



Towards a Mentally Flourishing Scotland: response from the Scottish Division of the Royal College of Psychiatrists

"Mental health improvement and population mental health" is an important area, and the College welcomes the interest shown by the Scottish government in developing an appropriate national response. The field has generated considerable academic, economic and political interest in recent years. Since Scotland performs relatively poorly on some measures of well-being, it is appropriate to renew our efforts to improve matters.

The attention paid to the links between mental and physical illness is very welcome, and we share the Government's concern to tackle inequalities.

Although commendably strong in outlining the "vision", this strategy is weaker when defining some fundamental concepts and in reviewing "what works?"

Comments on individual sections of the document follow below.

Context

3.1 "*..violent and abusive behaviour...*" The overall contribution of mental illness to violence is probably minimal, and there is little evidence to suggest that improving wellbeing can reduce violence in society. We note that "*variables such as male sex, young age, and lower socioeconomic status contribute a much higher proportion to societal violence than...mental illness*" (Walsh, E. & Fahy, T. (2002) Violence in society. *BMJ*, 325, 507-508. Walsh, 2002). Tackling licensing laws would probably have a greater effect.

3.1 "*..poor sexual health.*"

The term 'sexual health' warrants clarification. The WHO states that: "*Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality*" (<http://www.who.int/reproductive-health/gender/sexualhealth.html>). However, sexual health may also refer to the prevalence of sexually-transmitted diseases.

It would be appropriate to more closely define which aspect of sexual health the document is referring to. Similarly, the document should be careful to distinguish between causality and association in relation to obesity and mental health.

“definitions, themes and target groups”

The definition of mental illness in section 4.1 (*Mental illness refers to clinically identifiable illnesses or conditions that affect our cognitive functioning*) is incorrect. Many mental illnesses do not affect cognitive functioning, whereas many physical illnesses (MS, stroke) do. We would recommend that the WHO definition (below) should be used instead.

Section 4.1 splits “mental well-being” into three dimensions, without any discussion or referencing of why “emotional, social and psychological” components should together amount to well-being. Section 4.2 proposes that “someone could experience signs and symptoms of mental illness and still have good or flourishing mental well-being”. Given that most conventionally accepted definitions of mental illness include the experience of distress of some kind, (eg *“A clinically recognisable set of symptoms or behaviour associated in most cases with distress and interference with personal function.”* (World Health Organisation, 1992)) this statement is of questionable validity.

The Keyes paper cited states that *“These predictions may only apply to the most common mental disorders (e.g., anxiety and mood) rather than the less common but more severe psychotic disorders.”* (Keyes, 2005). In fact, Keyes found that *“individuals with any of the four mental disorders were at a very low risk of flourishing.”* Therefore, this model may only apply in certain mental disorders and those of particular severity.

The GHQ-12 (used to measure wellbeing in the National Public Surveys) is used to detect depression, suggesting that depressive symptoms will affect wellbeing. The recently-published ‘validation’ of the WEMWBS scale found that in a population sample there was a negative correlation between WEMWBS score and GHQ-12 score (Tennant, R., Hiller, L., Fishwick, R., *et al* (2007) The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes*, 5, 63).

Research evidence seems therefore to contradict the assertions made in this paper. It seems more likely that the two dimensions of mental illness and wellbeing are not independent of each other. Statements to the contrary should not be made without justification.

In our view, “mental illness” and “mental well-being” are profoundly intertwined, and simplistic two-dimensional models may not do justice to their complexity, nor to the lived experience of people with mental health problems.

5.1 "*There is a good evidence base*" This statement should be backed up with some reference to the evidence base.

Section 5.3 proposes that mental health problems and mental illness can be "prevented", but there is no justification given for such a sweeping statement. Mental disorders are frequently comorbid with a wide range of mental and physical illnesses, so the statement "*Prevent...co-morbidity*" requires more clarification: prevent comorbidity with what?

We are encouraged by the support proposed for people who are particularly vulnerable because of poverty, deprivation, & discrimination. However, it should be remembered that serious mental health problems also occur in affluent sections of the population.

Section 6 seems to struggle to come to terms with the conflicting needs of delivering a "population-based approach" and meeting the needs of particular target groups. For example, the statement in Section 6. Para 1 that "*it will not just be any one in four people*" is misleading and statistically incorrect. MH problems can affect any member of the population, though the risk will vary across different groups.

The document suggests that targeted groups might be defined by "those who need it most", by ages "ranging across the life course from early years later life" and also by the need to "address inequalities". Geographical targets seemed to be added in section 8.3 .2. It isn't clear which of these principles informed the list of "illustrative" groups cited in section 6.1. This "illustrative" list is confusingly referred to in section 8.3 .2 as "main target groups".

