Mind's response to Lord Darzi's review of the NHS

January 2008

Mind's vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental distress fairly, positively, and with respect.

The needs and experiences of people with mental distress drive our work and we make sure their voice is heard by those who influence change.

Our independence gives us the freedom to stand up and speak out on the real issues that affect daily lives.

We provide information and support, campaign to improve policy and attitudes and, in partnership with independent local Mind associations, develop local services.

We do all this to make it possible for people who experience mental distress to livefull lives, and play their full part in society.

Being informed, diversity, partnership, integrity and determination are the values underpinning Mind's work.

Mind welcomes the opportunity to submit policy ideas to the Darzi review. We are delighted that mental health is one of the priority areas. Although our response covers the mental health priority area specifically, we are also responding to a number of other priority areas that impact on mental health: acute care, maternity services, planned care and staying healthy. Mental health is not a purely medical issue and when looking at how health services should be provided and funded, Mind advocates a much more holistic approach to mental health. The pathway to effective support for people with mental health problems will need to include health, social care and third sector support.

Mental Health

Primary Care

Many people who use mental health services find it difficult to access support when they need it. Approximately nine out of ten adults with mental health problems receive all their support in primary care and around 30% of GP consultations concern mental distress.(1) However people's experiences of primary care services are often poor; there is very little training in mental health for primary care workers; a lack of access to psychological services; and mental health diagnosis and treatment is often led by an overly 'medicalised' approach.

There is an urgent need to improve the response of primary care to people who are experiencing early signs of a mental health problem. Clinicians need the support of a range of treatment options which offer a personalised service.

Diagnosis and treatment

Many of the measurement scales currently used to assess people's mood or mental state before and after treatment are neither developed by service users nor completed by the person concerned. The clinician's assessment and their proposals for treatment may not reflect in any way what matters to the person experiencing mental distress.

As part of a major consultation, Mind has been collecting views of what mental well-being actually means for service users, in order to develop a service user designed distress scale. Through a consultation and an on-line questionnaire, we have asked service users about what mental distress means for them. We hope that the service user designed distress scale will be used by clinicians and researchers to assess whether treatment is actually delivering the things that matter most to service users.

To achieve NHS mental health care which is patient centred, assessment, diagnosis and treatment needs to take more account of patient needs. This is particularly true in mental health where individual responses to particular treatments vary.

Training for professionals

People with mental distress often experience levels of ignorance and discrimination by health professionals in primary care services. A report by Shift (2007) found that positive attitudes towards people with mental distress has actually decreased since their survey started in 1994. Many studies have found that 'catching young people' when training to be medical students results in positive and optimistic attitudes towards mental health.(2)

[1] See ODPM (2004) Mental Health and Social Exclusion 2004:35
[2] See Thornicraft, G (2006) Actions speak louder… Tackling discrimination against people with mental illness. Mental Health Foundation

Given the numbers of people approaching their GP with a mental health complaint, it is essential that medical training incorporates mental health awareness training from a more social model approach. Primary care services should also ensure that they are meeting their obligations under the Disability Discrimination Act. Disability access is about much more than 'ramps and lifts'. For example, for people who experience mental distress, 'a reasonable adjustment' might mean letting an anxious person wait outside a GP's waiting room, or the front-line staff being more flexible about appointment times such as allowing people to book in advance to see the doctor of their choice.

Understanding of mental health by health professionals needs to be a major priority for the next generation of NHS staff. The outcome of this investment should be a fairer NHS which recognises mental health as an essential component to the wellbeing of every patient.

Health inequalities in primary care

People with mental health problems have higher rates of physical ill-health and premature death from non-mental health related problems, in comparison with the general population. In 2006 the DRC's formal investigation into health inequalities found that people with mental health problems (and learning difficulties) are more likely to have significant health problems such as heart disease, high blood pressure, respiratory disease, diabetes and stroke(3). The DRC found that people with mental health problems experience 'diagnostic overshadowing', that is reports of physical ill health being viewed as part of the mental health problem and not being investigated properly.

Access to Psychological Therapies

Access to psychological therapies has historically been very poor on the NHS with people waiting months (or in some cases years) for an assessment or treatment. There is currently very little choice of therapy or therapist. This choice can be important for people experiencing mental distress because talking therapies work in different ways. For example some people may wish to discuss their difficulties with a counsellor who plays a supportive role and may offer practical advice, others might want to use cognitive behavioural therapy to identify negative emotions and thoughts, in order to develop coping skills. Likewise, for some people, seeing a therapist with whom they identify, perhaps because of their sexuality or culture, may be important to building up the therapeutic alliance.

