No Health Without Mental Health: A Cross-Government mental health outcomes strategy for people of all ages

Supplementary note to the *No Health Without Mental Health* Impact Assessment, to accompany publication of an Implementation Framework

Introduction – Purpose of the implementation framework and its relation to the Strategy

1) [No Health Without Mental Health: A Cross-Government mental health outcomes strategy for people of all ages](#) ("the strategy"), was published in February 2011. An [Impact Assessment](#) ("the IA") was published at the same time.

2) The strategy sets out six objectives:
   a) More people will have good mental health.
   b) More people with mental health problems will recover.
   c) More people with mental health problems will have good physical health.
   d) More people will have a positive experience of care and support.
   e) Fewer people will suffer avoidable harm.
   f) Fewer people will experience stigma and discrimination.

3) The Implementation framework ("the Framework") aims to translate the strategy's six objectives into specific actions and interprets them for particular audiences (i.e. specific organisations). The Framework sets out potential actions that a range of local organisations can take to implement the strategy and to improve mental health and wellbeing outcomes for people, while contributing to the broader efficiency agenda.

4) It is important to note that **none of the actions set out in the framework are compulsory, and it will be for local organisations to decide which they take up.** This is consistent with a cross-government focus on holding local bodies to account for the outcomes they achieve, rather than the process of achieving them.

Purpose of this note: additions to the existing evidence base

5) The IA already outlines the economic benefits of many of the approaches and service models discussed in the framework. For instance, it discusses programmes for medically unexplained symptoms, collaborative care to treat co-existing physical and mental health problems[1], early intervention in psychosis, parenting interventions and debt advice services.

6) The present note adds to this evidence base where appropriate, in particular where an action featured in the framework has not been discussed in the IA.

7) Note that both this note and the IA do not discuss commitments and announcements which have already been made, and which the Framework is re-stating.

Policy objectives: improving mental health outcomes whilst improving efficiency

8) The IA points out that mental health outcomes can be improved whilst increasing efficiency, for instance by putting more emphasis on the promotion of good mental health and wellbeing as well as the prevention of mental ill health. Similarly, stigma about mental health services is pervasive and affects all parts of the health and care system including commissioning and service provision.

9) Pages 10-11 of the IA outline and briefly explain the reasoning behind the strategy's six objectives (see paragraph 2 above). As discussed, the framework aims to help local organisations to translate the strategy into action. It therefore aims to tackle the same problem as the strategy, and to bring about the same changes and effects.

10) The beneficiaries of the framework are the same as for the strategy (as detailed on p. 11 of the IA). The analysis in this section of the IA is therefore applicable to the framework.

11) The analysis set out in the IA is applicable to the measures discussed in the Framework. Newer evidence in a number of areas further supports the arguments put forward in the IA, underlines the scale of the problem (including both economic and human costs), and strengthens the case for change. Examples of such evidence include:

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[1] Another example of services tackling co-morbidities is the Rapid Assessment Interface and Discharge (RAID) team at Birmingham City Hospital offers comprehensive, 24/7 support for mental health and substance misuse to patients aged 16 and over. The main framework document presents evidence on the cost-effectiveness of this type of service.

a) The London School of Economics' report on [How mental illness loses out in the NHS](#) reaffirms that the economic and human costs of mental ill health are substantial. The cost of physical healthcare which has become necessary as a result of mental health illnesses is estimated to at least £10bn per year. Mental health is the single largest cause of disability in the UK and accounts for up to 23 per cent of the total burden of disease and 13 per cent of NHS health expenditure.

b) The King's Fund report on [Long Term Conditions and Mental Health: The cost of co-morbidities](#), published in February 2012, noted that co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition. Between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions– that is between £8 billion and £13 billion in England each year – are linked to poor mental health and wellbeing.

c) Independent mental health Charity Mind's [Listening to Experience](#) report, published in 2011, emphasises the human costs of mental ill health, and of poor acute and crisis mental health care.

