



Unite response to New Horizons: Towards a shared vision for mental health Consultation

This response to the call for evidence is submitted by Unite the Union. Unite is the UK's largest trade union across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport and local government, education, health and not for profit sectors.

Unite is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations - the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, health care science, family of psychology, counsellors and psychotherapists, the family of dental professions, audiology, optometrists, opticians, estates and maintenance, ancillary and ambulance workers.

Introduction

1.1 We welcome the opportunity to comment on this consultation document on behalf of our members and support its intended aims. However, as an 'aspirational document' we are concerned that although some trusts will welcome this free approach to developing future care provision we fear that some will not take the opportunity to invest in mental health services. We hope that the final document does have a process of review and action planning so progress can be appropriately measured.

1.2 This document acknowledges that mental health services for older people were generally excluded by the National Service Framework for mental health and that there has been very little new investment in services.

1.3 Ultimately the document refers to itself as a 'programme for action'. We have some concern that the document is more a preamble laying out the groundwork for action.

What do you think are the three most important changes for mental health and mental health care in the next 10 years? And why?

2.1 It is recognised (Health Commission 2009) that older people with mental health problems are already discriminated against. With the increasing numbers of older people this will result in increased numbers of mental health problems including dementia.

2.2 This will create an ongoing challenge in ensuring that there are sufficient resources including a skilled workforce able to support this patient demographic. Our members in older people's mental health services report that for many mental health practitioners, this is not a 'first choice' in specialism, due, in part, to previous under resourcing of services locally. To address this, the profile of this work needs to be significantly raised.

2.3 We are concerned that the numbers of mental health nurses are declining and this is being accelerated by an aging workforce. This can have a pernicious effect with a reducing number being able to support any new starters, in what is very complex work.

2.4 It has been identified that with the current economic situation in England the mental health of the public is likely to be adversely affected. However, we also see that with 'tightening' finances in local healthcare organisations, that the first area to be affected is that involved in primary prevention. Mental health services have a paramount importance during this time and should be protected from short sighted managers and commissioners who may see this service as an area where savings can be made.

2.5 Members have reported that there is an increase in the numbers of people accessing services from more diverse communities and backgrounds (examples given were BME populations, migrant workers and emerging groups an example of which could be people with learning disabilities who develop dementia in later life). This is obviously a positive step in terms of better equality of access. However this does have a massive strain on services already in place. They are expected to cope with increased demand with more complex cases with no increase in service provision.

2.6 Often 'new ways of working' is voiced as a solution. There needs to be real clarity as to what this means and how this will have a positive effect on service delivery.

2.7 Other issues raised by our members included:

- New approaches to education and learning how to deal with stress, self care. Skills for every day living and relationship management.
- Capacity for supporting people in all settings and protecting resources and retaining a skilled workforce that is both fit for purpose and offers best added value.
- Prioritising care e.g. those with greater risk and vulnerability to severe upsets, distress serious symptoms of mental health distress and illness particularly linked to drug and alcohol misuse.

Do you support the twin themes of public mental health/prevention and mental health service development? Please explain your views, giving examples if possible.

3.1 We support the twin themes. This approach helps individuals and organisations to recognise the links between health and mental wellbeing and will hopefully encourage more proactive approaches and a reduction in stigma.

3.2 However, it should be recognised that prevention is not always possible and some people will need hospital admission. It is felt the document gives insufficient recognition to the importance of the whole inpatient journey and the provision of acute mental health care across all ages. In-patient care has become a specialised area and deserves recognition as such.

3.3 The two main aims of *New Horizons* are laudable and no mental health nurse would argue that promoting mental health and improving mental health services are bad ideas. *New Horizons* acknowledges that Standard 1 of the National Service Framework for Mental Health has not been consistently well met but given its broad, non-specific stance this is probably not surprising. After all, how can it be judged in concrete terms? Our concern is that this fantastic ambition of public mental health continues to be rather abstract. *New Horizons* makes the case that 'mental health is everybody's business', however much greater clarity concerning just who is responsible and accountable for moving forward on this agenda is needed.

3.4 Mental Health promotion is the business of mental health nurses in several focused ways.

3.4.1. Firstly, in relation to promoting the mental health of those service users that they are working in partnership with;

3.4.2. Secondly, in relation to carers;

3.4.3. Thirdly, through influencing the values and work of others (for example, supporting district nurses in promoting the mental health of clients with long-term conditions);

3.4.4. Finally, they have a role with supporting colleagues towards mental resilience and in challenging stigma wherever it is encountered (including in the NHS itself).

3.5 Mental health nurse's primary focus and accountability will continue to be on their work with people who have mental health problems/mental illness and they will continue to be closely and enthusiastically involved with service improvement. We recommend that public mental health promotion initiatives are resourced and managed separately from mental health services. To do otherwise may result in their having 'icing on the cake' status, whereby they remain at the back of the queue and in competition with those who are mentally distressed in the here and now.

