Mental Health Social Care: What it is, why and how it matters for Integrated Care

Mental Health Social Care Policy and Oversight Group

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Association of Mental Health Providers

The Mental Health Social Care Policy and Oversight Group[i] has been invited by the Department of Health and Social Care (DHSC) to:

- Produce a succinct statement highlighting the distinct and vital contribution of mental health social care to local systems and better outcomes for individuals, and why, hence, it needs to be explicitly considered in wider, ongoing policy and reform planning;
- Consider how the Mental Health Investment Standard should be applied in the establishment of Integrated Care Boards to help secure the effective engagement and resourcing of mental health social care; and
- Consider the appropriate footprint(s) for the commissioning of mental health services and related support, to ensure that they are both coterminous with place and aligned with the mental health and wellbeing priorities of the people and communities therein.

Background

The report prepared by the Mental Health and Wellbeing Advisory Group (predecessor to the Mental Health Social Care Policy and Oversight Group) for the DHSC Social Care Task Force in 2020 noted that local authorities "*have substantial statutory responsibilities for mental health. This includes the approved mental health professional (AMHP) service, s117 aftercare support, community mental health services and the commissioning of a wide range of local providers-both VCSE [Voluntary, Community and Social Enterprise] and independent sector that support people with mental health issues in the community and leaving NHS hospitals. Indeed, it is LAs-and not the NHS-that are the majority public funders (i.e., through commissioning and grant funding) of VCSE sector provided mental health services and support.*"

That report also highlighted **the role of adult social care in meeting the needs of people with mental illness or those experiencing mental distress, keeping them safe and enabling them to lead a good life**

Local authorities, as 'leaders of place' also have a wide range of roles and civic duties significant to nurturing communities that support wellbeing, including cultivating joint working between housing, public health, leisure, learning, community safety, the police and criminal justice system. These duties, taken together, form the basis of the relationship between the state and local communities.

The Advisory Group made a series of recommendations, and these highlighted the imperative for (the then emerging) Integrated Care Systems (ICSs) to work effectively with councils and the VCSE mental health sector in the drive to modernise and personalise mental health care and support and improve outcomes for people with mental illness or experiencing mental distress and their unpaid carers. The latter remain a relatively overlooked but critical element of a mental health care and support system concerned with keeping people safe and well. Currently, 1.4 million people provide over 50 hours of care per week, and it is estimated that they save the economy £132 billion per year, an average of £19,336 per carer, with VCSE organisations underpinning support to many of those carers, in ways which is neither formally recognised nor funded. Unpaid carers are not a homogenous group, however, and those of people living with mental illness or mental distress can face challenges.

The following, drawn together based on the expertise of members of the Group, is intended to provide the basis for building a narrative that responds to the DHSC invitation. The paper seeks to maximise the opportunities presented by current policy developments (e.g., reform of adult social care, consultation on a new mental health strategy, Integration White Paper and Adult Social Care white papers), the ongoing implementation of the community mental health

framework for adults and older adults, and strategic health and care reorganisation via Integrated Care Boards and Systems.

Whist this paper is primarily concerned with mental health social care as it relates to the adult population, the Group is also clear about the need for improving policy and practice alignment with mental health social care services and support for children and young people – not least given that it is often families that are being supported, and the role played by adult social care in helping young people looked after or supported by children's social care, and as they move into adult social care services, if these are necessary.

Mental Health Social Care Defined

Mental health social care empowers people living with mental illness, people experiencing mental distress, their unpaid carers, and local communities. It seeks to enable people to lead fulfilling and independent lives by providing information, advice and offering practical, personalised support with everyday activities. It facilitates agency and the ability to access a life with purpose, meaning and a voice as an active citizen - not just the absence of symptoms. Through working in and with communities, mental health social care helps to develop their capacity to be supportive, resilient and emotionally healthy.

Social care (or more accurately regulated and non-regulated care and support, as set out in the Care Act 2014), is essentially defined by a social model of health and wellbeing, drawing on biopsychosocial theoretical frameworks and practice models. As such it should be seen to include an emphasis on relational, systems and rights-enhancing approaches in meeting the needs of people with mental illness or experiencing mental distress, with a focus on support and outcomes that are aligned with social justice principles, regardless of any formal medical diagnosis. This includes, of course, ensuring that the rights of people detained under mental health legislation are safeguarded and that there is an absolute focus on the principle of least restriction and identifying securing non-institutional, community-based care and support.

Mental health social care has a focus on promoting independence, recognising that recovery for people with mental illness or experiencing mental distress is often a complex, non-linear, multidimensional phenomenon (biopsychosocial) of which i) the social is an important part, but more crucially ii) the elements need to interlink and work holistically for each person's recovery of a good life.

This means the social care and support system (across the statutory, voluntary and community and for-profit sectors), as a community presence and connector, must be part of recovery narratives and support. It also means ongoing co-ordination is required across the local mental health system, which spans acute, community and social care and support services, for services to remain alongside people with mental illness or experiencing mental distress over the medium and longer term. This ongoing support seeks to enable people to develop their sense of identity, agency and belonging in their communities. The investment in and commissioning of these services must, therefore, be defined by these considerations.

Research[ii] on mental health social work identifies that people in need of care and or support **value most highly the fact that social workers 'think about my whole life. not just my illness'**, thus underlining the importance and value of person-centred approaches and the social of model of health and wellbeing that are fundamental to Mental Health Social Care. There are, of course, many social care roles, in addition to social workers, which help people achieve their recovery mental health social care through a **strengths-based approach**, with a focus on

the abilities, assets and other strengths that people with mental illness and mental distress possess, often in relation to their families, friends and communities, that are essential to their ability to live a better life.