Why is a further publication required?

12) The strategy was published in February 2011. At this time, the details (although not the overall principles) of reform of the health and care system were still being established, with relevant legislation still under discussion. As the timetable and details of these reforms are now clear, it is now possible to discuss how the strategy can be implemented by the new system.

13) Although it has the same aims and scope as the strategy, there are a number of reasons why an implementation framework will be beneficial:

a) **A more practical focus:** The Framework's focus is on supporting local organisations in translating the strategy into action. It is primarily concerned with specific actions, in contrast to the strategy's focus on more higher-level objectives.

b) **Specific content for specific organisations:** The framework divides content differently to the strategy. Whereas the strategy is structured around the six strategy objectives to improve mental health outcomes, the framework is structured around the potential contributions of specific *organisations.* This allows readers to find the content most relevant to them quickly and easily.

c) **Examples of assistance and good practice:** The framework provides additional links to helpful tools and examples of good practice.

d) **The context of NHS and wider public sector reform:** Since the strategy was published, the revised health and care landscape has taken shape. The framework is therefore able to explain what some of the fundamental system

changes will mean for mental health, and sets out how organisations can make best use of some of the levers and powers available to them to implement the strategy and to improve mental health and wellbeing in the most effective way.

e) **Measuring the impact of the strategy:** The framework sets out how progress mental health outcomes will be monitored. This draws on information from the three Outcomes Frameworks. These have been developed since the strategy was published.

Impacts, costs and benefit – additional evidence on specific proposals

14) As discussed, none of the actions proposed in the strategy and framework are compulsory. It is up to local organisations to decide which actions they take forward and how. As a result, any costs and benefits resulting from the strategy will depend on local decision makers.

15) For illustration, the IA includes analysis of a number of interventions consistent with the strategy. It shows that these interventions would not only be cost-beneficial, but could result in cost savings to the NHS and wider public sector. The framework specifically promotes many of the intervention types analysed in the IA (including programmes for medically unexplained symptoms, collaborative care to treat co-existing physical and mental health problems, early intervention in psychosis, parenting interventions and debt advice services). As these are covered in the IA, they are not specifically discussed in this note.

16) A small number of actions featured in the framework, have not been discussed in detail in the IA. These include:

a) Evidence-based mental health training for a wide range of professionals.
b) Involving people with mental health problems, their families and carers in commissioning and service design processes.
c) Measuring progress – the mental health dashboard.
d) Reducing mental health stigma and tackling discrimination.

17) All of these actions are consistent with the strategy, and therefore with the analysis set out in the IA.

18) However, given the emphasis placed on them in the framework, and following the example of the IA, summary assessments of their potential impacts, costs and benefits are included in **Annexes A to D.**

19) As with the IA, the non-prescriptive nature of the framework means that **the analysis in this note is an illustration. We would expect local organisations**

to consider costs, benefits and value for money of specific local proposals when considering which interventions to fund in their areas.

Mental Health Training

1) The framework makes a number of suggestions in relation to mental health-related training for non-mental health professionals. These include:

   - Training for managers to help them support the mental health of their staff: this is mentioned in the section concerning what employers – including all types of organisation – can do to implement the strategy. It is intended to be applicable to all organisations.

   - Awareness training to ensure professionals understand and support the needs of clients with mental health problems: this is mentioned in relation to organisations whose staff are likely to come into contact with people with mental health problems, including staff working in primary care settings, schools and colleges, and the criminal justice system. The Framework also suggests that local public health organisations can take the lead in commissioning mental health training for non-mental health professionals.

2) These suggestions aim to:

   - Tackle the stigma and discrimination experienced by people with mental health problems in the workplace, and in their dealings with organisations.

   - Encourage behaviour which is sensitive to the particular needs of people with mental health problems, and which does not exacerbate these problems.