The official guidelines from the National Institute for Clinical Excellence (NICE) states that psychological treatments should be available to all people with depression, anxiety and schizophrenia, unless the problem is very mild or recent. Despite this, in March 2006, a national survey found that 93% of GPs said they

[3] DRC (2006) Closing the Gap: formal investigation into health inequalities DRC

had been forced to prescribe anti-depressants instead of talking therapies due to a lack of availability of therapy. The research commissioned by 'Pulse' magazine found patchy provision of services across the country. Cognitive behavioural therapy, the therapy with the strongest evidence base, was not offered at all by a fifth of primary care organisations. Where it was, average waiting times were five months.(4)

Mind, in collaboration with four other mental health organisations, have campaigned for improved access to psychological therapies on the NHS.5 On the 10th of October last year, the Department of Health announced £170 million for their improved access to psychological therapies programme and PSA targets for delivering therapy. We are delighted with this announcement but would like this to be accompanied with a waiting time measure for psychological therapy. Whilst other parts of the health service are led by targets and waiting time measures, there is an absence of these in mental health and arguably this is one of the reasons why provision has been so poor.

The next phase of the NHS needs to deliver on this significant commitment to extend access to psychological therapies, and ensure that beyond 2010/11 there is a clear plan to extend this access to 100% of the population. For clinicians, prescribing psychological therapies should become as straightforward as prescribing anti-depressants.

Access to Ecotherapy

Last year, Mind commissioned the University of Essex to undertake two new studies investigating the benefits of ecotherapy for mental distress.(6) Ecotherapy is a natural, inexpensive (or maybe cost-effective?) and accessible treatment that boosts our mental wellbeing. Whether it's a horticultural development programme supervised by a therapist or a simple walk in the park, being outdoors and being active is proven to benefit our mental health.

Mind is calling for ecotherapy to be recognised as a clinically valid treatment for mental distress and for GPs to consider referral for green exercise as a treatment option for every patient experiencing mental distress. Access to green space should be considered as a key issue in all care planning and care assessments across health and social care.

Mind's wants to see a broadening of the range of treatment options and more research on non-drug based treatments for mental health.

Acute Care

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[4] Pulse News (March 2nd 2006) Depression Investigation
[5] We Need to Talk (2006) Mental Health Foundation, Mind, Rethink, Sainsbury Centre for Mental Health and YoungMinds
[6] Mind (2007) Ecotherapy

Crises Care

Mind welcomes the great deal of emphasis that has been placed on the development of community based services. In particular, assertive outreach and crisis resolution/home treatment teams have been responsive to service users' needs and has led to greater social inclusion.

Crisis Resolution Home Treatment (CRHT) teams help people through short-term mental health crises by providing intensive treatment and support, ideally in people's own homes. Crisis resolution home treatment teams are having a positive impact on local acute mental health services, providing an alternative to hospital admission. However, a report by the National Audit Office (2007) has found that services are being limited by a lack of input from specialist health and social care professionals and variations in staffing levels across the country. Department guidelines specify that teams should be multi-disciplinary with input from a variety of health and social care professionals.7

Access to crises care is also a problem. The Healthcare Commission has found that 77% of local implementation teams provides people in their area with specialist mental health services at all times. However when HCC asked service users whether they had a phone number or contact out of hours, only 49% said that they did. So even if the service is available, many people can not use it.(8)

Mind welcomes more emphasis on crises care in the community but it needs to be available at all times, to all those who need them.

With more emphasis on crises care in the community, a major debate about the purpose and focus of inpatient care is now needed.

In-patient Conditions

Mind survey of current and recent inpatients[9] found a mixed picture of in-patient conditions. For some it offered space to recover and get well but for many, poor accommodation and security, safety concerns, insufficient staffing levels and intense boredom exacerbated existing mental health conditions and even created new ones.

A staggering 51 per cent of respondents reported being verbally or physically threatened with 20 per cent reporting physical assault. Just one in five (20 per cent) of respondents felt that they were treated with respect and dignity by staff

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[7] NAO (2007) Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services

[8] Healthcare Commission (2007) No Choice, No Voice.

[9] Mind (2004) Wardwatch: Mind's campaign to improve hospital conditions for mental health patients

These findings have been supported by other reports[10].

