation will be encouraged to undertake Impact Assessments, where appropriate.

On the basis of the above proposals, full Impact Assessments will be required and the Committee will be kept advised of the outcomes.

7.0 CONSULTATION

7.1 Appendix 2 is the Inverclyde Council response to the initial Scottish Government consultation (November 2007 to January 2008). Inverclyde Council were also part of a broader NHS Greater Glasgow & Clyde consultation event in January 2008.

8.0 LIST OF BACKGROUND PAPERS

8.1 Appendix 1 – Towards a Mentally Flourishing Scotland (Briefing Summary)
Appendix 2 – Towards a Mentally Flourishing Scotland (Inverclyde Council Response)
Appendix 3 – An analysis of the responses to the national consultation.

Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009 – 2011

(Briefing Summary)

Context

Towards a Mentally Flourishing Scotland is the new Scottish policy and action plan aimed at promoting mental health and wellbeing. It was launched at national level on 6th May 2009 by Shona Robison, Minister for Sport & Public Health. As part of the national launch, Ms Robison stated: "We want to create a more successful Scotland with a thriving society that offers everyone the opportunity to reach their full potential." This will be demonstrated through the Government's continuing commitment to support:

- the promotion of good mental wellbeing
- reducing the prevalence of common mental health problems, suicide and self harm
- and improving the quality of life of those experiencing mental health problems or mental illness.

Mental health improvement refers to activity to promote good mental wellbeing in the general population; to reduce the prevalence of common mental health problems; and to improve the quality of life for those experiencing mental health problems or mental illness. The Scottish Government approach is based on a social model of health recognising our mental state is shaped by social, economic, physical, and cultural environments, including a person's own strengths and vulnerabilities, their lifestyles and health-related behaviours, and economic, social and environmental factors.

According to the Scottish Government, mental health improvement is a key area for action because:

- Mental wellbeing, mental health problems, and mental illness are directly related to
- An individual's socio-economic outcomes as well as to their health behaviours and physical health and vice versa.
- Poor mental wellbeing, mental health problems and mental illness are a burden to the economy, both in healthcare costs and lost opportunities.
- They all have social consequences and there are inequalities in the distribution of mental health problems and mental illness and in the quality of life of those experiencing illness and their carers.

Strategic Priorities

Scottish Government's work on mental health improvement is being taken forward in the context of the *National Performance Framework.* This is supported by action to promote solidarity and cohesion and Government action in key policy areas such as other health-related policies on alcohol, substance misuse, physical activity and health inequalities, and areas such as early years, education, older people, homelessness, poverty and social inclusion.

Mental health improvement is relevant to and involves a wide range of variables, including life stages, settings, interventions and approaches and populations. While there are certain approaches which are likely to have benefits across all of these domains, such as improving people's understanding of how to look after their mental health, there are also activities which are particular to one or more.

Priority areas of the Policy and Action Plan

Priority 1 - Mentally Healthy Infants, Children and Young People
Priority 2 - Mentally Healthy Later Life
Priority 3 - Mentally Healthy Communities
Priority 4 - Mentally Healthy Employment and Working Life
Priority 5 - Reducing the prevalence of Suicide, Self Harm & Common Mental Health Problems
Priority 6 - Improving the Quality of Life of Those Experiencing Mental Health Problems

Planning for Local Progress

Towards a Mentally Flourishing Scotland suggests most council services, including education, community care, employment and social inclusion, are directly relevant to mental health improvement. The key roles of local government in this area are to:

- Give local leadership to the mental health improvement agenda;
- Develop, with Community Planning Partners and Community Health Partnerships,
- Local plans for delivery;
- Develop and implement local interventions and approaches;
- Embed mental health improvement approaches into other services, building on the learning from implementing the *Mental Health (Care and Treatment) (Scotland) Act 2003* and the guidance in *With Inclusion in Mind*

Local Delivery

In developing local delivery plans and approaches in support of the above strategic priorities and locally identified priorities, community planning partnerships and community health partnerships are suggested to:

- Identify the local population's needs in relation to mental health improvement.
- Agree local actions to address the key determinants of mental wellbeing, mental health problems, mental illness, and suicide & self-harm - in key settings and across life stages.
- Make explicit linkages to relevant Single Outcome Agreements and NHS targets and commitments.
- Improve local capacity and awareness of practitioners and stakeholders.
- Increase the local population's understanding and awareness of mental wellbeing and mental health problems and illness, focusing, in particular, on disadvantaged communities.

- Develop local mechanisms to measure and monitor progress and outcomes.

The Scottish Government envisages actions are likely to include population-based approaches as well as more focused activities to address health inequalities and identified risk and protective factors. It is also suggested there are opportunities existing to embed mental health improvement into other service delivery approaches. Equally, the participation and engagement of individuals themselves in activities has a clear wellbeing benefit.

Notes

(i) Copies of *Towards a Mentally Flourishing Scotland* plan are available from the Scottish Government website: http://www.scotland.gov.uk/Publications/2009/05/06154655/0

(ii) National Performance Framework - http://www.scotland.gov.uk/Publications/2007/11/13092240/9

Appendix 2

Towards A Mentally Flourishing Scotland

Inverclyde Council

This document is welcomed in terms of promoting a broad based, cross cutting approach to the promotion of wellbeing in our communities.

The document emphasises the need to promote and support economic and social conditions which are conducive to the health and safety of our population.

We note the relationship between good mental health and wellbeing (which we view as having a relevance across Council services).

The three main themes developed in the paper are helpful i.e. promotion (of protective factors), prevention (of mental and physical ill health) and support (improvements in quality of life achieved through pursuit of social inclusion, better access to health and care services, employment, good quality housing, education and recreational activities.

In many respects the agendas developed are entirely consistent with the duties and functions of local authorities across a range of areas. Many of the themes developed resonate with the UK Equality Review 2007.

The paper advances and promotes a multi agency partnership approach to health and well being on a population basis and is necessarily 'broad brush' in its approach.

It is clearly essential that councils define areas of priority for partnership action to promote mental health and wellbeing.

Within our own local context we note that Inverclyde currently suffers from depopulation and that those who leave the area tend to be younger people who are able to compete in the broader job market. While this in itself is of concern it weakens the informal care available to the ageing population and places an additional challenge on council services in relation to the support and inclusion of our older adult population. Clearly social isolation, poor mental and physical health and poverty are of particular concern to us.

A partnership approach which provides better and more accessible health and care services to our older population is therefore high on our corporate agenda. This in combination with initiatives around economic redevelopment aimed at retaining our younger population is essential such that our community capacity for informal (and formal) carers is secured.

In Inverclyde we have severe challenges in relation to our addictions profile. This can only be addressed through a partnership approach in further developing our networks of services which provide inputs in relation to health improvement (e.g. in schools), treatment and rehabilitation, protection and control (e.g. drug availability and access to alcohol), community safety and

importantly providing a pathway back to training and employment for those who have experienced difficulties in this area.

The safety and protection of children and vulnerable adults is high on the council's agenda in developing partnership working which facilitates growth, inclusion and wellbeing.

Inverclyde Council has a well developed anti poverty strategy which includes the promotion of financial literacy and welfare rights representation.

The provision of good quality housing with housing support services which enable people with serious mental health problems to live full and integrated lives within their community is well developed. Support services have been redesign to maximise integration across all life domains e.g. vocational training, further education, recreation and volunteering opportunities.

The Council has fully met its obligation to fund the development of independent advocacy services and has developed opportunities for group advocacy and for carers support.

Inverclyde Council has led on the Workforce Plus and NEET strategy and has achieved favourable outcomes in both groups identifying the need to further develop employer engagement strategies and social enterprise to the benefit to those who are furthest from the labour market.

Inverclyde Council has engaged fully with the National Programme and has benefitted from creating Choose Life coordinator post which has facilitated a broad engagement with training and awareness campaigns and opportunities.

Support from Scottish Government in relation to licensing and the control of drugs is of key importance. Similarly assistance to councils in relation to the cost of a growing and ageing population (particularly where depopulation is an issue) is of paramount importance in the promotion of mental health and wellbeing.

The facilitation of broadly based opportunities for access into employment and training has a very high priority. The recognition that those furthest from the job market are also those who are most likely to experience poor physical and mental health and low wellbeing is noted and the potential for pathways which promote social integration (with related health gains), sheltered or supported employment, vocational training and further education is an area of fundamental importance.

We note that there is scope for further unification in relation to the development of an over arching framework which includes health inequalities, mental health and wellbeing and the UK equalities agenda and would welcome further input from Scottish Government in this respect.