   - Support the needs of employees with mental health problems and, through this, tackle the causes of mental ill health and help people with mental health problems to gain, or maintain, work.

3) This Annex summarises evidence from the evaluations of several mental health training programs aiming to help professionals to understand, identify and support people with depression.

Training at work - Centre for Mental Health

4) The Centre for Mental Health is an independent UK mental health charity working on training managers and staff to understand, identify and support people with depression and anxiety at work. Their Mental Health Workplace Training is based on Australian charity beyondblue's National Workplace

Programme which has trained more than 40,000 employees in over 400 organisations since 2004.

5)   During 2008, the Centre piloted the programme in the UK with managers in a range of organisations across the private and public sectors. The evaluation of the pilot showed:

- the training was effective and applicable in the UK

- All managers in the pilot felt significantly more confident about identifying and supporting employees with depression and anxiety and other related conditions (see graph below).

Increase in manager confidence after the pilot programme
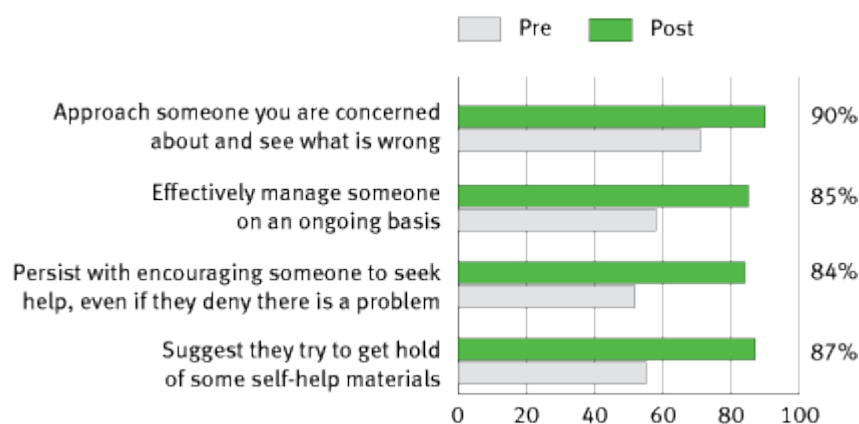
6)   The Centre also conducted follow up studies. Within 8 months, two out of five managers reported they had put into practice what they had learnt.

7)   Taken at face value, these results suggest that work place training can be effective in raising awareness and increasing knowledge of appropriate actions when dealing with mental health problems. Evidence-based workplace training for managers, as suggested in the Implementation Framework, could achieve similar outcomes.

8)   However, the Cente for Mental Health's evaluation did not compare costs and benefits of the interventions, so we do not have evidence on the cost effectiveness of these interventions. Furthermore, the collected evidence is on managers' self-reported behaviour. It does not measure how any changes to their behaviour affected the well-being of their colleagues or staff.

Mental Health Training of trainee teachers (Education not Discrimination) Evaluation[2]

9) The Education Not Discrimination (END) project is part of the Time to Change portfolio. It provides anti-stigma training for key professional audiences, medical students, trainee teachers and trainee head teachers / social inclusion workers. An evaluation report examines the impact of the project on trainee teachers' intended behaviour, attitudes, knowledge, and empathy.

Results

10) In a follow-up directly after the intervention, the evaluation found significant positive changes in 15 out of 16 questions relating to reported and intended behaviour, attitudes, knowledge, and empathy. For instance, respondents were substantially more likely to report that

- "In the future, I would be willing to live with someone with a mental health problem," (average change between the pre- and post-intervention responses of 0.46 points on a 5 point scale).

- "If a friend had a mental health problem, I know what advice to give them to get help" (average change of 1.1 points).

- "An important component of the relationship with my students is an understanding of the emotional status of the students and their families"

11) While this shows that training programmes such as END can change peoeple's attitutdes and behaviour in a postive way, the evaluation did not compare costs and benefits, so we do not have evidence on the cost effectiveness of the intervention. Furthermore, the collected evidence is on teachers' self-reported knowledge and attitude. It does not measure what they actually put into practice and how this affects the well-being of their students.

