The Church of Scotland

Church and Society Council

Official Response

SUBJECT: Mental Health in Scotland– a 10 year vision
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Introduction

The Church of Scotland welcomes the opportunity to comment on the Scottish Governments proposed framework and actions in relation to mental health in Scotland.

The Church of Scotland recognises the importance of all aspects of health, and commends the Scottish Government on the priority which it has given in the past to issues around mental health. Many challenges remain, however, and it is important that mental health remains high on the agenda.

The Church of Scotland Speak Out process identified that one of the issues which matters most to people in our communities is the way we relate to one another, with emphases on health and wellbeing and flourishing local communities. In addition, discussion at the Church of Scotland National Youth Assembly recently highlighted many of the issues around mental health (see, for example, http://www.churchofscotland.org.uk/news_and_events/news/recent/silence_is_not_strength_when_it_comes_to_our_mental_health).

Response:
1. The table in Annex A sets out 8 priorities for a new Mental Health Strategy that we think will transform mental health in Scotland over 10 years.
Are these the most important priorities?
Yes / No / Don't know
If no, what priorities do you think will deliver this transformation?

While acknowledging the importance of starting well, we are disappointed at the apparent lack of priority being given to mental health in people as they move through adulthood and into older age groups. For example, there is a need to recognise stresses and other conditions in the workplace which can precipitate or exacerbate mental health issues.

We are conscious that transition points in life (e.g. from childhood to adulthood, from work to retirement) can be times of stress, and can also be where people can "fall through the

cracks" in care systems. Special attention needs to be paid to people in these periods of transition.

While we recognise that many issues of mental health can have their roots in early life experiences, and are keen that the identified need of "starting well" is embedded in the approach, we are also aware that many older people face specific mental health issues. For example, social isolation due to a lack of physical mobility, and sometimes the consequent inability to access the necessary support services, will disproportionately affect those in the older age groups. In addition, the move to digital and online access for advice and support can also mean that older people are more likely to miss out on the services they need.

We therefore feel that there is a need for an explicit strand addressing issues around mental health in older people. There has been a lot of recent work by organisations such as the Joseph Rowntree Foundation around loneliness to highlight the need for a more fully integrated strategy. The challenge is that starting well does not recognise the changing 'third age' living patterns which will become increasingly the norm. This can also be seen as an essential component of a preventative approach, highlighting, for example, the work of organisations like 'Befriend in Bellshill' – a befriending service which goes to people's homes and brings people together (see http://oncbellshill.org/befriending.html).

In addition, as many of the issues in mental health are life-long in nature, many family members of those experiencing mental health issues need to be supported over the long term. The strategy needs to ensure that there are ways in which we help to "care for those who care". Family carers are a frontline resource which is hugely important in terms of early intervention, but which is often undervalued and under supported.

Cognisance should be taken of the mental health of families within a "whole systems" approach. There is much evidence to support the understanding that where one family member is experiencing a mental health issue, a huge strain can be also experienced by others in the family. We would welcome specific reference to early actions within the context of perinatal mental health for fathers and partners, children's mental health for parents, and long term conditions for carers/caregivers. Alternatively, an additional "early action" around family impact assessments could be included.

2. The table in Annex A sets out a number of early actions that we think will support improvements for mental health.

Are there any other actions that you think we need to take to improve mental health in Scotland?

The table in Annexe A outlining early actions suggests a medical based model, largely centred around primary health care. We would urge recognition that the third sector provides a significant proportion of support to people with mental health challenges, and this is highly valued by the people who use their services. Third sector providers are also able to provide a model of mental health support which works in a social and situational context, e.g. where mental health is affected by poverty, disability etc, and provide a holistic

service within these contexts. Furthermore they are often user led or have high levels of user participation which capitalises on lived experience.

There is a wealth of good practice examples within this sector and much evidence based practice. This much not be ignored or undervalued. A good approach for those who are struggling with mental health issues involves being aware enough to care, small enough to notice and moving slowly enough to actually deliver. Relationships are very important in mental health.

People with mental health issues often have other mainstream conditions e.g. addiction, poor general health. We feel that the reference to vulnerable groups is vague. There is good evidence to highlight groups who are at very high risk of experiencing mental health issues and where early intervention would be particularly beneficial. We would welcome specific reference to and early action points in section 2 to children who have an experience of being taken into care, for families where domestic abuse is known, and where children are affected by parental substance use.

We would like to make some specific points: in relation to Priority 3 introducing new models, it would helpful to have explicit reference to service user involvement in the Early Action column. This will both set the expectation for (and hopefully realise) the involvement of service users.

Priority 4: In the Action column point 2017-18 – reference to self-help. There is no mention of peer support/mentor resources. This should be a major asset for consideration.

Priority 5: The reference to use of computerised CBT is positive in terms of development of resources, but should be considered in the context of the skills/knowledge and abilities of people to make use of this type of resource. The reference to universal CBT support concentrates on the alleviation of symptoms; we would emphasise the need for the approach to mental health issues to be recovery focussed.

While good coping strategies are important they do not necessarily allow for understanding the root causes of mental health issues within a situational context and allowing for the healing and insight which will help prevent the risk of further breakdown for individuals and the intergenerational effects, which can run through families. We would support an "early action" which improves access to psychological therapies but is not limited to the rolling out of computerised CBT programmes.