Appendix 2

Towards A Mentally Flourishing Scotland

Inverclyde Council

All of the above have resource implications for local authorities and while we embrace the underlying values and ambitions additional resources will be required if we are to deliver on population health and equalities agenda.

Our Local Outcome Agreement contains implementation targets which will demonstrate progress towards achieving our objectives for the Inverclyde community.

Our targets are derived from our community planning aspirations which reflect whole system partnership working.

As a council we have been fully involved with partners in taking forward this agenda in line with the national strategy.

An analysis of the responses to the national consultation on *Towards a Mentally Flourishing Scotland*

Final report

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18 April 2008

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Table of Contents

1. Introduction **1**

2. Description of respondents **2**

3. General points **4**

Positive points 4
Issues needing attention 4

4. Shared objectives and actions for local delivery **6**

Promotion 6
Prevention 9
Support 11
Targeting 14

5. National supports needed **16**

Funding 16
Setting realistic timescales for change 17
Ensuring consistency in implementation of national priorities at a local level 17
The role of the voluntary sector 18
Other issues 19

6. Tracking progress and assessing performance **21**

Use existing agreed indicators and targets 21
Evaluation of projects and initiatives 22
Seeking the views and feedback of service users and carers 22
Other suggestions 23

7. Other comments **25**

Annex 1: List of respondents **27**

Annex 2: Participation in multi-agency consultation exercises or events **29**

1 Introduction

1.1 In October 2007, the Scottish Government published a discussion paper outlining the direction for mental health improvement and population mental health for 2008-2011. This paper, called *Towards a mentally flourishing Scotland: The future of mental health improvement in Scotland 2008-11,* was intended to build on the Scottish Government's National Programme for Mental Health and Wellbeing. Thus, it forms part of the Government's wider strategy for improving the health and wellbeing of people in Scotland.

1.2 *Towards a mentally flourishing Scotland* (hereafter referred to as TAMFS) primarily focuses on actions which could be undertaken at a local level — that is, by local authorities, NHS Boards and other key stakeholders — with national support. As such, TAMFS represents a shift in emphasis and focus from national activity to local action on mental health improvement.

1.3 The Scottish Government undertook a national consultation on the TAMFS proposals between November 2007 and February 2008. The Government supported the consultation process by offering small grants to NHS Boards to organise local consultation events, and by arranging for Government officials to attend the events to present the discussion paper. Many NHS Boards made use of these grants and held one or more events in their areas to gather the views of individuals from a wide range of agencies and interests. A number of areas also gathered written responses to the consultation from local stakeholders.

1.4 Local areas were asked to consider three questions in responding to the TAMFS discussion paper:

- What shared objectives and actions for local delivery should be made for 2008-11 that would be deliverable, measurable and valuable?
- What national supports would help you to meet these objectives and actions?
- How can progress be tracked and performance assessed?

1.5 This report provides a high-level summary of the responses received to these three questions, along with a brief analysis of other major themes which arose in the consultation.

1.6 The deadline for written responses to the consultation was 28 February 2008. However, the deadline was extended to allow late submissions. This report includes only responses that were received by 19 March 2008.

1.7 The Scottish Government has established a National Reference Group to consider the outcomes of the national consultation and discussion process. This group will provide advice to the Government on the next stages of work in developing an action plan for mental health improvement for the next three years. It is expected that this action plan will be available early in 2008.

2 Description of respondents

2.1 The consultation received 76 written responses. However, one-quarter of these responses were submitted by representatives of multi-agency groups or partnership bodies. In many cases, these groups were specifically gathered for the purpose of commenting on the consultation paper, and their responses were collated and submitted by NHS Boards or local authorities. Annex 1 of this report provides a list of all the respondents to the consultation.

2.2 Table 1 below provides a breakdown of the responses by sector (NHS, local authority, voluntary, etc)

Table 1: Breakdown of responses, by sector

	n	%
Charity / voluntary sector	22	28.9%
Multi-agency groups or partnership bodies	19	25.0%
Service users / carers or their representatives	10	13.2%
NHS (including two individual GPs and one nurse)	6	7.9%
Local authorities	6	7.9%
Professional representative body (Royal Colleges, BMA, trade union)	5	6.6%
Other interested individuals	5	6.6%
Central government non-departmental public body	2	2.6%
Education	1	1.3%
	76	100.0%

2.3 Just over a quarter of responses (28.9%) came from voluntary sector agencies or other charitable organisations. In most cases, these agencies had a national remit (e.g., Alcohol Focus Scotland, Alzheimer Scotland, Depression Alliance Scotland, etc). Responses were also submitted by current and former mental health service users, carers or their representatives (13.2%).

2.4 As mentioned above, one-quarter of responses (25%) came from consultation exercises or events involving multi-agency groups or partnership bodies. Table 2 on the following page, provides an indication of the scale of these local consultations, and Annex 2 provides further details of the participants in local consultations.

2.5 Thirty-two respondents (42.1%) represented organisations with a national remit. These included, for example, NHS Health Scotland, NHS Education for Scotland, the Scottish Children's Reporter Association, professional representative bodies and trade unions, and many of the voluntary sector respondents. Thirty-one respondents (40.8%) represented organisations that had a remit within a local area. These included, for example, responses from local authorities, or locally organised multi-agency events and local service users' or carers groups. The remaining 13 responses (17.1%) came from individuals. These included individual service users, carers, doctors, nurses or other interested individuals.

2.6 Because such a large proportion of responses were submitted by multi-agency / partnership groups, no attempt has been made in this report to undertake an analysis of responses by sector. However, where a particular theme arose from within just one particular sector, this will be highlighted.

Table 2: Participation in multi-agency consultation exercises or events

	Respondent (on behalf of multi-agency group or partnership)	Number of individuals participating in consultation
1	Alcohol Focus Scotland	Not stated
2	City of Edinburgh Council / NHS Lothian	Not stated
3	Dumfries & Galloway roundtable discussion on older adults' mental health	12
4	Dundee Community Transport & Dundee Accessible Transport Group	Not stated
5	Fife Health & Wellbeing Alliance	Not stated
6	NHS Ayrshire & Arran	208
7	NHS Borders / Scottish Borders Council	6
8	NHS Dumfries & Galloway	99 + collective responses from 2 groups
9	NHS Forth Valley	47
10	NHS Greater Glasgow & Clyde	170
11	NHS Highland	Not stated
12	NHS Lanarkshire	165
13	NHS Lothian	130
14	NHS Orkney / Orkney Island Council	Not stated
15	NHS Tayside	100 (est)
16	North Ayrshire Choose Life Steering Group	Not stated
17	Orkney Disability Forum	Not stated
18	Scottish Association of Alcohol and Drug Action Teams	13
19	Shetland Mental Health Partnership	Not stated

3 General points

3.1 Overall, respondents were very much in agreement with the general approach outlined in TAMFS. Respondents were in favour of shifting the focus from mental illness to mental wellbeing and strongly supported the move towards greater action at a local level. In addition, they welcomed the focus on early years and the attention given to families and parenting. Respondents also strongly supported the emphasis on reducing inequalities. The consultation document was clearly well-received, and one individual described it as “positive and inclusive.” Several others commented on the enthusiasm with which the document was received at a local level.

Positive points

3.2 Respondents also:

- Welcomed the recognition of the relationship between mental and physical health, and in particular, the relationship between mental health and drug / alcohol use
- Supported the shift away from the ‘medicalisation’ of mental health issues and towards an emphasis on promoting mental health and wellbeing across a range of services
- Supported a population-based approach, but also agreed with the need to target certain groups
- Supported the links made between self-management and recovery
- Supported the need to build capacity and ‘mental health literacy’ within primary care and wider community services
- Agreed that staff attitudes, the accessibility and responsiveness of services, and the availability of social and psychological (as well as a medical) support were issues needing to be addressed.
- Agreed with the need to monitor progress and measure outcomes in relation to improving mental health and wellbeing.

3.3 There was a suggestion that TAMFS could be used as a tool for proofing other national and local policies for their contribution towards mental health improvement.

3.4 In addition, respondents largely agreed with the three broad themes for action proposed in the document — *promotion, prevention and support*. However, one individual commented that they would have liked to see some consideration of the idea of *maintenance* — i.e. how people can be supported to *remain* mentally healthy.