Mental Health Training in Schools

12) The National Institute for Health and Clinical Excellence (NICE) [guidance on promoting the social and emotional wellbeing of children in primary education](#) recommends training and support to teachers and practitioners in schools. This should provide knowledge in how to develop children's social, emotional and psychological wellbeing, how to manage behaviour and how to build successful relationships, and identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary schoolchildren.

13) According to NICE, there is good evidence to support the implementation of multi-component programmes, which comprise teacher training and

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[2] Education Not Discrimination Trainee Teachers First Follow-Up Report, Jillian London, Institute of Psychiatry

development as well as support for parents.[3] However, there is little information that would allow us to disentangle the effect of teacher training. In addition, most of these programmes have been researched and developed in the US and may need adapting for the UK. Interventions with similar characteristics are available in the UK but have not been the subject of robust trials.

14) We are not aware of any information on the cost-effectiveness of specific teacher training interventions in relation to mental health issues.

15) Similarly, NICE guidance on [promoting the social and emotional wellbeing of children in secondary education](#) recommends integrating social and emotional wellbeing within the training and continuing professional development of practitioners and governors involved in secondary education. This could ensure practitioners have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing. Again, there was no information on cost-effectiveness of interventions.

Summary

16) There is some evidence that the type of mental health training interventions proposed in the framework has a positive impact. However, further research is needed to assess the cost-effectiveness of these benefits.

17) In particular, the evaluations described above do not measure the overall impact on wellbeing of any intervention. Rather, they evaluate its impact on stated behaviour or attitudes. Although such changes are important (see below on the importance of tackling stigma and discrimination in mental health), it is not certain that they will translate into better experiences for people (including people with mental health problems). Consequently, it is not possible to judge the cost-effectiveness of the interventions discussed.

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[3] Examples of programmes for which there are evaluations include the Linking Interests of Families and Teachers (LIFT) programme, the Seattle Social Development Project and the Resolving Conflict Creatively programme.

Involvement and choice

1) Involving service users in decision-making is a key policy principle, enshrined in the objective that there should be 'no decision about me without me'. Recent legislation introduces, or modifies, various duties of involvement throughout the NHS. Mental health stakeholders and others, including representatives of service users, families and carers (including user- and carer-led organisations) have argued consistently that greater involvement in shaping services, and greater choice of care and treatment, are some of the most important changes required to bring about significant improvements in mental health outcomes.

2) The framework suggests a number of specific actions in relation to service user involvement. These include:

- Involvement at an individual level, ensuring that people who use mental health services, their families and carers, are involved in decisions about their care, including care planning, and can exercise choice and control in relation to their care and treatment.
- Involvement at a collective level, including the involvement of patient representatives or representative groups in commissioning and service design processes, in scrutinising services, and in organisational governance.

3) The objective of involving patients and service users in decision making about their care is to
- improve service users' wellbeing
- put emphasis in planning and commissioning on issues which are most important to patients
- scrutinise services with regard to whether they deliver the outcomes service users want, and whether they are built around service users' needs and those of their families and carers.

4) This Annex summarises evidence on how individual and collective involvement may achieve these objectives.

Individual involvement and personalisation – the example of personal health budgets and individual social care budgets

5) The Audit Commission reports that, in 2010/11, 45% of local councils see personalisation as a driver for better value for money, notably by improving the quality of outcomes.[4]

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[4] Audit Commission, *Improving value for money in adult social care*, 2011.

6) Personalisation may mean to give those in receipt of care control about the way their care budget is used. This has been introduced as **individual budgets in social care**. The framework recommends the roll-out of personal budgets.

7) The evaluation of the individual budget pilots found that satisfaction rates were higher for the group that had received personal health budgets than a random control group. 49% of recipients with personal budgets were satisfied with their services as opposed to 43% in the control group (cited in the Impact Assessment for the 2009 Health Act).

