Scrutiny of the Draft Budget 2012-13 and Spending Review 2011

Mental Health Foundation

1. Mental Health Foundation

1.1. The Mental Health Foundation is the UK’s leading mental health research, policy and service improvement charity. In February 2011 the Scottish Development Centre for Mental Health joined the Mental Health Foundation’s existing Scottish presence. This merger created a strong third sector centre of research and development excellence in mental health, with a combined 75 years of experience in Scotland. The Foundation operates across four offices in London, Newport, Edinburgh and Glasgow. Just over a third of our staff are based in Scotland.

1.2. We work across all areas of mental health, from promotion and prevention activities at all levels, to supporting organisations in evaluation and development of mental health services, and empowering people with lived experience of mental ill health to recover and thrive. At our core is a belief that inequality is a critical determinant of population wellbeing, and a major inhibitor of recovery from mental illness. We are therefore committed to addressing structural inequality, poverty, discrimination and exclusion at every level, highlighting the role of mental health in the cross-policy solutions to these wide ranging issues.

1.3. We work on a range of mental health projects focusing on the connections between policy, research and practice, in Scotland, and in collaboration with colleagues in other parts of the UK and beyond.

2. General Comments

2.1. We welcome the opportunity to submit evidence to the Committee in its work to scrutinise the Draft Budget and Spending Review. This is a critical time for public services, and a key opportunity to achieve reform necessary to improve efficacy and reduce cost in times of necessary reductions in budgets. We believe that mental wellbeing is a critical key to unlocking some of the major challenges in Scotland, and should be regarded as such across public policy.

2.2. The central tenets of the Christie Commission report on the future of public services fit extremely well with a mental health in all policies approach, both in relation to the promotion of recovery from mental illness, and in the protection and promotion of public mental health more generally. We are preparing a broader briefing on this subject which will be available shortly.
2.3. The Scottish Government currently has an open consultation on a
future mental health strategy for Scotland, to succeed and further
develop pioneering work undertaken since devolution on both mental
health law and service reform, and on public mental health. A key
challenge of that new policy will be in maintaining necessary
momentum and leadership for mental health in all policies whilst
making necessary savings and improvements in outcomes in the core
areas, or primary policy areas of mental health services, suicide
reduction and reducing discrimination.

2.4. MHF believes that one method of doing this is to include mental
health and wellbeing at the heart of secondary and tertiary mental
health policy. These could be described respectively as areas of
policy that influence mental health directly, or determine demand on
primary mental health areas (such as education, health, inequalities
or communities) and upstream policy areas such as economic
development and social protection.

2.5. Being subject to inequality is a major factor in the erosion and
corrosion of mental capital, and development of poor mental health.
There is a greater risk of developing mental health problems, the
experience of and treatment for which further erode resilience and life
skills. In many communities in Scotland, the prevailing climate of lack
of hope, sense of purpose and agency leads to poor mental health,
poor self-esteem and a learned helplessness and interdependence on
multiple public services. It is highly likely that addressing mental
health and wellbeing in strategies to support this population would
bear fruit.

2.6. We welcome the inclusion of the Cities role in the Health Portfolio, as
it is clear that a number of the inequality related challenges we face
require a concentrated effort in our urban centres of deprivation.
Equally, we urge that the different, equally disruptive, but in
population terms less high impact effect of rural inequalities is not lost.

2.7. The challenge remains that some levers of mental health outcomes in
Scotland, such as access to benefits, and the protection afforded by
equality legislation are outside of the current remit of the Scottish
Parliament, but that policy set in Westminster still has downstream
effects on the services, and outcomes achieved in Scotland.

3. Preventative Spending

3.1. Mental health determines and is determined by a wide range of social
and health outcomes at individual, community and societal levels and
has an impact on all aspects of our lives. Poor mental health
contributes to socio-economic and health problems such as higher
levels of physical morbidity and mortality, lower levels of educational
attainment, poorer work performance/productivity, greater incidence
of addictions, higher crime rates and poor community and societal
cohesion. The breadth of the impact of poor mental health makes a compelling case for the prioritisation of mental health improvement actions in any framework of preventative spending.

3.2. In the context of the current economic downturn it is clear that difficult decisions on prioritisation are required. When resources are scarce a common default position is to focus on immediate need. Within a mental health context this could translate to a focus solely on service provision and a contraction of mental health promotion and prevention activities. It is critical to continue to prioritise mental health promotion and prevention within mental health policy but also to understand the many impacts that poor mental health can have on a range of budgets that go beyond health and social care, including employment, education, housing and criminal justice. Investing in mental health improvement now should generate substantial economic savings within a whole host of public policy areas and reduce future negative outcomes and failure demand as a result.

3.3. Pragmatically speaking, we recognise that resources are scarce and we would argue that prioritisation does not need to be a choice between service provision and a preventative agenda. Instead prioritisation should be based on evidence of where investment can have the most impact, much of which territory overlaps substantively with the areas of preventative spend proposed in the draft budget.