Issues needing attention

3.5 Other respondents would have liked the document to include:

- More explicit information about the evidence base for the strategy (This is discussed further below.)
- Some recognition of the relationship between spirituality and mental health
- A discussion of the levels at which mental health improvement operates — individual, community and structural — at an earlier stage in the document
- Greater emphasis on promoting links between services and sectors, and in particular, making use of the skills and expertise available in the voluntary sector

- Links to a wide range of other relevant policy initiatives and related health and non-health policy documents
- An explicit discussion of equality impact assessment — to ensure that the proposed plan and delivery modes do not exacerbate existing inequality
- Clarification of terms such as "mental health literacy" and "emotional literacy"
- Clarification of roles and responsibilities (e.g. of the health service, local authorities, Community Health Partnerships, government departments and the voluntary sector) and performance management processes
- SMART objectives (SMART = specific, measurable, achievable, relevant, timed).

3.6 While respondents welcomed the emphasis on local action, many were also concerned that this should not be at the cost of national support activity. (This issue will be discussed in more detail in Chapter 5.)

3.7 Some respondents (particularly service users / carers and their representatives and those in the voluntary sector) expressed the opinion that TAMFS did not go far enough in its proposals. However, it was more common for respondents to suggest that the strategy was trying to do too much, and to ask for greater focus in relation to priorities.

3.8 At the same time, a concern was also expressed that some of the actions may be unachievable at a local level — particularly those concerning early interventions with children and young people and their families — since in some areas, there are no clear systems or processes for identifying children at an early stage of risk in social / community settings such as schools and colleges, nor were there sufficient services available to address needs for early intervention.

Evidence base for the action plan

3.9 A recurring theme in comments on the TAMFS document was a request for more explicit information about the evidence base for the proposals. One respondent made the point that, although the document included a long list of research funded by the National Programme, the outcomes of this research were not discussed. Nor was there any critical reflection on the evaluations of initiatives such as Choose Life, 'see me,' and others.

3.10 Respondents wanted assurance that the outcomes and recommendations of the research and evaluation funded by the National Programme over the past few years were being used to inform the direction of future policy and action. It was suggested that the final action plan should be more explicit about its evidence base, and also about how current gaps and needs in relation to knowledge transfer might be addressed. One individual felt it would be helpful if the action plan included examples of (evaluated) good practice.

3.11 Another individual felt that TAMFS should include an economic argument for its proposed actions. Several respondents suggested that reference should be made to a report published by the Northern Ireland Association for Mental Health (Friedli & Parsonage 2007), which identifies cost-effective interventions in this area.[1]

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[1] Friedli L & Parsonage M (2007) Mental health promotion: Building an economic case. Available for download at: www.chex.org.uk/uploads/mhpeconomiccase.pdf?sess_scdc=ee4428ebde41914abac0e0535f55861c.

4 Shared objectives and actions for local delivery

4.1 The first question in the consultation paper was: *What shared objectives and actions for local delivery should be made for 2008-11 that would be deliverable, measurable and valuable?*

4.2 The responses to this question were detailed and varied. However, as mentioned in the previous chapter, respondents generally agreed with the three broad themes for action — promotion, prevention and support. Therefore, these three themes will be used as the basis for summarising responses. Where additional themes arose, these will be addressed at the end of this chapter.

Promotion

4.3 Respondents had a range of views on possible objectives and actions to promote and improve mental health and wellbeing. In general, these focused on:

- Individual lifestyle interventions
- Population interventions
- Structural interventions
- Interventions with children and families

Lifestyle interventions

4.4 Respondents agreed with the links made in the document between mental health and wellbeing and lifestyle issues. It was suggested that ongoing work to reduce tobacco, alcohol and drug use should continue. There was also a view that greater priority should be given to reducing alcohol problems in Scotland, and that this might include an increase in taxation on alcohol to reduce the prevalence of drinking among young people and stricter controls on licensing of pubs. There was also a suggestion that action was needed to raise awareness among the general public of the relationship between alcohol and mental health.

4.5 Respondents suggested that, on a local level, much more could be done to link mental wellbeing more explicitly to other health-related strategies, including strategies on physical activity, healthy eating and substance use.

4.6 Finally, there was a call for awareness-raising and increased action to reduce the risk of dementia through encouraging healthier lifestyles.

Population interventions

4.7 Respondents agreed that it was important to promote positive mental health and wellbeing through interventions targeted at the general population — in schools, workplaces and other community settings — and it was suggested that where they were available, existing networks such as Health Promoting Schools and Healthy Working Lives should be used for this purpose.

4.8 Respondents made general comments about how to promote mental health and wellbeing. For example:

- Foster hope in communities and families
- Undertake media campaigns to inform and educate the general public
- Strengthen the factors that promote positive mental health
- Tackle the cultural barriers to prevent people from being able to talk about their emotions.

4.9 They also made suggestions for more specific interventions and activities:

- Promote gardening and community allotment schemes, particularly in deprived areas of Scotland *("Local Councils and NHS Boards should fund at least one Community Allotment Health Project in their area.")*
- Give people opportunities to participate in more cultural, social and artistic activities *("Identify, foster and protect the things that give people a 'lift' — musical entertainment, drama, games, sport, cinema." "School holiday programmes should be widened to include more cultural / art activities and evening classes.")*
- Continue to tackle bullying in schools
- Develop emotional resilience among young men
- Use community development methods to encourage people to support each other.

4.10 Respondents were very much in support of the suggestion made in TAMFS that action needed to be taken to improve 'literacy' around mental health and wellbeing among service providers and the general public, and one respondent suggested that 'mental health literacy' should include 'dementia literacy.' This work should include all public sector staff, including social workers, medical staff, teachers, community learning and leisure staff, and staff in further and higher education. (However, note that there was also a request among some respondents to clarify what is meant in the document by 'mental health literacy'.)

4.11 Similarly, respondents agreed that 'emotional literacy' should be taught in schools to children of all ages, and that action was needed to educate the general public about coping skills and strategies.

Structural interventions

4.12 Respondents very much saw the promotion of mental health and well-being as "everyone's business." The point was made that activity needed to be undertaken at a local level to engage with organisations and agencies that previously would not have seen themselves as involved in the business of mental health improvement.

4.13 There was a strong feeling that local planning policies on transport, environment, economic development, housing, recreation, etc. needed to be 'proofed' for their impact on mental health and wellbeing. One respondent, representing a local authority, suggested that action at a local level in his area might involve the inclusion of actions on mental wellbeing in all council department service plans and strategic documents. Another respondent suggested that, to promote more positive mental health, it would make sense to tackle poverty and the lack of affordable housing first.

4.14 Respondents made specific suggestions about ways of improving local infrastructure to better promote mental wellbeing. Many of these suggestions were similar across sectors and across the urban-rural divide. However, respondents perceived that increased action

was needed specifically to reduce isolation and social exclusion of people living in remote and rural areas, and of older and disabled people.

- Improve access to community services such as dial-a-bus and Shopmobility (for elderly and disabled people)
- Invest in and improve access to public transport, recreational / community leisure facilities, sport centres and cafes, particularly in remote and rural areas.
- Improve the physical environment of colleges and workplaces.
- Provide safe / comfortable street corners for young people to hang out on.

4.15 One individual commented there was a need to encourage communities to adapt to an older age profile in relation to housing, transport and community services.

Interventions with children and families

4.16 As mentioned in Chapter 3, respondents strongly supported the TAMFS proposals to increase early years interventions as a way of promoting and improving mental health and wellbeing in Scotland. One individual (representing a local authority) pointed out that the focus on early years was in line with the conclusions drawn in the report, *Mental health promotion: Building an economic case* (Friedli & Parsonage 2007, mentioned in Chapter 3) recently published by the Northern Ireland Association Mental Health.

4.17 The point was made that the mental wellbeing of a child is often inextricably linked to the mental health and wellbeing of parents. Therefore, it was important that action in this area focus on families — both parents and children together. Respondents felt that such interventions should *"start at as early an age as possible — it's crucial to identify and address problems in infancy, if possible."* However, there were some concerns about whether local areas had the infrastructure and services on the ground to support this.

4.18 Respondents highlighted that there were likely to be special needs among children with long-term physical health conditions, looked-after and accommodated children, children whose parents have drug / alcohol problems, children who have been victims of abuse and children whose parents have a mental illness.

4.19 There were also suggestions for some specific interventions, including making a primary mental health link worker available in every school, and improving access to youth leadership programmes.

Other points

4.20 Respondents made a large number of additional suggestions in response to the question about shared objectives and action for local delivery. A few of these are listed below (in no particular order of priority), to illustrate the range of comments received.

