# Adult mental health strategy

# Visions and priorities

## Public engagement
## May 2021

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## Overview

Following on from the research supporting the development of the Adult Mental Health Strategy, the CCG had drafted some visions and priorities for the strategy. These had been drafted after considering the wide range of information gathered from the extensive engagement period. Subsequent internal conversations were held on these visions and priorities through Programme 2 of All Together Better, The Community Mental Health Transformation Group, and with Governing Body.

Before finalising the vision and priorities for the strategy, the CCG wanted to engage members of the public to ask their thoughts. The Involvement Team reached out to all participants who expressed an interest through the survey in taking part in future engagement activity around the strategy. From this, a total of 28 people said they would like to take part and three online discussion sessions were set up on Friday 7 May. Overall, 12 participants were able to join these discussion sessions (4 in the first session, 2 in the second session, 5 in the third session). The table on the next page summarises the demographic information for these participants.

A short presentation was given at each session which discussed the various phases of research for the adult mental health research, the detailed methodology for the public phase of engagement, and the extra steps the research took to engage a wider audience and to reach as many people as possible. The presentation also covered some of the top-line key findings including the impact of COVID-19 on mental health, the key areas for improvement, and how adult mental health services would look in an ideal world.

This led us into the discussion around the visions and priorities. Participants were asked to think about the following:

- Which of the two vision statements participants preferred?
- Have we missed anything?
- What were participants thoughts on the wording used?
- Was there anything participants particularly liked?

### Table 1: Demographic information

| | |
|---|---|
| Gender | ▪ Male (n=3)<br>▪ Female (n=9) |
| Age | ▪ 25-34 (n=2)<br>▪ 45-54 (n=1)<br>▪ 55-64 (n=5)<br>▪ 65-74 (n=3)<br>▪ 75+ (n=1) |
| Pregnant or pregnant in past year | ▪ No (n=9)<br>▪ Does not apply (n=3) |
| Marital status | ▪ Single (n=2)<br>▪ Separated (n=3)<br>▪ Married (n=5)<br>▪ Divorced (n=2) |
| Disability, long-term illness, or health condition? | ▪ Yes (n=7)<br>▪ No (n=4)<br>▪ Prefer not to say (n=1) |
| Caring responsibility | ▪ None (n=9)<br>▪ Primary carer or assistant for a disabled adult (n=1)<br>▪ Secondary carer (n=1)<br>▪ Primary carer or assistant for an older person or people (n=1) |
| Race or ethnicity | ▪ White (British, Irish, European, or other) (n=11)<br>▪ Rather not say (n=1) |
| Armed forces | ▪ Currently serving in the UK Armed Force (n=0)<br>▪ Ever served in the UK Armed Forces? (n=1)<br>▪ Member of a current or former serviceman or woman's immediate family / household (n=1) |
| Sexual orientation | ▪ Heterosexual (n=8)<br>▪ Asexual (n=1)<br>▪ Prefer not to say (n=3) |
| Religion | ▪ Christianity (n=6)<br>▪ No religion (n=5)<br>▪ Prefer not to say (n=1) |

## Vision

**EVERYONE'S MENTAL HEALTH MATTERS**: Empowering and supporting individuals, families, and communities to improve their physical and mental health so that they can lead fulfilling and healthy lives.

**EVERYONE'S MENTAL HEALTH MATTERS**: Empowering and supporting individuals, families, and communities to lead fulfilling, healthy lives both physically and mentally.

Respondents were presented with the above two visions for the adult mental health strategy and were asked to tell us which of the two they preferred. Participants in the first session preferred the second statement because it was more direct. However, participants in the second and third discussion sessions preferred the first statement as it was easier to understand, broken down more, and it referenced 'mental health' rather than referring to being healthy 'mentally'.

There was some discussion in the first session about swapping around physical and mental health to show a priority towards mental health. Participants felt you needed good mental health for good physical health to follow.

Participants in the first discussion mentioned how they liked the use of the word 'empowering' as it placed ownership of good mental health with the person, allowing them a level of control, and that they had a say in what happens to them rather than being told what to do. One participant described this as 'giving you the power rather than the power being elsewhere'.

However, they felt there needed to be more included around how people go about being empowered and suggested the wording could be changed to 'empowering people to support individuals….'. This therefore describes how we can empower people to look after their own mental health (through providing support). One participant summed up the word empowering as providing the opportunity to 'live the life you want to live'.

They also felt it was important to empower families and wider support networks to support loved ones to achieve positive mental health. One participant described how their personal experience of not feeling listened to by professional services, led to them not being able to confide in friends and families. Therefore, to empower individuals and support families, people need to feel listened to within mental health services as well.

Participants in the second discussion group said they liked the word 'improve', and there was discussion around including the word 'maintain' here also. They also liked the inclusion of the word 'supporting' because this is an important part of mental health. This would be supporting the individual themselves and supporting families as well as wider networks and communities to support individuals. A participant from the third discussion group talked about the importance of communities being able to support individuals. They described how in the past, society was more community focussed, and how although times have changed, there is still an importance in community and how communities can support people's mental health

## Priority one

**An ounce of prevention is better than a pound of care**

Strengthening and promoting mental health wellbeing with the aim to prevent or reduce mental ill health

Participants felt this priority was an important one and a good target to have; however, they also recognised it would be a long journey to achieve this, and they were not sure how it could be delivered, as mental health isn't obvious until it becomes a problem. Therefore, being able to prevent poor mental health may be quite difficult. Participants in the second discussion session mentioned how this priority is even more a priority because of covid.

There was discussion through the third session around ensuring this priority references and reflects people of all ages, through life-long good mental health from childhood through to adulthood and continuing into old-age. One participant talked about the importance of embedding this in early education and schools, to plant the understanding of strong mental health from a young age so people will grow with the knowledge and skills. Through this, there is more opportunity to address negative stigma of mental health as it would have been normalised at a younger age.