4. Early Years

4.1. The early years of life are a critical time with the parent/child relationship being vital to a child’s development, to his or her future psychological well-being, and to a range of long-term outcomes such as educational attainment, social networks and employability (Shonkoff & Phillips, 2000). We strongly welcome the proposals in the draft Budget to invest in Early Years via Early Years and Early Intervention Change Fund. We were struck by Susan Deacon’s Remarks to the Christie Review, where she reflected that had the spend devoted to anti-social behaviour been devoted to early years, the effect would have been transformative.

4.2. One of the most important factors for childhood mental health is to have a small group of adults in early life with whom the child can form an attachment and who respond effectively and appropriately to their needs (de Caestecker & Killoran-Ross, 2010). Interventions that support family life are therefore among the most effective, with the provision of parenting support and improving the home learning environment being hugely cost effective. Indeed, it has been estimated that for every £1 spent on this, there is an £8 return. (Health Scotland, 2010)
4.3. The DataPrev project\(^1\) was funded by the European Commission under the Sixth Framework Research Programme, for Scientific Support to Policy. It conducted rigorous reviews of evidence in several areas of mental health improvement in order to advise policy makers on what worked, based on sound evidence. Professor Sarah Stewart Brown of the University of Warwick led the Early Years and Parenting review. It suggests that the following areas are most evidence based, and in most cases have effective activities at a range of cost levels to public services, suggesting that not all areas of evidence based preventative spend need be big ticket expenses

- Practices in the perinatal period.
- Practices to prevent and treat postnatal depression.
- Practices that provide parenting support in infancy and early years.
- Parenting practices with a focus on the prevention of behaviour problems.
- Parenting support in very high-risk groups.

4.4. Findings from Growing Up in Scotland study into maternal mental health and its impact on young children suggests that maternal mental health had a significant impact on their child’s development by the age of 4. This study found almost a third of mothers experienced poor mental health in the first 4 years of their child’s life with between 12% and 16% experiencing mental health problems. Mental health difficulties were associated with their social circumstances; those experiencing poverty and living in deprivation were more likely to experience brief and repeated mental health problems. Children whose mothers were emotionally well throughout the survey period had better social, behavioural and emotional development.

4.5. Parenting is the major single modifiable variable implicated in outcomes for children, notably accident rates, teenage pregnancy, substance misuse, truancy, school exclusion and under-achievement, child abuse, employability, juvenile crime and mental illness. Investing in the mental health of young children and their mothers (main caregiver) and providing parenting support can produce long-term improvements in outcomes across a wide range of sectors.

4.6. We believe that his approach needs to be targeted based on the evidence that outcomes are poorer for children and mothers experiencing poverty and living in deprivation. We would hope that parenting support for people with chaotic lifestyles, complexity in health or social issues, or mental health problems could be effective not just in early years prospects of children, but also in reducing negative perceptions of the competence of some excellent, dedicated parents from these groups.

\(^1\) [http://www.dataprevproject.net](http://www.dataprevproject.net)
4.7. Universal programmes are of course valid and will be successful in producing mental health gain, however without targeting or indeed a focus that is proportionate based on need then the families that most need access to the support may not receive this.

5. Later Life

5.1. Scotland like the rest of the UK has an ageing population where the proportion of older people is increasing due to low birth rates and increased longevity. By 2020 two in five people in the UK will be over 50 years of age and one in five over 65. The oldest age group (85 and over) is growing the fastest with an increase in the proportion of the population from 1.9% in 2004 to an estimated 2.7% in 2020.

5.2. By 2050 in Europe 30% of the population will be over 65 years of age and 11% over 80 years (Office of National Statistics, 2009). This will have a major impact on society not only in terms of family structure and roles but also on economic issues related to wealth production and the costs of care. It is one of the most significant and challenging issues to be faced this century (Goldie, 2010).

5.3. The number of older people with mental health problems is forecast to increase as the population ages and often such problems are not identified or appropriately treated. Mental health problems particularly depression and dementia are more common and have a worse outcome in the 60% of older people who suffer from a long-term illness (Healthcare Commission, 2009).

5.4. Depression affects 20% of people aged between 65 and 69, rising to 40% of people aged 85 and over and often the illness is underestimated being mistakenly viewed as an inevitable consequence of ageing (Beekman, Copeland, Prince, 1999; Depression Alliance Scotland, 2010). According to reports from one later life organisation, fewer than 10% of older people with diagnosed depression are referred to specialist mental health services compared with around 50% of younger adults who experience mental health problems. In some cases, GP’s are unable to refer older people onto other services that could help them because of age related exclusion criteria operating within services.

5.5. Overall, eight out of ten older people with depression do not get any treatment (Age Concern, 2007). Within Scotland the Dementia Strategy has potential to have a significant impact on the lives of people with Dementia. Investment in this vital area needs to be viewed as a priority. A commitment within TAMFS led to the development of a later life action plan, the challenge now is to match this commitment with appropriate investment. Older people, particularly those most isolated or living with Dementia are seldom
represented within service planning meetings. This lack of visibility has until recent years meant that their needs have been overlooked.