- *"Need to find the '5 fruit and veg message' for mental health"* – move the focus from mental illness / crisis intervention to wellbeing and prevention.
- People have a responsibility to take ownership of their own mental health and wellbeing. It's important to realise that people are the experts in relation to their own lives and experiences.
- Equip and support the voluntary sector to deliver the promotion agenda.

Prevention

4.21 Respondents agreed that local action should be undertaken to prevent mental health problems, mental illness and suicide, and the view was frequently expressed that service provision needed to shift its focus more towards early intervention rather than crisis management. Respondents also agreed with many of the suggested actions listed in the TAMFS paper, Section 9.2, although one individual questioned the extent it was possible to prevent psychosis (Section 9.2, point 2).

4.22 Once again, there was a range of views expressed on the subject of *promotion*. However, comments can generally be grouped according to three main themes:

- Mental health needs of people with physical illness or long-term conditions
- Primary / community care interventions
- Preventing self-harm and suicide

Mental health needs of people with physical illness and long-term conditions including sensory impairments

4.23 Respondents welcomed the suggestion that there was a need to better address the mental health and wellbeing needs of people with physical illnesses and long-term conditions, such as diabetes, epilepsy and dementia. One respondent called for increased funding for services to prevent mental health problems among older adults, including those with dementia, and concerns were voiced that the focus on early years interventions in the TAMFS document should not be at the expense of services for older people.

4.24 The point was made that, for some conditions, such as diabetes, it would make sense to support mental health and wellbeing through established Managed Clinical Networks.

4.25 Respondents also highlighted the particular challenges of identifying and addressing the mental health needs of deafblind people, people with communication support needs, and people with complex and multiple needs related to sensory impairment and learning disabilities. All of these groups experience poorer mental health compared to the general population, and the needs of these individuals often go undetected by services. Respondents requested much greater emphasis on identifying and meeting the needs of these groups in the TAMFS action plan.

4.26 Another respondent suggested developing ‘wellbeing centres’ (along the lines of the Thistle Foundation in Edinburgh) as one way of addressing long-term physical health conditions along with mental health and wellbeing.

Primary / community care interventions

4.27 Respondents very much agreed with the proposals for action set out in TAMFS in relation to primary care interventions for people with mild to moderate mental health problems.

4.28 In particular, there was strong support for the use of ‘social prescribing’ and ‘anticipatory care’ approaches, and one respondent went so far as to suggest that targets should be set locally by Community Health Partnerships to encourage social prescribing. Another called for a reduction in the practice of *“prescribing anti-depressants as a first*

resort." However, other respondents argued that targets for reducing anti-depressant prescribing were unhelpful.

4.29 However, the point was made that it is important for GPs to have up-to-date information about what is available in their areas and what is effective. Some respondents were clearly concerned that the infrastructure to support social prescribing was not available in their areas. It is also worth noting that at least one individual expressed a lack of certainty about the effectiveness of 'social prescribing' and 'Keep Well' approaches, and a second individual, citing a study by Bream (2006), suggested there was insufficient evidence of the effectiveness of primary care prevention approaches targeted at deprived populations.[2]

4.30 Other suggestions related to primary care or community care interventions included:

- Making available a mental health and wellbeing person in each GP surgery
- Giving priority to the identification of mental health problems in new mothers (ante-natally and post-natally)
- Increasing the levels of formal drug and alcohol screening in primary care
- Improving the accessibility of psychological therapies (including "health coaching" / life coaching), alternative therapies and self-help groups for people with mild to moderate mental health problems (However one respondent questioned the effectiveness and appropriateness of cognitive behavioural therapy for older adults.)
- Promoting the use of garden projects, volunteering and outdoor recreational activities within social prescribing approaches.

4.31 Although there was overall support for greater action in this area at a local level, it is important to note that one respondent had a question about the role of community nurses in meeting the aims and objectives set out in TAMFS document.

> *A number of the nurses we consulted raised questions about the links between the new community nurse model being tested in four health boards and the needs identified in the discussion document to focus on early years' interventions and the opportunities to expand community-based mental health improvement. [We] would be interested to see how this vision for population mental health is to be mapped on anticipated changes to health visitor, school nurse and district nurse roles. (Representative of NHS professional group)*

Preventing suicide and self-harm

4.32 Respondents highlighted a need for ongoing work to prevent suicide and self-harm in Scotland, and there was a call for *"more defined action in relation to suicide prevention"* than that which is set out in Section 9.3 of the TAMFS document. It was also suggested that action to prevent self-harm should be separated from action to prevent suicide, and there was a call to develop a more strategic approach to the prevention of self-harm.

4.33 Respondents argued that suicide prevention activity needed to be targeted at communities, neighbourhoods and whole populations. As one individual said, *"Training and*

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[2] Bream E (2006) Prevention 2010: Engagement and Concordance Evidence Overview. Available from: www.scotland.gov.uk/Topics/Health/health/Inequalities/Overview.

awareness-raising in relation to suicide is not just about meeting Commitment 7."[3] One respondent suggested that action on a local level could involve the delivery of suicideTalks in local communities, poster campaigns in bars and pubs and direct work with young people in schools.

4.34 Respondents also highlighted a need for a much greater focus on preventing suicide among people who misuse drugs and / or alcohol. The point was made that published suicide statistics do not accurately represent the scale of the problem among this population because the statistics do not include non-fatal overdoses, or 'near-misses.'

4.35 Respondents suggested the following actions could take place at a local level in relation to preventing suicide and self-harm:

- Improve access to cognitive behavioural therapy and art therapy
- Develop better joint-working between NHS and voluntary sector agencies to support those at risk of suicide
- Offer support to young people who self-harm at school or in college
- Identify and support children affected by parental substance misuse – many of whom are known to self-harm and / or have suicidal thoughts
- Improve multi-agency training for health and social care staff in relation to self-harm and suicide
- Target young men, older people and farming / rural communities.

4.36 Finally, there was a suggestion by some respondents that post-vention support needs to be more widely available to friends / family of people who have attempted or completed suicide, and there was a request for advice in taking forward work in this area.

Support

4.37 Respondents strongly agreed with the need to support improvements in quality of life, social inclusion, equality and recovery among people who experience mental illness. Suggestions were made for a range of actions and many of these reflect those listed in the TAMFS document in Section 9.4.

4.38 Before going on to look at these suggestions in detail, it is worth mentioning that, in general, respondents strongly supported the concept of "recovery." However, it should be noted that two individuals highlighted that the term "recovery" can be misleading and cause confusion. It was suggested that the term implies to many people that, *"You will get better and be illness free, and therefore not require support services."* This may not be so for some people with mental illness, and will not be so for people with dementia.

4.39 The main themes arising in respondents' comments about *support* related to:

- Training and employment
- Supporting recovery
- Giving people options

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[3] The reference here is to Commitment 7 of *Delivering for Mental Health* which is to train / educate 50% of staff in key frontline mental health services, primary care and accident and emergency services in using suicide assessment tools / suicide prevention training programmes — by 2010.

- Providing people with a safety net
- Giving people a voice

4.40 Some respondents also stressed the need to improve the quality and consistency of services in their areas.

Training and employment

4.41 About half of respondents highlighted the importance of meaningful employment in promoting recovery for people experiencing mental illness. Employment was also seen to be the key to recovery for people with co-morbid mental health and substance misuse problems.

4.42 Service users and carers echoed these sentiments, and provided personal examples from their own lives of how the move into work helped their process of recovery. One respondent, a GP, confirmed that he had seen similar positive results from an initiative in his area which involved placing people with severe and enduring mental illness into part-time employment.

4.43 A large proportion of respondents argued that public sector employers had a duty in this respect — not only to support people back into jobs as part of the process of recovering from mental illness, but also to create environments that were conducive to positive mental health and wellbeing among their employees. Respondents felt that local authorities and NHS agencies should be *"exemplar employers."*

4.44 However, there was a feeling that some employers (including further and higher educational institutions) may need advice, guidance and training to put in place policies and procedures that supported mental health and wellbeing in the workplace. Respondents felt that there would be benefit in working with local businesses to foster relationships and create opportunities for employment for people recovering from mental illness, and it was suggested that more could be done at a local level to recognise 'good-practice' employers.

4.45 Finally, in relation to employment and training to support recovery, there was a call from service user groups for information and advice to recovering service users wanting to set up their own businesses, and training for those wishing to become befrienders.