3.6 We believe that the success of this aim rests heavily on changing attitudes amongst the population and emphasising individual responsibility for mental health. Awareness and education will need to complement and possibly compete with other health priorities. Integrating mental health and physical health campaigns may be more effective.

3.7 To achieve this we believe there should be;

- Greater reference to the principles of recovery and recovery based approaches across all ages.
- Encouragement to educational establishments (including schools and colleges) both to educate their staff and students about mental wellbeing/mental ill health and be more proactive in supporting those likely to be effected, promoting early intervention.
- An expectation that large organisations should be expected to take more responsibility for the mental health and wellbeing of it's workforce and provide specialist support at times of redundancy and retirement, two of the most significant precursors to depressive illness.

3.8 It can also be argued that prevention is best achieved by improving insights and awareness in the individual - knowing our personal risk factors, disposition or vulnerabilities can help develop a survival/success toolkit for every day life. This should be part of the rethink on helping everyone be proactive about their own health: whether in early or later life, we all need a 'prevention tool kit'.

3.9 Unite is also concerned that activities which are known to have poor mental health outcomes, such as smacking children, are still legal – the Community Practitioners and Health Visitors Association (a professional association in Unite) is a supporter of the 'Children are Unbeatable Alliance'. Unite also has concerns that very young children who are not capable of giving informed consent are allowed to take part in reality TV shows where their mental health is compromised.

3.10 Currently, Dr. Steve Boormanⁱ is carrying out a health and well being review in the NHS. Uniteⁱⁱ has contributed to this review and submitted information to the call for evidence request. We would encourage that this response is considered in contribution to *New Horizons*.

Are the guiding values described in section 1 the right ones? Please explain your view giving examples, if possible.

4.1 The guiding values are sound and sensible in theory (spanning across all ages, genders and diversities) but will only be meaningful in real life action. We recommend that consideration is made of using them within an impact evaluation framework when developing (and reducing) services and as part of the outcomes indicators framework. One of the greatest challenges however may well be in providing and developing services that are competent to deliver on them all.

4.2 Our members also highlight the following as further 'guiding values'

- Equality
- Consistency
- Transparency
- Enabling real choice of service
- Concentration on the hardest and greatest need groups
- Fairness
- Balanced (e.g. between choice and risk, localised and centralised)
- Practical over idealistic/unrealistic
- Skilled and fit for purpose
- A culture of improvement, valuing and recognising best quality service.
- Open to self and external scrutiny and questioning.

What should the Government do to promote more personalised services for people with mental health problems and their families? It would be helpful to hear about both what works in your area, and, if appropriate, what does not and what could be done in the future.

5.1 Personalised care has become synonymous in some people's minds with providing cheaper home support and care, particularly for dementia patients. This is a risky and delicate issue. Choice is about helping people act in their own best interests where they

may not be able to make a rational or safe judgment on their needs due to symptoms or underlying difficulties in being objective.

5.2 Services to support people of all ages with mental health problems and dementia, in particular in the third sector, are seeing cuts in budgets from social services to fund the personalised agenda. While this allows service users the choice to purchase services that they want, this has had a significant effect on services ability to function and for their future planning.

5.3 It is essential that budget agendas do not 'force' carers to care. This is particularly important for carers of people with dementia when they themselves may be older and/or have their own health problems or commitments to younger family members. There needs to be balance for those who are unable or do not wish to care.

5.4 Further issues raised by members included:

- Budgets need to have greater flexibility with regards to how they can be used.
- Free financial management services need to be available to support people who are unable to manage this themselves e.g. people with dementia, elderly carers
- Improve options for respite care, flexible short stay and 'time out' facilities to reduce avoidable admissions and for people who recognise their own relapse signatures

In your view, which are the most important areas in mental health services where value for money could be improved? And how should that be done? If possible, please indicate examples of the current costs of services and areas where the potential savings might exist.

6.1 Unite is currently campaigning on the issue of the marketisation of the NHS leading to privatisation which will both have a negative effect on patient care and the cost of delivering health services. Professor Allyson Pollock has estimated that the transactional costs of the internal market as £20billion annually.

6.2 We also do not support the vast sums that are wasted in the NHS in commissioning external consultancy companies to review services, rarely involving the experienced and committed staff in these 'reviews'. An example of our members views on this issue were;

"Overwhelmingly my immediate view is the need for fewer 'bean counters' and swathes of 'performance monitoring apparatchiks' seeing huge salaries paid to back room superfluous roles offering no real value."