However we still do not know the full extent of the problems in in-patient units as reporting mechanisms vary so much and the information given to the NPSA is voluntary. A further report by Mind[11] has found that incidents in hospitals are often not identified as crimes and victims do not expect justice to be done. A more robust system of identifying, reporting and monitoring is needed.

The Healthcare Commission (2007) have also found the true state of mixed-sex wards: a disturbing 68 per cent of mental health patients were accommodated on these wards this year[12], despite the Government insisting that 99% of trusts are

[10] For example, the National Patient Safety Agency revealed an alarming number of incidences of violence and self harm in mental health services

[11] Mind (2007) Another Assault: Mind's campaign for equal access to justice for people with mental health problems

[12] Healthcare Commission (2007) Count Me In: Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales

now single sex. The census of in-patients also found no improvement in racial discrimination in the NHS, with black men 79 per cent more likely than average to be secluded (locked away in a room by themselves).

The Government must meet its commitment to single sex wards

Hospitals should be a place of recovery. Action must be taken to reduce levels of violence and abuse.

Maternity Services

Mental distress during or shortly after pregnancy is not unusual- in fact it affects 1 in 6 women. Despite this prevalence, the issue hasn't commanded the attention it deserves - evident in the drastic shortfall in services and support for new mothers experiencing mental distress. Mind's report in 2006 showed that mental health care during this period is falling short of expected standards in a number of ways- lack of provision, a failure to identify risks, inadequate treatment of severe mental health problems and a lack of co-ordination between services.

Over two thirds of our respondents had to wait a month or more for treatment, and worryingly, over 1 in 10 had to wait over a year. ¾ of the women had medication and just over 1/3 were offered counselling. This is worrying, given the potential risks of taking medication during pregnancy and whilst breastfeeding. Of those who were admitted, 63% were placed on a general psychiatric ward, usually without their baby. Mental health services are generally not organised around the needs of mothers and their children and some trusts are still admitting mothers and babies into non-specialist wards, contrary to national recommendations[13].

Effective management of women with maternal mental health problems depends on good co-ordination between the different services and specialists. The Confidential Enquiry into Maternal and Child Health (2004) found that professionals can fail to communicate important information and that GPs and psychiatrists often fail to provide information to maternity services about previous mental health problems[14].

Women who responded to the Mind survey felt strongly about the need for health professionals to have a good working knowledge of the nature of maternal mental health problems. Health professionals (including midwives, health visitors and general practitioners) should be aware of the importance of mental wellbeing in pregnancy and the postnatal period. Mind would like to see mental health and

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[13] Mind (2006) Out of the Blue

[14] The Confidential Enquiry into Maternal and Child Health (2004) Why mothers die- Deaths from psychiatric causes. London RCOG Press.

social care services being more responsive and flexible to the needs of mothers and children. This might involve providing childcare so women can attend appointments on their own or providing opportunities for women to meet other mothers.

Planned Care

For those who experience mental distress, planned care is important as many different people might be involved in the care package. This is usually carried out through the Care Programme Approach (or CPA). There has been much research documenting the problems with the CPA, dating back to when it was first used in 1991. These concerns have included: 1. Problems with the delivery of the care plan (for example, professionals not consulting each other, services not being able to address needs and care plans not being reviewed adequately); 2. Issues with the role of the care co-ordinator (staff training issues, high volumes of cases, resources issues); and 3. Service users not being sufficiently involved and supported (review meetings taking place without service users being there, not being listened to and service users not knowing who their care co-ordinator is).[15]

Problems with implementing the CPA were highlighted by many of our service users and local Mind associations in our own consultation last year. Local Mind associations highlighted operational problems such as the care co-ordinator's large case loads, current budget difficulties and a breakdown in partnership working in some areas.

However the CPA 'tool' itself is not the problem, rather it is the contextual problems within which the CPA operates- such as lack of resources and services. Mind believes that mental health service users, regardless of the severity of their mental distress, are entitled to have their needs identified and met through co-ordinated support and that service uses should be supported to identify their needs and wishes. We are concerned about the current proposals to only offer CPA to those with the most severe mental health problems as the CPA is often used to decide whether people are eligible for services in some areas, this might result in a disturbing pattern of higher thresholds for access.

Mind's expects co-ordinated support and planning for all those who experience mental distress.