Section 6.3 implies (correctly) that there is good evidence to support the effectiveness of interventions in early years, but section 8.3.4 suggest this could be "before birth to up to eight years old". We are aware of good evidence supporting intervention in the under-twos and in preschool years, but the proposal to establish a cut-off of up to eight years requires more justification. Given the strength of the evidence favouring preventive action in early years, more emphasis on intervention for this group should have been made.

We would also recommend increased support for families where a parent has mental health problems.

The document implies that substance misuse problems develop secondary to failure to address mental wellbeing or mental health concerns. In fact alcohol & drugs can give rise to severe mental and physical health problem in people with no predisposing vulnerability factors- so controls such as price, availability and access to treatment are also important considerations.

No mention is made of people with learning disabilities, who are very likely to experience discrimination, poor social circumstances, poor housing and high risk of mental ill health.

“what works?”

The National Programme has been implemented since 2001, and it would be appropriate in this document take a view as to which interventions are likely to be most effective and therefore be the focus of the strategy. Section 7.2 seems to draw an obscure distinction between the previous emphasis on “output” and the new emphasis on “outcomes”. The questions asked in this section are important, but the strategy should seek to answer them rather than proposing further national consultation.

The document is weak in two areas:

- Evidence for interventions
although the strategy would not be the place for a formal literature review, the references cited are rather sparse. Although there was a list of research funded by the programme, the outcomes of this research are not mentioned, and its influence on strategy not mentioned. It is a pity that the excellent documents in the series “Cultural Influences on Health & Wellbeing in Scotland” by Sandra Carlisle (Research Fellow in the Department of Public Health & Health Policy at the University of Glasgow) were not used to inform this paper. The Scottish programme is not set in the context of other international initiatives.
- Outcomes of current initiatives
the programme has funded a number of successful initiatives, and a list of publications is given in table 2. However, there is no critical reflection on the outcome from individual projects, nor the interrelationship between them.

Broad themes for action

Section 8.3 suggest that:

“We want to promote and embed the skills, attributes, belief, values and circumstances that increase resilience, self efficacy, a sense of mastery, coherence and control that enable us to realise our own abilities and to flourish, contributing to greater optimism, hope and an ability to cope with the challenges of life.”

This sentence is difficult to read. It links uncontroversial aspirations (“greater optimism, hope and an ability to cope with the challenges of life”) with a series of psychological qualities (“increased resilience, self efficacy, sense of mastery, coherence and control”). It implies these might be achieved by interventions that could “embed and promote...skills, attributes, belief, values and circumstances”.

These are laudable aims, but will require much more careful definition if they are to be useful: the skills, attributes, beliefs, and circumstances that are referred to should be specified. Which skills should be “promoted and embedded”?

8.3.1 *"Work in this arena should draw on the available and developing evidence base and the body of growing experience."* This sentence makes reference to both evidence-based and experiential knowledge, which is itself informed by values. However, the subsequent sentence refers to 'evidence' in general suggesting that both epistemological methods have equal validity. This is not necessarily the case. For example, a values-based approach would condone the statements in 8.3.3 that *"Mental health...literacy...should include a recovery-oriented approach"* and in 8.5.2 that *"Belief in recovery is key to tackling stigma and discrimination and improving people's quality of life, inclusion and opportunities."* But what evidence is there to support this in practice?

Section 9.2 advocates *"using the health inequalities evidence base and a Keep Well type approach"*, but 12 out of 22 interventions had no evidence of effectiveness (Bream, E. (2006) Prevention 2010. Engagement and Concordance: Evidence Overview - A resource for pilots Scottish Public Health Network) Bream's review concludes that *"The quality of individual reviews was not assessed"* and that much of the evidence *"does not relate specifically to deprived populations in the UK"*.

Conclusion

The RCPsych in Scotland wholeheartedly supports this national initiative to promote mental health and wellbeing, and we know from clinical experience the importance of tackling inequalities. However, we would recommend the following:

- It would be helpful to describe outcomes from initiatives funded to date and a critical commentary on their effectiveness. This should form part of a critical review of other relevant evidence.
- It would be helpful to review the model by which MH promotion in different areas is presumed to have an effect. The existing model lacks rigour.
- The centre should make some clear decisions about policies and interventions, albeit based on limited information. Such decisions should not be devolved to local areas or groups. In particular, serious consideration needs to be given to targeted vs population-based measures. The centre should develop a national strategy and then act as a resource to local areas as they seek to implement it.

- The “priority areas” are inappropriately all-encompassing and need to be refined.
- It’s clear that action will need to be taken across a range of agencies and disciplines. More explicit reference should have been made to the responsibilities not only of the health service, but also to local authorities and CHPs as well as government departments and agencies and the voluntary sector. The paper should make explicit reference to other governmental initiatives, for example in schools and prisons and to promote exercise
- We would support closer links between “see me” and the Scottish Recovery Network, since a proportion of their work overlaps.

The College welcome the establishment of a National Reference Group for Mental Health Improvement, and look forward to participating in future planning.

THE SCOTTISH DIVISION
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