8) Overall, the evaluation of the Individual Budgets Pilot programme shows that those with individual budgets were significantly more likely to feel in control of their daily lives, the support they accessed and how it was delivered. For mental health patients, this was linked to improved well-being.

9) However, the evaluation itself notes several limitations to these findings:

- Follow-up was after six months. Thus, we cannot assess the longer term implications of individual budgets.
- A quarter of recipients could not be interviewed, e.g. because they were not able to answer, so that a proxy such as a carer was asked.

10) In the health sector, **personal health budgets** are currently being piloted. The fourth interim report on the evaluation of the Personal Health Budget Pilots analyses interviews of 58 personal budget holders about their experiences in the first three months of receiving a personal health budget. Some interviewees reported greater choice and in some instances direct health gains.[5] However, interviewees also anticipated difficulties such as anxiety about managing their own care.

11) In summary, while there is evidence of positive impacts of personalisation and service user/patient involvement in decision-making, in particular for mental health, we do not know yet what the overall impact of personal budgets will be after a longer period of implementation, when both benefits and disadvantages may be more obvious. It is also worth noting that, for any personalisation of care, some care recipients will require substantial support.

Collective involvement

12) Importantly, the framework also proposes to enhance patients' influence on the design and monitoring of services through means of collective involvement. It suggests a number of options for such involvement and areas where it is particularly important, including:

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[5] For example, through new equipment that increased their overall quality of life.

- Service user, family and carer involvement in NHS commissioning. including joint working with local service user groups. Clinical Commissioning Groups will have a duty to promote involvement.

- Feedback from users of specialist mental health services, to inform service improvement. This includes implementing the NICE quality standard on service user experience in adult mental health and the You're Welcome standards for young people.

- Providing input to health and wellbeing boards, to help people inform the joint strategic needs assessment, and shape the joint health and wellbeing strategy of their local area.

- Informing scrutiny reviews by Overview and Scrutiny Committees and the work programme of local healthwatch organisations.

13) There is evidence that collective patient involvement can increase the quality and efficiency of services. The [IA accompanying the Health and Social Care Act](#) presents case studies from Local Involvement Annual Reports which give examples of successful improvements resulting from patient involvement in Local Involvement Networks (LINks):

- In Sefton PCT, the LINK-led research with patients, carers and hospital Trusts led to improved discharge procedures and reductions in delayed discharge. As a result, between 2008/09 and 2009/10, the number of days of delayed discharge fell by 34%. This is estimated to have caused savings of £346,000.

- In Blackburn with Darwen PCT, the LINK identified a problem with signage in a hospital which led to people missing their appointments. Improvements made in reaction to LINK involvement led to a 6% reduction in the "did not attend" rate. This resulted in savings of £115,000.

14) When implemented well, patient involvement can thus increase both quality of services and reduce costs. Based on three case studies, the Health and Social Care Act IA estimates that Local Involvement Networks (LINks) have delivered savings of £3.7 for each £1 invested. However, the same Impact Assessment also points to a study by PriceWaterhouse Coopers which finds that these benefits can only be maximised when certain conditions are met such as support for public engagement at the PCT level and existence of ongoing networks including key user groups.

Mental Health Dashboard – providing coherent information

1) The Framework sets out proposals to produce a mental health dashboard. The aim of the dashboard is to provide a high-level, concise and easy-to-understand overview of mental health outcomes, and therefore of the progress made in implementing the strategy as a whole. It will draw on the best measures currently available, to build a picture of progress. This will have two primary purposes:

   - Guiding future policymaking: in providing an overview of progress in implementing the strategy, the dashboard will indicate which areas would benefit from further policy development.
   - National information and accountability: the dashboard will allow Government to explain, in a simple and concise way, what progress is being made in implementing the strategy.