Mind supports the independent living agenda, which is about enabling people to live independent lives with the support and services they need. This incorporates individual budgets and direct payments (IB/DP) to the extent that IB/DP allow people to take control of their needs and buy services that suit their lifestyle. Yet

[15] See North and Richie, 1993, Newton et al, 1996 and Wolfe, 1997 in Warner, L (2005) Review of the literature on the Care Programme Approach Sainsbury Centre for Mental Health

Mind is keen to emphasise that IB/DP are not the most important mechanism for promoting independent living in mental health. Independent living should be about supporting recovery, having equal access to and a right to quality health and/or social care services when you need them, promoting advocacy, and eradicating discrimination.

The Government has made a commitment to reform social care with the injection of £520million including a commitment to create "first stop shops", to allow easy access to social care, with advocacy, advice and info all provided in the same place locally (and accessible through online and phone services too). Mind supports the need for "first stop shops" and believes that it is essential that where people with mental distress are given greater control of their care through personal budgets and choice initiatives, strong and accessible support networks must be available to promote empowerment and manage risks to the service user.

Mind believes that the initial gateway to services should be co-ordinated and streamlined across health and social care, so that people with mental distress do not have to undergo different assessments for health services and social care services.

Streamlining across health and social care might provide the opportunity for preventive health and care services to be provided to people experiencing mental distress, to reduce the burden on acute-end health services. Through personal budgets for preventive care, service users could better manage their own wellbeing, through psychological therapies, exercise prescriptions or ecotherapy, day services and a range of other interventions.

Mental health is not just about 'health,' it is a rights and equalities issue.

People with direct experience must have a central role in their treatment and support.

The health service must recognise the role and importance of non-health based services.

Staying Healthy

Mental Health Promotion

The National Service Framework for Mental Health (1999) went some way to acknowledge the importance of providing appropriate mental health promotion. However, mental health promotion often falls off the agenda when more pressing calls on funding are made. Despite its inclusion in the NSF, mental health promotion is not currently part of quality incentive schemes in primary care. In addition community-based approaches to mental health promotion often fall

outside what is traditionally understood as “health” – for example, housing and employment and social exclusion. A social, rather than medical model of health promotion needs to be used in planning and funding decisions.

In recognising the importance of mental health promotion, Mind is one of the organisations (with Mental Health Media, Rethink, the Institute of Psychiatry, King's College London) leading the ‘Moving People’ programme of national and local activity. Modelled on similar programmes that have worked elsewhere in the world, ‘Moving People’ aims to create a measurable shift in public attitudes, and a genuine reduction in discrimination. It’s based on two years of consultation with people who experience mental health problems and will include a national campaign and community activity, to reduce stigma and discrimination.

Non-health based services

A method which focuses only on health services will not be sufficient or effective in achieving good mental health for the whole population. People’s mental health is affected and can be improved as much, if not more, by social factors such as housing, employment and social engagement as by medical interventions. A joined-up approach needs to be taken to address the breadth of factors which affect the mental health of the population.

The needs of diverse groups

Mental health services must be responsive to the needs of diverse groups. It is often the people who are most marginalised in society who both experience greater mental health difficulties and also find it difficult to access services appropriate to their needs. People from black and minority ethnic groups, older people, people living in rural areas, refugees and asylum seekers, disabled people and people with learning difficulties, war veterans, people in prison. people who are gay, lesbian or bisexual are all known to have a greater incidence of mental health problems, but their particular needs are often not met by mainstream services.

There needs to be more emphasis, for example, on ensuring the delivering race equality programme is applied to local communities. Professional’s training must include alternative representations of mental illness and well-being which characterise a diversity of cultural understandings and providers who fall short of their statutory requirements must be called to account.

Summary

Mind believes that the health service should be holistic in it’s approach to mental health. When looking at how health services should be provided and funded, Mind advocates a much more holistic approach to mental health. The pathway to effective support for people with mental health problems will need to include

health, social care and third sector support, as well as a number of other agencies.

Key points:

- **NHS mental health care should be person centred.**
- **Understanding of mental health by health professionals needs to be a major priority for the next generation of NHS staff.**
- **Mind's wants to see a broadening of the range of treatment options, including psychological therapies and ecotherapy**
- **Mind wants crisis services and more community based services to be available to all those who need them.**
- **Mind's expects co-ordinated support and planning for all those who experience mental distress.**
- **Mental health is not just about 'health,' it is a rights and equalities issue.**

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