Supporting recovery

4.46 In addition to employment and training, respondents suggested a wide variety of other interventions and initiatives to support recovery among people experiencing mental illness at a local level. Respondents clearly saw the need for care and support to extend beyond clinical and psychological services to include social supports. At the same time, however, the point was made that good-quality acute services would still be needed, but a number of respondents (service users, carers and one GP) expressed concern that service users still often had the experience of being discharged from psychiatric hospital into the community with little or no support.

4.47 Service users and carers, and respondents from across all sectors suggested that the following types of services helped support recovery:

- Good quality housing and housing support services
- Befriending and peer support services

- Advice and education regarding healthy eating
- Occupational therapy in hospital and in the community — yoga, painting, woodwork, musical activities, exercise, supper clubs
- Comfortable, homely, relaxing environment in hospital
- Alternative / holistic therapies

4.48 Service users and carers, as well as other respondents, agreed strongly there was a need to take action to improve staff attitudes and behaviours towards people with mental health problems, people with drug and alcohol problems and people with communication support needs.

4.49 There was also a suggestion that local areas may wish to consider the development of 'Individual Health and Wellness Accounts' (like 'Individual Learning Accounts'). This would involve making direct payments to people on lower incomes who could then use the payments to access supports such as exercise, relaxation or sport, which are currently only available to those on higher incomes.

Giving people options

4.50 There was a feeling among respondents that action needed to be taken to provide people with a greater range of options for support, particularly options other than medication. One respondent suggested that people should be provided with a 'menu' of *"mainstreamed and innovative support services"* to take into account their needs and preferences. This increased range of services should include greater availability of out-of-hours and drop-in services.

Providing people with a safety net

4.51 Respondents felt that safety nets needed to be available to those who were most vulnerable — including prisoners upon release and older homeless people with mental health problems. Service users and carers also highlighted a need for better response times from services when people were in crisis.

Giving people a voice

4.52 Respondents felt that action was needed to give a greater voice to people who were subject to inequality and discrimination. Respondents wanted:

- Improved interactions between deafblind people and professionals – e.g., through the provision of guides / communicators, increased awareness, and the establishment of a national guide / communicator service.
- Increased support for service user networks — to allow service users to voice their views collectively or individually.
- Greater availability of advocacy services.

Other points

4.53 Finally, respondents felt it was important not to overlook the needs of carers, including carers of people with drug and alcohol problems, and it was suggested that action

was needed at a local level in this area. There was a specific request from service users and carers for increased respite provision for carers, including at Christmas.

Targeting

4.54 Another of the major themes that arose in the consultation responses was in relation to the issue of targeting. Section 6 of the TAMFS paper made suggestions for groups that could be targeted, and nearly half of respondents made some comment in relation to this section.

4.55 In general, respondents agreed with the points made about targeting, and agreed with all six of the illustrative target groups for local and national action (listed in para 6.1).

4.56 However, one respondent suggested that the focus of Section 6 was too broad. (*"Currently almost all of the population is included."*) This individual felt it would be helpful to prioritise some key groups to provide the intensity of effort required to make a difference.

4.57 Another respondent seemed to be arguing for the opposite approach. This individual suggested that, rather than attempting to target too many groups, any future strategy should target national and local action in three broad areas:

- Population at large (through provision of skills for life in education / workplace)
- At-risk groups (people without access to key assets or resources)
- People with long-term conditions (including people with physical and / or mental illness, and those who experience discrimination).

4.58 This person made the point that promotion, prevention and support would be required for all of these groups at different levels, and that local planning committees should decide what the priorities for targeting are in their areas.

4.59 However, most of the respondents who had comments on the subject of targeting either made suggestions for additional groups to be targeted, or — as was more often the case — they were requesting that particular groups should be mentioned explicitly. (It should be noted that many of groups proposed by respondents for targeting would have been encompassed within the groups listed in para 6.1.) Such groups included:

- Older adults, including those with dementia
- Refugees and asylum seekers
- Black and ethnic minorities
- Lesbian, gay, bi-sexual and transgender people
- Armed forces veterans
- Homeless people
- People involved in prostitution
- People with learning disabilities
- People with epilepsy and other long-term physical health conditions
- People with sensory impairments and / or communication support needs, particularly those with complex and multiple needs
- All children identified by agencies as requiring particular support

4.60 As has already been mentioned elsewhere in this chapter, respondents were particularly concerned that the emphasis on children and young people in the TAMFS

document should not exclude action to promote the mental health and wellbeing of older people.

4.61 Three additional groups which, perhaps, did not obviously fall into any of the categories listed in para 6.1 included:

- People living in rural and remote areas of Scotland
- Men (In particular, efforts were needed to address the stigma associated with men acknowledging they have a need for some form of help.)
- Unpaid carers (including carers of people with long-term physical and mental health problems and / or dementia).

4.62 In relation to TAMFS para 6.1, point 5, one respondent expressed the view that "people without access to key assets or resources" was not explicit enough. This individual suggested that such a statement should be more directly linked to the Scottish Government discussion paper, *Taking forward the Government economic strategy: A discussion paper on tackling poverty, inequality and deprivation in Scotland* (February 2008).[4]

[4] Available at: www.scotland.gov.uk/Publications/2008/02/01150409/18.

5 National supports needed

5.1 The second question posed in the consultation paper was: *What national supports would help you to meet these objectives and actions?* In Section 10 of the TAMFS paper, four potential areas for national support were suggested. These were:

- Undertaking and commissioning national research and evaluation, and disseminating evidence of what works and what looks promising.

- Helping to build capacity though evidence-based training and providing opportunities for networking and learning.

- Undertaking social marking and national campaigning, and supporting the media on issues to do with mental health promotion, suicide prevention and improving the quality of life of people living with mental illness.

- Developing national indicators of mental health and wellbeing and supporting data collection and review.

5.2 Respondents strongly agreed that ongoing national support for each of these activities would be valuable and necessary. Respondents frequently voiced concern that the shift towards greater activity at a local level *must not be at the expense of national co-ordination activity and initiatives,* such as 'see me,' Choose Life, Heads-up Scotland and the Scottish Recovery Network, to name a few. These initiatives were clearly perceived as important and effective, and respondents stressed that there was ongoing need for national support and co-ordination in these areas.

5.3 In addition, respondents commonly saw a need for national support in relation to:

- Funding, in particular, long-term funding
- Setting realistic timescales for change
- Ensuring consistency in the implementation of national policy at a local level
- Giving greater recognition to the value and role of the voluntary sector in carrying this agenda forward.

5.4 Each of these points is discussed further below, and some comments from respondents are included to illustrate the points made.

Funding

5.5 Respondents commonly expressed a need for support in the form of funding. In some cases, individuals specifically called for more resources for their own organisations or special areas of interest. And it is perhaps worth noting that some of these organisations were not "mental health services" but rather services that could offer health-promoting activities, or which had a remit for supporting vulnerable people at risk of mental health problems.

5.6 Other respondents (including many service users, carers and their representatives) argued, more generally, for additional resources to be made available to support the work of mental health improvement in Scotland, particularly since, as one respondent pointed out,

the pressures on existing mental health services (which are largely there to support people with mental illness), will also continue to require investment and development.

5.7 Some respondents wanted additional funding to be "mainstreamed." Others wanted it to be "ring-fenced." Some wanted both. However, all agreed that additional resources would be needed (particularly within the voluntary sector) to take this agenda forward, and that the funding should be long-term (that is, longer than three years). The issue of timescales is discussed below.

5.8 Several respondents specifically requested additional funding for Choose Life (suicide prevention) activity. One individual agreed that suicide prevention should be part of a wider mental health improvement agenda, but argued that there was also a need for specialist knowledge and long-term investment in this area.

Setting realistic timescales for change

5.9 Respondents repeatedly made the point that change in the area of mental health improvement required major attitudinal and behavioural changes among individuals and communities — a "cultural shift" as one respondent called it. It was felt that this would take time and a long-term vision by the Scottish Government to sustain it.

5.10 Respondents stressed the need for mental health policies to be *"politically neutral"* and *"not subject to unnecessary change if the party in power changes."* As mentioned above, many argued that there was a need for longer-term funding in this area, and highlighted the disruption that was caused, particularly to voluntary sector agencies, through the constant need to pursue short-term project funding.

> *"A period of three years is too short to bring about the long-term change inferred in the consultation document…. There needs to be a longer, more sustained approach towards mental health improvement and building mental wellbeing." (Local authority respondent)*

> *"Projects need adequate time and money to make an impact, and the Scottish Government needs to ensure that (when a project is found to be successful after evaluation) the funding continues. Fragmented and unstable funding sources contribute to the fragmented nature of mental health services, particularly in the voluntary sector." (Voluntary sector respondent)*

Ensuring consistency in implementation of national priorities at a local level

5.11 Another major theme concerned the relationship between national priorities and local actions. There were a range of views on this issue among respondents. However, in general, these represented differences in emphasis, rather than disagreement.