6.4 Further examples expressed by members include:

- Improved discharge from hospital, improve options for early discharge, halfway houses, step down beds etc.
- Improve home treatment services (there is sufficient evidence to support that such services reduce admissions to hospital).
- Encourage 'tighter' pathways of care, reduce inappropriate admissions, use payment by results currency (PBR).
- Reduce ineffective out-patients clinics with direct positive effect on transport costs.
- Encourage the 'functional' model of care for consultants (NB. It is recognised that while costs savings would be made this may have negative effects on continuity of service

users care and relationships. This model is less likely to be effective in older people's mental health service).

- Developing the skills of the existing workforce to provide holistic care and be less reliant on resources from other sources e.g. phlebotomy, non-medical prescribing. This needs to be seen in context as the core business must always be providing high quality mental health care but may be a useful consideration in older people's mental health settings where there is a high co-morbidity of physical medical problems. A further example would be in rural areas are often unable to access services because of poor transport links. However, school nurses should all be trained to do brief interventions, and tier 1 and 2 work where the problem is mild, and before it becomes intractable (see Mark Haddad's unpublished work with the Institute of Psychiatry, and Marion Friel's work with adolescents in Northumberland).
- Insistence on common shared IT systems between agencies to avoid time consuming repetition of information gathering

Which areas can you identify where innovative technology can help people with mental health problems, and their families? It would be particularly helpful to hear about examples of what works well in your local area and what could be done in the future.

7.1 We believe that access to support and training for all mental health patients should be a mainstay of what is offered. Using mobile phone text reminders regarding appointments and medication prompts should be core service features.

7.2 All in-patients should be 'skilled up' in using the internet to self manage their own care needs. Empowering people with new skills rather than the current all too common lack of intervention when in hospital should be a key part of therapy for patients

7.3 Further examples raised by members included:

- Assistive technology is a growing area in the care of people with dementia. (See evidence from Dementia Services Development Centre at Stirling University).
- E-clinics where service users can access advice and support on line.
- 'Beat the Blues' self help IT package for people with depression (Doncaster).
- On-line 'user friendly' information about common psychiatric drugs.

In your view, where are the current gaps in research evidence supporting the development of New Horizons?

8.1 As already commented, supporting patients with mental health issues understand how to self manage, particularly those taking medicines is a vital part of helping people stay well. Research into compliance, concordance, side effect controls and early warning sign recognition for patients and families/carers is a much needed strand of work to look at.

8.2 Unite would be interested in seeing evaluated examples of similar strategies used by colleagues in other countries.

How can we support local leadership in building mental well-being and mental health care services? Please explain your view giving examples, if possible.

9.1 We believe local leadership is about:

- Priority for mental health work.
- Inspiration to and by those involved.
- Motivation and incentive—self interest of those involved.
- Managing risk as well as being innovative and imaginative.
- Proper resourcing to MH services is essential and a retained a fully skilled workforce is a key to delivery of patient centred care.
- Ensuring those in influential positions are committed, dynamic and have a strong sense of the best interest of service users at the core of their approach

9.2 We also understand there have been good examples where mental health and wellbeing posts have been developed locally (e.g. In Doncaster within older people's mental health service).

How can we promote joint working between local authorities, the NHS and others to make New Horizons effective in your local area?

10.1 Mental health nurses have been at the forefront of inter-professional teamwork and have led the way in learning to co-operate with the many stakeholders in mental health services. They have embraced the role developments that have emerged through new ways of working but organisations have not always kept up with them. We know, for example, of mental health nurses who have become non-medical prescribers only to be unable to practice because their NHS Trust has not got an agreed infra-structure in place.

10.2 Promoting effective joint working is at the heart of mental health nurses work. What we have learnt is that too many 'priority' initiatives impede effective joint working. More strategic and systematic planning around service developments within realistic time scales that focus on clear goals, with clear lines of accountability are what is required. Good team work is costly and the 'headless chicken syndrome' that over-ambitious and multiple initiatives provoke wastes those precious resources. Why not consider forms of incentives based on successful project outcomes? The GP QOF model might have useful lessons for mental health services.

10.3 It is also important to have signed up commitments to joint working, and pooled budgets with clear lines of responsibility and accountability. Members have given examples where that are currently too many variations and 'grey' areas.

10.4 It is also felt that common IT systems must be a priority to encourage sharing of information, avoiding duplication.

10.5 Members have raised concerns that this should not become a 'cottage industry'. *New Horizons* working should be integral to local area plans and joint working, not a separate topic. All services should be benchmarked for quality and equality impact assessed, so in order that we reduce health inequalities in those with mental health problems, their needs should be assessed under 'equality'.

10.6 Frontline practitioners and teams would love the time to promote joint working, but there simply isn't the workforce. So move the money to frontline services.

What do you think are the most important steps that the Government can take to reduce the inequalities that affect our mental health? And why?