Priority 6: Scotland has a long tradition of research and innovation, with a host of world-renowned universities and other research institutes. It would be excellent if the Scottish Government would consider funding some well-designed trials of specific interventions to see if they are likely to be effective. For example, some ongoing psychiatric genetic studies are producing a lot of new data and the Scottish Government could consider funding some well-designed trials to test the effects of early intervention in specific targeted groups.

In relation to evaluation of SAMH – It would be helpful to have research/evaluation included in the priorities considering a range of service delivery. One of the Actions may be to

provide research support/funding for community based early intervention models in particular.

Priority 7: There is reference to “employment and welfare programmes are designed to take account of mental health conditions”. This is specified as an action but we do not see an outcome aligned to this. It would be good to see what the expected outcome is, and how this will enable people to participate in some form of part-time work without major concomitant impact on benefits.

Priority 8: this sets out a number of reviews, but there is no review of numbers of suicides across Scotland and subsequent outcome on how this can be reduced.

The final section refers to “developing indicators that measure clinical and personal mental health outcomes these will be applicable across primary care and specialist mental health services”. These should also be available to voluntary/third sector services in order to maintain consistency in measuring clinical and personal outcomes.

In order to ensure that the third sector is in a place to continue to provide a solid support structure in this area the early actions should include explicit and specific reference to third sector engagement and investment. For example where do third sector organisations sit within a managed clinical network or clinical pathways? How will the wealth of evidence based practice within this sector be evaluated alongside the testing and evaluating successful models of support in primary care?

Perhaps inevitably, the strategy as presented looks largely at the “high level issues”. We feel that it is essential that local delivery mechanisms be identified, as a major obstacle to improving mental health may be the ability to appropriately access the necessary services. In CrossReach, the social care arm of the Church of Scotland, which is directly involved in the delivery of services to those affected by mental health issues, a Social Care Mission Officer has recently been appointed. The intention is that they will act as a bridge between formal mental health services and the communities and congregations in which people live and worship. There will be opportunities for synergies between professional health care providers and faith groups and others embedded in local communities. As mentioned above, Befriend in Bellshill is just one example of the wider work being supported through the Church of Scotland Go For It initiative. For some other examples, please see http://www.churchofscotland.org.uk/serve/go_for_it/postcards_from_go_for_it.

We are disappointed to see no mention of mental health as it affects asylum seekers or refugees in the consultation document – a regrettable omission given how the New Scots strategy on refugee integration places a clear emphasis on health, and particularly the specific mental health issues likely to be faced by asylum seekers and refugees (see http://www.gov.scot/Resource/0043/00439604.pdf, pp. 67-69 of the PDF). This states that: “….[t]here are opportunities to inform the implementation of the Health and Social Care Integration and Mental Health strategies.” We would urge that these opportunities are taken.

It is also important to recognise 're-neighbouring' – the building of good relationships within communities. As mentioned above, the Speak Out process has identified Health & Wellbeing and Local Flourishing Communities as important themes within our work over coming years.

The strategy document mentions that £150m is to be invested over 5 years in mental health issues. While this is to be welcomed, we would seek clarification that this represents an additional resource, over and above what is already being spent on mental health issues. Strategies do not filter through to practice quickly, regardless of their obvious merits. This process is clearly hindered if local authorities are left with insufficient funds to do what needs to be done now.

3. The table in Annex A sets out some of the results we expect to see.
What do you want mental health services in Scotland to look like in 10 years' time?

The Scottish Government is to be commended for the initiatives already taken in this area. The success of the "See Me" campaign and the funding of Breathing Space have started to reduce stigma around mental health issues. While the recent 50% increase in children calling Childline with suicidal thoughts is shocking, it may also be interpreted as evidence that stigma reduction has led to a greater willingness to talk about wellbeing. We would also welcome some more specific targets being included within the strategy, in order that the effectiveness of the strategy be more accurately assessed.

We would want early intervention and early identification of mental health issues, with these being picked up as early as possible at GP/School/Health Visitor level, and then the appropriate resources put in place to address the issues. This may involve working with parents pre- and post -birth in order to alleviate the stresses on parents which can often affect the early years of a child.

There should be a holistic approach as opposed to working with the service user in isolation. Provision of mental health supports in schools is important as currently we see a growing need among children at school for mental health support. Family structures have changed drastically over the last decade or so and this has had an adverse effect on the wellbeing of children and may contribute to the mental health issues being evidenced in school aged children.

Developing new services is not just about investing more money. Attention needs to be paid to issues of availability of staff to fill new posts created. This needs a long term investment in recruitment, training and retention of staff in key mental health services.

We would want to see services for mental health offer timely, appropriate and proportionate support to all who need it when they experience mental health issues. Where services are accessible and needs led, and where there is a mixed economy of support, all aspects of which are equally valued for what they can offer and which work well together. Which is adequately resourced and effective, and which can understand and work well within the social contexts in which people live. Where the impacts on families and carers is understood and which can extend support within these contexts as appropriate.

Conclusions:
Mental health impacts on all aspects of life, including social status, employment status, relationships with those around us, and status within the community. One of the best ways of dealing with mental health issues is through healthy relationships. Our churches and faith communities can play an important role in making Scotland a place where everybody can be sure of having someone to listen, somebody who cares and where everyone is valued.