5.12 Some respondents suggested that there was a lack of consistency across Scotland in the interpretation of national strategy and in service delivery, more specifically. These individuals felt there was a need for national support and guidance to ensure greater consistency in the interpretation and implementation of national policy at a local level. There was a call for the development of service standards (*"minimal and 'gold standard'"*) to ensure best practice and consistency of service quality across agencies.

"The National Programme needs to continue to work more closely with local partners — national strategy can be confusing and subject to local interpretation resulting in inconsistency of approach. . . . Need a mechanism in place to ensure consistency across Boards / CHPs / Local Authorities when interpreting national actions locally." (Multi-agency consultation event)

"If targeting early years is the best way of addressing wellbeing, then national policy should give this clear direction. Targeting early years, including parenting, should be the main health inequalities / wellbeing priority. This also needs to be a clear and consistent message across both Local Authorities and the NHS." (Local authority respondent)

5.13 In contrast to this view, other respondents suggested that the Government should set general objectives with clear outcomes, but allow for flexibility in action at a local level.

"We would stress the need to balance national activity on evaluation, training, skills development and communication with the need to deliver on these issues locally, have local ownership and be able to deliver initiatives that take into account local circumstances." (Multi-agency consultation event)

5.14 Some respondents were very concerned about the impact of incorporating monies that had previously been ring-fenced for Supporting People and Choose Life, into the general budgets for local authorities. Several feared that the result would be a lack of prioritisation for promotion and prevention activities within local authorities.

"Both the Supporting People Grant and Mental Health Specific Grant have been abolished with this money being incorporated into overall funding for local authorities. This is of serious concern given that mental health improvement work and services for people with mental health problems are frequently not seen as a priority for local authorities." (Voluntary sector respondent)

"Concern that loss of ring-fenced funding to local authorities will result in loss of priority for this area. Also concerned that the HEAT targets will result in this area being perceived as only an NHS responsibility." (Multi-agency consultation event)

"Need proper checks and balances at a national level to ensure that mental health and wellbeing remains a priority under the new local authority funding arrangements, as there is a real danger that it could fall off local agendas due to competing priorities for funds." (Multi-agency consultation event)

The role of the voluntary sector

5.15 Comments (generally received from the voluntary sector and from multi-agency events), frequently highlighted the importance of the voluntary sector in taking forward the mental health improvement agenda. Respondents requested that the role of the voluntary sector should be given greater emphasis and endorsement in the TAMFS document, and suggested that there was a need for national support to ensure that the voluntary sector has an equal role with other partners in the planning of local services.

5.16 One local authority respondent suggested that national support was needed to address a perceived need for *"ongoing development of a shared language and improved*

understanding of contributions of the non-healthcare sector to mental health improvement." However, it was not clear from this comment whether the improved understanding was needed by service providers *outside* the healthcare sector, or *inside* it.

Other issues

5.17 Respondents highlighted a very wide range of other issues which they felt would benefit from national support in taking forward the mental health improvement agenda over the next three years. Those mentioned by three or more respondents included:

- **Reviewing the benefits system:** Respondents felt that Scotland needed a benefits system that supports people when they are out of work, but which also supports their return to work. One individual made the point that people with few skills often gain little financially from being in work, particularly if they have low wages and high rents. Another respondent asked that employment regulations be changed so that people can do voluntary work while on benefits (having travel expenses reimbursed).

- **Making mental health improvement everyone's business:** In different ways, respondents pointed out that the work of mental health improvement had to be undertaken by services and initiatives far beyond the health-care sector. Respondents suggested that national infrastructure support was needed for local post offices, public transport, community facilities, housing and economic development, particularly in areas of deprivation, or in remote and rural areas. At the same time, there was a concern that mental health improvement may be seen as "everyone's business but no one's responsibility." Thus there would be a need for clarity about who was accountable at a local level for progress in this area. (Issues of accountability and performance assessment are discussed in the next chapter.)

- **Ensuring 'joined-up' policies:** Related to this last point, respondents clearly saw mental wellbeing as a cross-cutting policy issue. The view was expressed that significant ongoing work was needed at a national level, to ensure that Government departments were "joined-up" in this respect. One respondent argued that ministerial portfolios in every policy area should include the priority of promoting and maintaining mental wellbeing. One individual also suggested that national support was needed to introduce Mental Health Impact Assessment into all major local policy decisions.

- **Making leisure, sporting and cultural activities more accessible and affordable:** Several respondents argued that participation in recreational, sporting and cultural activities (including walking and gardening / community allotment initiatives) were proven to have a positive impact on mental wellbeing, and that the Government needed to ensure that these types of activities and initiatives were more widely accessible and affordable at a local level. One respondent requested that the Scottish Government establish a working group to develop a strategy and action plan for gardening in Scotland, in relation to its role in supporting positive mental health and wellbeing.

- **Employment guidance:** As discussed in the previous chapter, respondents strongly felt that NHS and local authority organisations should act as "exemplar

employers" in promoting mental health and wellbeing among their staff, and in providing opportunities for people with mental health problems to return to work. However, some respondents requested guidance from the Scottish Government in developing policies that promoted positive mental health, as well as guidance about the duty of care employers had in relation to the Disability Discrimination Act.

- **Reducing self-harm:** It was pointed out that there are many complex issues surrounding the issue of self-harm, and that it would be helpful to have a national strategy and action plan on reducing self-harm.

- **Developing post-suicide resources:** Several respondents felt there was need in their local area to provide greater support to family and friends of people who had attempted or completed suicide, and there was a request for support in developing resources in this area.

- **Developing a national "good practice databank":** This would provide evidence of what works and support implementation of best practice locally.

6 Tracking progress and assessing performance

6.1 The third and final question in the TAMFS paper was: *How can progress be tracked and performance assessed?*

6.2 Before presenting a summary of respondents' replies to this question, it is important to note that, in general, respondents **strongly agreed** with the premise that progress *should* be tracked and performance *should* be assessed in this area. **None** of the respondents questioned, or disagreed with, the need to measure progress, and indeed a number of respondents called for the development of more robust accountability processes between local areas and the Scottish Government.

6.3 However, two individuals pointed out that any system to track and assess performance must be able to take into account the complexity of the issue.

> *… Large numbers of people coming for help with bereavement issues may look bad statistically, but actually it is better that they come for help rather than languishing in the misery of loss. (Individual respondent)*

> *Things may get worse before they get better, which doesn't mean changes in direction are required, e.g., if GPs make referrals for early intervention, then uptake of these services could increase, but the long-term impact may be that referrals to acute services will reduce. (Multi-agency consultation event)*

6.4 Although respondents generally agreed that it was important to measure outcomes for people, some suggested that it might be difficult to measure outcomes in certain areas — for example, in relation to preventing self-harm. In this case, it may be necessary to rely on indicators which measure the quantity and quality of local services.

6.5 There were a range of views about what form performance monitoring should take, and in some cases, there were opposing opinions on the matter. However, the vast majority of respondents suggested that progress should be tracked and performance assessed through one of three methods:

- Through the use of existing agreed indicators and targets
- Through evaluation of projects and initiatives
- By seeking the views and feedback of service users

Use existing agreed indicators and targets

6.6 The majority of respondents felt that, as much as possible, local area performance in relation to mental health improvement should link into existing, nationally agreed indicators and targets such as, for example:

- Single Outcome Agreements (local authorities)
- HEAT targets (NHS)
- Scottish Recovery Indicator
- National mental health indicators (under development by Health Scotland)

6.7 There was a less common view which argued for a move away from "a target-focused mentality." However, the much more prevalent view was that local areas should not be burdened with *additional* targets and reporting structures.

6.8 Many felt that the Warwick Edinburgh Mental Well-being Scale (WEMWBS) was useful, and should be used across Scotland to measure changes in population mental health and evaluate the impact of projects and other initiatives. One individual specifically requested whether it might be possible to include WEMWBS in community health profiles. Another asked whether national data from WEBWBS could be made available at local authority level, as well as health board level, to help local authorities assess their performance and progress.