11.1 As previously commented, a key area to reduce inequalities is to ensure that there is appropriate and comprehensive primary preventative services in place. Again as previously reported, this area is often the first to be reduced in periods where cost savings are required. This has the negative effect of increasing the budget required for future services (as outlined by Wanless, 2002ⁱⁱⁱ).

11.2 The Government should also continue to address the issues that affect both mental and physical health like; poverty, joblessness, inappropriate housing, debt, unsupportive relationships, access to benefits and training.

11.3 Also for the most vulnerable (e.g. all those who have had an admission in last 12 months, particularly those who have been detained under the Mental Health Act) there needs to be good proactive support with key worker reviews as needed, in an individual approach.

11.4 While it is recognised that national standards are set to reduce inequalities in services using resources to ensure these are in place, this may also prevent or stifle innovations and initiatives to develop services that are needed locally. There are also concerns expressed by our members that Government statistics and league tables are not always felt to be helpful as they do not report on the detail of local variations such as demography, epidemiology, geography and so forth that influence the results. A very successful service may then be wrongly negatively viewed.

11.5 Concerns have also been raised that there are currently large gaps in the knowledge of people who are caring for vulnerable clients (for example in care homes). It should be insisted that all staff working in areas that provide care to people with mental health problems must receive appropriate training.

11.6 In terms of primary prevention and improved public health, there were frequent responses highlighting the need for education to address the stigma and prejudice in all settings, and at a young age, using the principles of 'normalisation'.

11.7 Unite has campaigned tirelessly on recruitment and retention of health visitors and school nurses. With greater resources in this area they would be able to fulfil and deliver on the *Health Child Programme* delivering on early detection and facilitating effective intervention which is so valued in the Government's policy documents. At the moment it is not at all clear who is meant to be doing this work; no one has operational responsibility for children's public health.

11.8 In taking the *New Horizons* strategy the government needs to involve CAFCAS in the referrals. An assumption must be made that any child or young person who is a refugee or asylum seeker has mental health problems, and must be assessed. The government must follow the United Nations universal declaration on the rights of the child. The police service needs to be a significant presence in partnership working with local communities so that they 'tolerate' those who appear different.

How best can we improve a) the transition from child and adolescent mental health services to adult services, and b) the interface between services for younger and older adults? What works well in your local area? And what does not?

12.1 There is a growing concern about the numbers of adolescents aged between 16-18 requiring services and ensuring that there are appropriate resources to care for them. The current ward environments do not always provide safe options, younger people may be vulnerable from other service users but, depending on the reasons for admission, the opposite can also be true.

12.2 We believe a policy statement is required from Government detailing standards and statements about appropriate places of safety and requirements of hospital in-patient care. There also needs to be clarity over the interpretation of child/adolescent/adult as the age range is currently 16-25

12.3 Between each transition there needs to be an effective handover period which may involve joint working for several weeks prior to transfer. It is concerning that CAMHS services often seem to be less integrated into mental health services than they should be.

12.4 Greater emphasis is needed for 16-18 year olds who are homeless. These service users are more likely to not have a fixed abode, moving around various hostel and temporary accommodations and are more likely to have trouble accessing services or to disengage.

12.5 All transitional services must be seamless, proactive, delivered in partnership and with choice for the young person.

In your view, what more should the Government do to combat stigma?

13.1 Anti-stigma campaigns were received by members with reports that 'well known' personalities do help in 'normalising' mental illness and can be inspirational. For example, using positive role models in campaigns that talks to celebrities known and less known about hard or bad times in their lives.

13.2 As previously discussed, promotion of early education about mental health and wellbeing with appropriate additions to schools curriculum and/or encourage engagement with mental health providers is key. We are aware of several local initiatives around where services users present in secondary schools and where junior schools have projects to work with day care centres with older adults with dementia.

13.3 A lot of stigma is that based on the shame and embarrassment felt individually or within families – helping us recognise the huge incidence and prevalence of mental health problems that there are and that it's not about weakness or negativity.

13.4 There were also proposals that CAMHS should be renamed as Child and Adolescent *Mind* Health service. In newspapers and the media, *mentally* ill people are reported to carry out criminal acts. Families who do not want the stigma on their records, simply avoid the service and miss appointments.

13.5 People understand common mental health problems such as depression, sadness, stress and grief as problems of the mind, not as mental illness. Adolescents who self harm or have eating disorders do not diagnose themselves as mentally ill, and are therefore unlikely to refer themselves to mental health services. The public and the health services need to see mind health as something which is normal, affects lots of people, comes and goes and is treatable and often preventable.

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ⁱⁱ FLEMING, D & REAY, K Unite response to the NHS Health and Wellbeing 'Boorman Review': Call for evidence. Unite the Union.

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ⁱⁱⁱ WANLESS, D. (2002) Securing our future Health: Taking a long term view: Final Report. http://www.hm-treasury.gov.uk/consult_wanless_final.htm