Participants in the first discussion session talked about coping strategies, and perhaps referencing this in the supporting information for this priority. This was based on someone's personal experience of coping with mental health issues, and how the development of personal coping strategies helped them to overcome barriers to their own mental health.

The theme 'feeling listened to' was discussed at length during the first discussion group, which links to the wording and meaning behind the vision, priority one three, and priority three. It was felt that by strengthening and promoting mental health awareness and wellbeing amongst family members, this would provide the skills for

them to listen to their loved ones and will help break the stigma of mental health. There was also a need for people to feel listened to by mental health services.

There was discussion in the first group how organisations and workplaces could do more to understand and support their staff through mental health.

## Priority two

**Right Response, Right Time**

Ensuring mental health care is accessible and timely. Our response will focus on the whole person and be flexible and inclusive.

Participants felt this was an important priority; however, it was discussed in the second session how this priority has been lacking during COVID-19, as it's been very difficult to access health services, both for physical and mental health support. For mental health, it can be quite difficult for a person to build up the confidence to reach out for help, and the delays to accessing services due to COVID-19 is an additional barrier.

Following on from this, there was some discussion around barriers due to NHS staff particularly in primary care. They felt that GP receptionists needed some additional training around dealing with patients with mental health issues when they contact the practice. Participants also felt GPs needed more training around mental health services, and what can be done to support patients rather than focussing on prescribing medication.

One participant in the first session discussed how the telephone number for the crisis team is over-used. They suggested there should be one number for people to deal with administrative issues such as rearranging appointments, and another number for people in need of immediate and urgent mental health support. There was also conversation around how mental health services were directing people to the Samaritans as they provide a 24/7 service. This led to conversations around this priority including a reference to 'appropriate access' to the right care – not just about access. This theme was echoed through the second discussion group, when discussing barriers for people accessing mental health support through primary care. One participant from this group described their own personal experience of a loved one falling through the gaps between mental health services because they did not receive a timely response, and there was no appropriate service available to offer them support. Through their personal experience, they felt the problem lay with transition between services. This again strengthens the need for timely access to

appropriate mental health support through this priority, and links to the third priority, around removing barriers between services.

When discussing current mental health services, participants in the first discussion group mentioned how the services currently operate until 5pm, and that if the priority is to ensure accessible and timely care, this care needs to be accessible to the needs to the patient when the patient needs them. Following on from this discussion, a participant shared their personal experience of services not being joined up. After expressing suicidal thoughts, a participant experienced a four and half month gap between access to services. In addition, after numerous assessments for services, the participant waited approximately 2 years for appropriate treatment. This therefore adds an additional perspective on the phrase 'accessible and timely', and links to the third priority for 'joined-up services'.

One participant through the third discussion group talked about their experience of accessing mental health services, the long waiting period to access the right care, and the transition between services. They described the feeling of repeatedly failing at mental health service assessments, to be signposted to an alternative service, and to repeat this process of failing assessments before getting access to the right service. For the service-user, this makes them feel there is no hope of appropriate support available for them. This identified a failing in the current pathways for services, and how the patient needed to fit in with this assessment criteria, rather than the service treating the patient holistically and as an individual.

Participants in the second discussion session liked the phrase 'accessible and timely' and how this sums up priority two. They felt this meant they could get to the help they need when they need it, and that people are not waiting for support in a situation which could be making their mental health worse.

One participant in the third session felt this priority was implicit around accessibility of services for different groups of the community, but that it needed to be more explicit and inclusive.

## Priority three

**Working with you on what matters to you**

Delivering person centred outcome focused care without barriers across teams, services, and organisations

One participant in the first discussion group described their personal experience of trying to access mental health services and being passed between the services.

They summarised their experience as not feeling like a priority for anyone, nor cared for. This led to discussion about including the term 'priority care' and being listened to. They followed this up by saying they felt unable to approach friends and family for support, as they felt if professionals did not make them feel listened to then friends and family equally would not want to listen to them. This links back to the vision for the overall strategy, and also to priority one.

When discussing the term 'person-centred', participants in the first discussion group mentioned how the crisis team read from a script rather than took a person-centred approach to a conversation with patients. They felt this script needed to go to ensure they felt listened to, like a priority themselves, and that they were receiving person-centred support.

There was also discussion around person centred care focussing on the individual if they are not able to keep an appointment. Rather than that person being put to the back of the waiting list, a suggestion put forward was for staff to use the appointment time to proactively try to engage with the patient.

Participants in the second discussion group felt the phrase ' Delivering person centred outcome focused care' was a bit of a mouthful, a bit jargon, a bit too wordy, and that some people might struggle to understand what that means. Using the word individual, or the phrases 'individually tailored care' or 'individualised care' may be better suited, as the priority is indicating that care will be focussed on the individual and be different for everyone.

Participants in the third group talked about the importance of the transition out of services as well as into services or between services. They described how some people have been cut off from all mental health support, only to lead to a relapse and end up back into the service. This will ensure a commitment to the right support at the right time (priority two), to ensure people are supported so they don't need to re-enter more high-level support. This also links to the first priority, around empowering individuals and providing the support for them to self-care. A suggestion was made about linking with the community to offer community support when a person is discharged from services, which links to the vision for the overall strategy. A participant identified that even if there were things in place, currently the communication of these transition services is so poor, that people do not have appropriate awareness of the available services.

A participant described how with high-level mental health illness, there was a barrier to services wanting to accept responsibility for that patient. They described a stigma associated with these patients within the mental health services itself, which would need to be addressed to remove barriers. This links to priority one.