6.9 It should be noted that some respondents expressed concern that local authorities may not include relevant mental health indicators in their single outcome agreements. One individual said that:

> *"While supporting the setting of objectives and actions for delivery at a local level, we believe it is unsatisfactory that the question of targets for mental health and social care should be left to each individual local authority." (Voluntary sector respondent)*

Evaluation of projects and initiatives

6.10 Evaluation was proposed as another method for measuring progress and assessing performance, and several respondents suggested that evaluation should be built in to all planned activities. One of the advantages of evaluation was that it would allow more qualitative data to be collected on outcomes, and it could present a more rounded picture of the process of change, using a variety of methods.

6.11 Respondents suggested that the Evaluation Guides developed by Health Scotland were useful for this purpose.

Seeking the views and feedback of service users and carers

6.12 There was widespread agreement among respondents across all sectors that it was important to involve service users (and their carers) in the ongoing development of services that affect them. Some suggested that much more needed to be done to seek honest feedback from service users and carers when measuring the impact of services — and to act on that feedback in a positive way.

6.13 It was suggested that seeking the views and feedback of service users and carers could be done in a variety of ways:

- Before and after surveys
- Use of self-assessment tools
- Measuring other behaviour change (smoking, drinking)
- User satisfaction questionnaires
- "Stress questionnaires" (to measure wellbeing at work)
- Applying user ratings to services (in the same way that accommodation and restaurants are graded)
- Asking service users and carers what they think

6.14 One respondent praised the work of Heads-up Scotland in meaningfully involving children and young people in issues that affect their mental health and wellbeing. This individual called for similar work to be undertaken across Scotland particularly if children and young people and their families are going to be a focus of mental health improvement interventions. Another respondent echoed this point, and pointed out that engaging with children and young people needs resources, and longer timescales than those generally used in Government consultation processes.

Other suggestions

6.15 In addition to the three methods described above, respondents suggested that a wide range of outcomes and indicators could be used to track progress and assess performance in this area. Some of these suggestions are listed below. In some cases, the relevant data is already being collected, but may not be used as a measure of mental wellbeing. In other cases, the development of new tools would be required.

- Measure levels of staff absence (in the NHS) due to stress, depression, bullying and harassment.
- Collect and publish information on waiting times for psychological therapies.
- Gather evidence of the impact of volunteering on mental health and wellbeing. [Suggested using the Volunteering Impact Assessment Toolkit for this purpose.]
- Set targets to address the needs of young carers.
- Set targets for a reduction in the prescribing of drugs / anti-depressants. (Note, however, that other respondents argued that targets to reduce anti-depressant prescribing were unhelpful.)
- Gather statistics on the number of referrals to Housing Investigation Teams due to chaotic lifestyle disturbance, identify how many of these referrals relate to people assessed as having a mental health problem, track what support was given, and the outcomes of those interventions.
- Monitor unemployment rates.
- Measure levels of hazardous drinking.
- Develop national indicators to measure the mental health and wellbeing of children and young people, and in particular looked-after and accommodated children.
- Develop national systems (via ISD) to record the use of counselling and other psychological therapies.
- Develop indicators of better multi-agency working (for example, better referral pathways for people who present to A&E or out-of-hours services due to self-harm or suicide attempt).
- Develop primary prevention measures, including indicators of whether people are being connected to preventative and early intervention services.
- Develop indicators of community participation and social activity (e.g., levels of volunteering, youth club participation, library usage, use of community and leisure facilities).

Need to develop qualitative measures

6.16 Some respondents argued that it is not enough to simply collect statistics and report on numerical targets. There was a strong feeling that **more qualitative data** ('soft indicators') was also needed to assess the progress of the mental health improvement agenda. One local authority respondent said that:

> *"There needs to be a greater movement towards a social model of health, rather than solely a medical model…. The challenge for the social model is the qualitative aspect of change generated." (Local authority respondent)*

6.17 Another individual — the same respondent who suggested measuring levels of staff absence due to stress, depression, bullying and harassment (see point 1 above), also suggested that additional qualitative information was needed to truly measure improvement:

> *"We note that NHS Boards currently only report a single, annual staff sickness absence figure to the Scottish Government. We would like to see Boards report on certain reasons for absence in the future so that the NHS can demonstrate the improvements it is making for its own staff." (Representative of NHS professional body)*

6.18 Similarly, another respondent asked for national support to develop a framework that would capture information about the factors that contributed to suicide — in addition to simply measuring the number of suicides in an area. This would assist local planning committees to commission better prevention services. Another individual argued that it was necessary not only to measure whether people move on from services (throughput), but what they move on *to.*

7 Other comments

7.1 A number of themes arose in the consultation which came from a smaller number of respondents. Many of these may be considered to be general comments on the TAMFS discussion paper. However, as they came from a relatively small proportion of respondents, they were not included in Chapter 3. Nevertheless, it was felt they were significant enough to merit a very brief summary here.

- **Readability of TAMFS:** A number of respondents commented that they found the TAMFS document difficult to read. These comments came from respondents across all sectors. It was suggested that the final action plan should be written in plain English, avoid the use of acronyms and technical jargon, avoid use of numerous bullet points, and provide a glossary of terms.

- **Concepts and definitions:** One respondent suggested that the term “mental flourishing” was not a commonly recognised concept. Another felt that terms like “languishing” and “flourishing” were inaccessible to many people. There was a suggestion that work should be undertaken to find out how members of the general public referred to the idea of mental wellbeing.

  One respondent argued that the definition of mental illness given in para. 4.1 of the TAMFS document was incorrect. (*“Many mental illnesses do not affect cognitive functioning.”*) This respondent suggested that the World Health Organisation definition be used instead: *“A clinically recognizable set of symptoms or behaviour associated in most cases with distress and interference with personal function.” (WHO 1992).* This same respondent felt that some discussion was needed about why mental wellbeing was defined in para 4.1 as having “emotional, social and psychological” components. Furthermore, she questioned the premise in para 4.2 that “someone could experience signs and symptoms of mental illness and still have good or flourishing mental wellbeing” since most conventionally accepted definitions of mental illness include the experience of distress of some kind.

  There were a number of comments on the ‘dual continua’ model presented on page 3 of the TAMFS paper. Some respondents wanted to know upon what evidence this model is put forward. Furthermore, although one individual felt that the model was extremely useful, others argued that it was confusing and simplistic. There was a suggestion that further work should be undertaken (possibly led by Health Scotland) to develop a causal / explanatory model of mental health improvement.

- **Need better partnership working:** Better partnership working is needed to improve integration of care and planning processes. The mental health and wellbeing agenda is not just a role for health. Agencies need to be encouraged to be more pro-active and less reactive. Local partnerships should include carers, churches, community groups, trade unions and professional bodies, voluntary sector organisations, workplaces and young people.

- **Community Health Partnerships:** It was agreed that CHPs have a key role in taking forward the mental health improvement agenda, but in some areas, CHPs were felt not to be robust enough.

- **Local co-ordination is important:** There needs to be an individual at local level whose job it is to make sure things happen. Support is needed for local ‘champions’ who are committed to fostering mental health improvement in their communities. More local research, evaluation and needs assessment is required to enable local priority setting.

- **Pilot programmes:** These were perceived by some respondents not always to be useful. Once the pilot ends, the problem recurs. Longer-term funding and consistency of service provision was felt to be needed.

- **Get rid of the word ‘mental’:** Comments were received from several respondents across different sectors that the use of the word “mental” was stigmatising, particularly for young people. The suggestion was that the TAMFS action plan should avoid using it in favour of simply using the term “wellbeing” or “health and wellbeing.”