2) The proposed dashboard will operate at national level only. The production and use of local dashboards will at the discretion of local organisations.

3) While dashboards have been widely adopted by business, there is little academic evidence on their effectiveness or on the effectiveness of similar tools such as scorecards. [6] Most literature underlines that the usefulness of dashboards crucially depends on their design and purpose - what data is collected? Does it suit the needs of decision makers? [7]

4) An article by Clarke et al (2006) reports on the results of surveys of 88 and 139 senior marketing managers in 2001 and 2003. [8] The surveyed managers argue that dashboards improved the accountability of marketing departments. They made it easier to calculate the productivity of marketing budgets, thus increasing accountability, but also giving firms the opportunity to reallocate resources in a way that improves outcomes.

5) However, it remained unclear, whether the benefits of dashboards outweighed the costs and under which conditions. It is also unclear how these findings translate to the mental health sector. Positive impacts will crucially depend on design features such as the accuracy of data, the relevance of chosen components of dashboard.

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[6] A point made by Velcu-Leitinen, O. and Yigitbasioglu, O.M. 2012: The use of dashboards in performance management: evidence from sales managers. The International Journal of Digitial Accounting Research 12, p39-58.
[7] For instance, Eckerson W. W. 2010 : Performance Dashboards: Measuring, Monitoring, and Managing Your Business, contents list on Google Books.
[8] Clarke, Bruce H., Abela, Andrew V. and Ambler, Tim 2006: Behind the wheel, Marketing Management May/June 2006

6) However, it is important to note that the proposed mental health dashboard will consist only of existing, publicly available information. Thus, the cost of producing the mental health dashboard will be negligible. Even small improvements in the effectiveness of the policymaking process due to increased accountability and transparency would justify this investment.

Reducing stigma and discrimination

1. One of the strategy's six objectives is that fewer people will experience stigma and discrimination. Reducing stigma and discrimination will also contribute to achieving the strategy's other five objectives, and therefore underpins the strategy as a whole.

2. The IA makes clear the damaging impact that stigma and discrimination have on people with mental health problems.

3. The framework suggests

    *   that a range of organisations sign up to the Time to Change Campaign, to raise the profile of mental health, and to address stigma among staff.

    *   that providers of mental health services provide local leadership in tackling mental health stigma and discrimination.

    *   raising the profile of mental health issues and improving awareness of mental health problems (see Annex A)

    *   improving service design and promoting dignity and respect for people using services,

    *   promoting the involvement of people who use services, their families and carers in decisions about services and about their care (see Annex B)

4. In addition to what has been said in the IA as well as Annex A and B of the present note, it is worth to consider the initial evaluations that are available on Time to Change. These evaluations give a good indication on the degree to which interventions proposed by the framework can help reduce stigma.

5. In a paper from 2010, Evans-Lacko et al[9] evaluate the impact of short-term campaign activities in Cambridge. Activities included advertising at bus stops, on the local radio and in the local paper, advertising using beer mats and postcards, street art in the City centre, public sofas staffed by people with experience of mental health problems and a one day 5-a-side football tournament.

6. The researchers performed interviews before and after the campaign and found significant shifts in the responses to two out of six mental health knowledge related questions. There was a 24 percentage point increase in people agreeing with the statement "If a friend had a mental health problem, I know what advice to give" and a 10 percentage point rise in the proportion of patients agreeing with

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[9] Evans-Lacko et al 2010: Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work? BMC Public Health 10: 339

the statement that "medication can be an effective treatment for people with mental health problems".

7. However, there are limitations to these findings: not the same group of people was questioned before and after the campaign and while the characteristics of both samples were controlled (to ensure the same representation by age, gender etc), differences in attitudes may be due to sampling characteristics. In addition, the study measures attitudes, not outcomes. Thus, we cannot say whether someone saying that they feel able to help a friend with mental health problems, would really be able to do so and what impact this would make on their friend's quality of life.