5.6. One example of work undertaken by the Mental Health Foundation to prevent depression in isolated older people is the Brighter Futures project\(^2\), funded by the Big Lottery fund (Goldie and Grant, 2010). The majority of project participants described themselves as experiencing low mood prior to engaging with Brighter Futures and all attributed improvements in their mood to the project. This project also provided evidence of the value placed on the peer support and mentoring element of the approach and the support given to enable isolated older people to re-engage with their local communities. Many of the people participating in Brighter Futures had become isolated as a result of living with a disability or long-term condition (including Dementia) and required support to get out of the house independently. The project also helped to support the transition into retirement by providing socially valued roles for volunteers. There is a strong economic argument that investing money supporting the transition into later life will work to achieve better health and mental health outcomes at a later stage and reduce the failure demand that will otherwise be a consequence. Many older volunteers told us that they were concerned about their mental health post retirement and attributed to the project positive outcomes in relation to their mental health but also in relation to their own development. They felt that the project had provided them with the opportunity to claim a new positive identity and the confidence to move onto a new phase of life.

6. **Anticipatory Care and Long-term Conditions**

6.1. The number of people in Scotland with Long Term Conditions is rising, and the likelihood of developing a mental health problem rises with the presence of multiple long-term conditions. In areas of deprivation the risk is disproportionately higher. The outcomes for long-term health conditions are worse where mental health is poor. Health checks for older adults and those subject to inequality are key aspects of preventative spend in screening and addressing long term conditions in areas of deprivation, via Keep Well.

6.2. We have been delivering a new training course for practitioners to increase confidence in exploring mental health in the health check, bridging mental health, seen as a specialist or complex issue to the daily work of a range of public service roles. We see this as pivotal to enabling the public service workforce to realise and mobilise the mental health component of their role within existing capacity. The training has been seen as a way of improving the effectiveness of the whole health check, and not solely as a means of addressing the small formal mental ill health section.

\(^2\) [http://www.mentalhealth.org.uk/content/assets/PDF/publications/Brighter_Futures_Report.pdf](http://www.mentalhealth.org.uk/content/assets/PDF/publications/Brighter_Futures_Report.pdf)
6.3. The training session has been delivered fourteen times in eight health boards in Scotland, and has reached workforce groups as board as practice nurses, physiotherapists, healthcare assistants and pharmacists. We have seen many examples of public service workers thinking laterally about their role in relation to mental health and wellbeing.

6.4. We have seen some novel widening of access to the health check for other groups subject to inequality, such as in prisons and in employability services. This was widely seen as beneficial by both providers of the check, and by colleagues in these services.

6.5. There have been some pressures on Keep Well practitioners observed in the sessions we have run, particularly in relation to the time they are actually given to complete the checks and the time they feel they need to make the checks maximally beneficial.

6.6. Depression is the most common mental health problem in Scotland. In later life physical ill health and disability are the most consistent factors contributing to depression. For example, one in three people with heart failure and one in five people with coronary heart disease (CHD) experience depression. Depression is also found in 30% of people with diabetes. The diagnosis of a long term condition can challenge a person’s view of life as orderly and having continuity. Such challenges may have significant psychological consequences. Some people feel unsupported emotionally and psychologically and people with more negative views of their condition are more likely to be depressed. Those who view their conditions as more serious, chronic, and uncontrollable tend to be more passive, report more disability, have poorer social functioning and more mental health problems. Perceptions of control over symptoms and/or the course of disease often relate to mood and are associated with the process of recovery from disability.

6.7. The presence of psychological symptoms will often make it more difficult to cope with physical symptoms of chronic conditions. Some people face significant challenges in regulating and expressing the emotions and feelings associated with life with a long-term condition. Enabling people to express their feelings will often have positive benefits on how they cope with physical symptoms and can have positive benefits on mental health (e.g. less unwanted intrusive thoughts) and physical health (e.g. influence health status and quality of life).

6.8. Living Better was an extensive three-year Scottish Government funded initiative led by The Royal College of General Practitioners (Scotland) in partnership with the Mental Health Foundation and University of Stirling. The project involved over 1000 participants across 5 ‘test’ sites in Scotland: Angus, North Lanarkshire, East
Dunbartonshire, South East Glasgow and Western Isles. Living Better concentrated particular focus on coronary heart disease and diabetes – because these are the 2 conditions included for screening in the QOF, and because we know from the evidence that about 1/3 of people with these conditions will go on to experience depression.

6.9. Living Better highlighted the importance of providing emotional support to people with long term conditions and emphasised the role that primary care has in supporting people to self manage their conditions and maintain positive mental well-being. Working with patients and primary care professionals, the project developed and piloted training, self-management approaches and to undertook research with these groups to ascertain need and understand and negotiate barriers across the conditions discussed and across a range of test sites with different geographical, demographic and social challenges. A comprehensive evaluation strategy enabled the project to confirm the value of its outcomes.

The project recommended that mental health awareness training be made widely available to all health professionals and that patients are given information and resources to enable them to take steps to improve their wellbeing. It developed a suite of training materials for both patients and professionals to do this. The project underlined the value of peer support to people in relation to protecting their mental well-being when diagnosed with a long term condition. It highlighted the need for staff to be better prepared for this.

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References