- **Suggested areas for future research:** Several respondents made suggestions for future research:

    - Need a national programme of research on how mental ill health affects the lives of deaf, deafblind and deafened people
    - Evaluation of social and therapeutic gardening projects for improving mental health and wellbeing
    - Evaluation of the provision of services to support mental health service users with communication support needs
    - Evaluation of the impact of volunteering on mental health and wellbeing
    - Evaluation of mental health-related training for professionals
    - More child-specific mental health research
    - Longitudinal research involving children and families

Annex 1: List of respondents

Responses from groups / organisations

Alcohol Focus Scotland
Alzheimer Scotland
Art in Healthcare
British Medical Association (BMA) Scotland
Carers Scotland
Children in Scotland
City of Edinburgh Council / NHS Lothian
Convention of Scottish Local Authorities (COSLA)
Deafblind Scotland
Depression Alliance Scotland
Diabetes UK Scotland
Dumfries and Galloway - Older Adults Mental Health and Wellbeing
Dumfries and Galloway More Choices More Chances Partnership
Dundee City Council
Dundee Community Transport and Dundee Accessible Transport Group
East Lothian Council
East Renfrewshire Mental Health Forum
East Lothian Involvement Group (ELIG)
Epilepsy Scotland
Fife Families Support Project
Fife Health and Wellbeing Alliance
Flourish House
Inverclyde Council
Long Term Conditions Alliance Scotland (LTCAS)
Mental Health Sub-Group to Local Service Users Network
Midlothian Council
NHS Ayrshire & Arran (multi-agency consultation event(s))
NHS Borders / Scottish Borders Council (including Borders Voluntary Community Care Forum)
NHS Education for Scotland (NES)
NHS Dumfries and Galloway
NHS Forth Valley
NHS Greater Glasgow & Clyde (multi-agency consultation event(s))
NHS Health Scotland
NHS Highland / Highland Council
NHS Lanarkshire (multi-agency consultation event(s))
NHS Lothian
NHS Lothian Health Promotion Service
NHS Orkney / Orkney Island Council (multi-agency consultation event(s))
NHS Shetland (multi-agency consultation with Shetland Mental Health Partnership)
NHS Tayside (multi-agency consultation event(s))
North Ayrshire Choose Life Steering Group
North Ayrshire Council
Orkney Disability Forum
Paths to Health (The Paths for All Partnership)
Patients' Council Royal Edinburgh Hospital – 2 respondents

Royal College of Nursing (RCN) Scotland
Royal College of Psychiatrists (RCPsych)
Royal College of Speech and Language Therapists
Scottish Association of Alcohol and Drug Action Teams (SAADAT)
Samaritans
Scottish Association for Mental Health (SAMH)
Scottish Allotments and Garden Society
Scottish Children's Reporter Administration
Scottish Council on Deafness
Scottish Further Education Unit
Scottish Natural Heritage
Scottish Social Networks Forum
Sense Scotland
Trellis
UNISON Scotland
Volunteer Development Scotland
Young Scotland in Mind

Individual responses

Greta Doig
Robin Bate
Sandra Paterson
Robert Bell
+ 9 individuals who responded anonymously, or who requested not to have their names published.

Annex 2: Participation in multi-agency consultation exercises or events

Respondent	Consultation participants	Number of participants
Alcohol Focus Scotland	Representatives from: • Youth Link Scotland • East Ayrshire Council • Health Scotland • Alcohol Focus Scotland	Not stated
City of Edinburgh Council / NHS Lothian	Not stated – response takes into account "views from across all relevant Council Departments, as well as wider discussion with partner agencies, including key agencies such as Capital City Partnership, Voluntary Organisations, Edinburgh Community Health Partnership."	Not stated.
Dumfries & Galloway roundtable discussion on older adults' mental health	Representatives from NHS, local authority and voluntary sector agencies working with older people in Dumfries & Galloway.	12
Dundee Community Transport & Dundee Accessible Transport Group	Not stated	Not stated
Fife Health & Wellbeing Alliance	Not stated	Not stated
NHS Ayrshire & Arran	Four discussion sessions were organised across Ayrshire and Arran — one in each local authority area + one on the island of Arran. Participants included representatives from: • Access • ADD It Up • Alcohol & Drug Action Team • Ayr Academy • Ayr Action for Mental Health • Ayr College • Ayrshire Eating Disorder Action Group • Becogent • Community Horizons • Crosshill Primary School • Cumnock Academy • Diabetes UK Ayrshire Volunteer Group • Diageo Global Supply • East Ayrshire Advocacy Services Ltd • East Ayrshire Council • East Ayrshire Libraries • Epilepsy Action Scotland • Friends of Newton Park • Fullarton Community Health House • GE Caledonian • Glenfairn Housing Support Agency • Hansel Alliance • Headway Ayrshire	Group 1: 50 Group 2: 74 Group 3: 68 Group 4: 16

	• Healthy North Ayrshire Project • Houston Travellers Site • Job Centre Plus • Kilmarnock College • Momentum • Morven Day Services • National Autistic Society (Daldorch House) • Newton Primary • NHS Ayrshire and Arran – including: Addiction Services, Area Partnership Forum, Community Mental Health Team, Community Mental Health Team (Elderly), East Ayrshire CHP, East Ayrshire Public Partnership Forum, Kilbirnie Health Centre, North Ayrshire CHP, North Ayrshire Public Partnership Forum, School Nursing Service, South Ayrshire CHP, South Ayrshire Public Partnership Forum • North Ayrshire Adult Mental Health • North Ayrshire Carers Centre • North Ayrshire Children's Panel • North Ayrshire Community Planning Partnership • North Ayrshire Council • North Ayrshire Volunteer Centre • North Cunningham (Arran) Community Mental Health Team • North West Kilmarnock Area Centre • Panel of Reference • Partners for Inclusion • Public – Carers • Public – Parents • Saltcoats Community Council • Scottish Association for Mental Health • School of Social and Political Studies • Scottish Ambulance Service • Scottish Enterprise Ayrshire • Scottish Stampings • See Me • Serco Health • South Ayrshire Befriending Project • South Ayrshire Council • South Ayrshire Night Stop • South West Scotland Justice Authority • The Simon Community • Three Towns Resource Centre • Training Toolbox • Turning Point Scotland • Unison • Viewpoint • Wallacetoun and Newton Regeneration Forum	
NHS Borders / Scottish Borders Council	Representatives from: • NHS Borders (2) • Scottish Borders Council (3)	6

	• Borders Voluntary Community Care Forum (1)	
NHS Dumfries & Galloway	Respondents from: • Individual consultation • Consultation event • Members of the Safe & Healthy Partnership in Annandale and Eskdale • Group on Older Adults' issues • Group of carers in Wigtownshire • Secondary school students in Stewartry	99 from individuals + 2 collective responses from Safe & Healthy Partnership and group on Older Adults' issues
NHS Forth Valley	Representatives from: • NHS (15) • Local authority (12) • Voluntary organisations (11) • Service user and carer groups (5) • Central Scotland Police (3) • Further education (1)	47
NHS Greater Glasgow & Clyde	Representatives from: • ACUMEN • Acute Planning & Women & Children's Directorate • Adult Community Mental Health Team • Carr-Gomm Scotland • Charleston Centre Mental Health Resource Centre • Community Addiction Team • Create Consultancy • Deaf Connections • Dykebar Hospital • East Glasgow CHCP • East Dunbartonshire CHP • East Renfrewshire CHCP • Flourish House • Glasgow Association for Mental Health • Glasgow Centre for Population Health • Glasgow City Social Work • Glasgow City Corporate Planning & Policy • Glasgow Mental Health Partnership • Greater Glasgow Mental Health Network • Inverclyde CHP • Inverclyde Council • Jubilee Social Centre • Lifelink • National Resource Centre for Ethnic Minority Health • NHS Greater Glasgow & Clyde (Acute) • NHS Greater Glasgow & Clyde (Child Public Health Team) • North Glasgow CHCP • Royal Alexandra Hospital	170

	• Renfrewshire Association for Mental Health • Renfrewshire CHP • Scottish Association for Mental Health • 'See me' • South Clyde Acute Hospitals • Southeast Glasgow CHCP • Southern General Hospital • South Lanarkshire CHCP • Southwest Glasgow CHCP • Steps • Strata House • University of Edinburgh • West Dunbartonshire CHP • West Dunbartonshire Council • West Glasgow CHCP	
NHS Highland	Not stated	Not stated
NHS Lanarkshire	Representatives from housing, regeneration, voluntary sector, police, addictions, schools, NHS and social work. Service users and members of the public also represented.	165
NHS Lothian	Not stated	130
NHS Orkney / Orkney Island Council	Not stated	Not stated
NHS Tayside	Three local discussion events held in Angus, Dundee and Perth, involving representatives from NHS, local authorities, voluntary sector and service users' groups.	100 (est)
North Ayrshire Choose Life Steering Group	Not stated	Not stated
Orkney Disability Forum	Not stated	Not stated
Scottish Association of Alcohol and Drug Action Teams (SAADAT)	Representatives from: • Forth Valley Substance Action Team (2) • Shetland Alcohol & Drug Action Team (1) • Aberdeen City Joint Alcohol & Drug Action Team (1) • Aberdeenshire Alcohol & Drug Action Team (2) • Moray Drug & Alcohol Action Team (1) • Angus Drug & Alcohol Action Team (1) • Orkney Drug, Alcohol & Smoking Action Team (1) • SAADAT (3)	13
Shetland Mental Health Partnership	Not stated	Not stated

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