Mental health social care is **relational** (as opposed to transactional) in understanding and responding to mental illness and mental distress and their social and economic determinants. This requires people in support roles having the capacity to build consistent and trusting relationships over a period determined by the needs and wants of the person themselves.

Mental health social care is characterised by positive risk taking, with a distinct and defined **safeguarding focus and as such involves a considerable amount of risk management/judgement and extensive multi-agency, inter-professional planning**. A diverse range of roles and skills are required to undertake these activities, such as social supervision and forensic social work, so that, if and when required, appropriate help is available to the individual to keep them safe and protect what they have achieved in their recovery.

The provision of effective advocacy and securing access to it is an essential element of mental health social care and particularly in safeguarding situations. The often-complex nature of many people's mental health circumstances and needs and the equally complex nature of the care and health system intended to help them means that sometimes they require need more support. Occasionally this includes professionals to speak for and with them, from a position of knowing them, understanding and respecting their rights, and committed to sharing power and handing it back at the earliest possible moment.

As such, what is becoming referred to as **mental health social care can be seen to have a distinct practise base**, with application for all those in the adult population who may have care and support and related mental health needs e.g., older people or homeless people or those dealing with addiction/substance misuse.

In this respect, an effective and sufficiently resourced mental health social care sector is vital in preventing the disruptions and dislocations in the lives of people with mental illness, those experiencing mental distress and their unpaid family carers, by avoiding unnecessary admissions, reducing length of hospital stays and minimising out-of-area placements. As such it can also reduce the need for NHS care and associated costs as well as leading to better, more sustainable outcomes for people.

Other considerations in relation to Mental Health Social Care and Policy and System Reform

Authentic and equitable partnerships between health and social care are also key to working with people at their most vulnerable–in crisis, the acute pathway and discharge planning, reablement and in helping them to reclaim and retain their independence through personalised care and support, e.g., Personal Health Budgets and Direct Payments.

The importance of the Care Act 2014 legislation, in setting out councils' extensive responsibilities for identifying and assessing, holistically, the care and support needs of its adult population and in giving expression to and accountability for a social model of mental health needs, is also clear in relation to the prevention and wellbeing promotion, and safeguarding duties that mental health social care should perform. These responsibilities include provision of Information, Advice and Guidance, market development and shaping and enablement, and the requirements to prevent, reduce and delay the need for care and support services. NHS organisations do not operate under these legal

requirements when arranging, providing and commissioning mental health services.

Councils also have a long history in commissioning and providing, via their statutory duties for social care adults and children and young people, services such as welfare rights and money advice, which respond to the widely acknowledged social and economic determinants of wellbeing generally, including poor mental health.

The VCSE mental health sector is host to significant expertise in the delivery and design of mental health social care (including social work and community support) for people living with mental illness or mental distress. For many people experiencing mental illness or mental distress, it is through interaction with these non-statutory social care and support organisations that their mental health needs are often first identified. Equally, it is through a relationship with them that their recovery journeys and growing sense of identity and agency can be realised.

A related consideration here is the significant role that the VCSE mental health sector, often funded or commissioned via councils' Care Act duties, plays in prevention and enabling effective and timely discharge and its provision of crisis cafés and step up and down support. There is a need for greater recognition and understanding of the nature and extent of VCSE sector's role as a provider of crisis services and support, which demonstrates its flexibility, ability to work innovatively and at pace, with highly skilled (often 'non-qualified' staff) who deliver the personalised care required to keep people in a crisis safe.

A key feature of the importance of the VCSE mental health social care sector is that local organisations are seen as part of communities and, hence, are often more trusted; this may be most significant in terms of addressing inequalities, especially amongst black and minority ethnic communities, and in advancing diversity and inclusion imperatives.

However, for this value that the VCSE sector brings to be both realised and sustained, a flexible approach to commissioning is required that explicitly considers nurturing and sustaining the sector. Person centred, personalised care for people living with mental illness or mental distress cannot be delivered through 'one size fits all' commissioning. The latter must work in partnership and design services with individuals and families, trust that they will make the right decisions if given the right support and if they don't, ensure there is a mechanism to keep them safe should those decisions not work in their best interests.

The funding of section 117 and non-chargeable services and related shared partnership arrangements, that are sometimes characterised by a lack of effective governance or assurance, can inhibit the delivery of personalised mental health care and support. The current financing landscape can also mean that even good, evidence-based initiatives may fail to secure traction because any savings and expenditure are not (or not seen to be) shared across NHS and Local Authorities. Resolving apparent disincentives for and short-term nature of funding is key to ensuring the commissioning of rehabilitation and recovery services informed by a strengths-based, inclusive approach to working with and promoting the independence of people with mental illness - and not their continued micro-institutionalisation in the community.

With the current reform agenda comes an opportunity to rebalance and elevate the critical contribution local authorities and, in particular, adult social care play in delivering the ambition for mental health. The relative lack **of influence**, (aligned to a lack of understanding of its function and value) of **local authority-led adult social care**, continues to present challenges in making the case for investment in social care for

people experiencing mental illness or mental distress and better integrating support.

It is the responsibility of councils under the Care Act 2014 (not the NHS) for assessing and meeting the eligible needs, of **unpaid carers** of people with mental illness or experiencing mental distress. Integrated Care Systems will, therefore, need to review how councils are able deliver this responsibility.

The only measures in current **Adult Social Care Outcomes Framework** in relation to relation to mental health pertain to the housing and employment status of service users. Whilst important, this does not adequately capture the significance of mental health social care. The expansion of and necessary addition to the metrics for these outcomes and alignment with those for mental health in PROMs utilised by the NHS is evident in the context of the ambitions for relevant service and system reform, particularly in relation to personalised care. For example, measures in relation to the assessment of the needs and support for unpaid carers of people with mental illness should be established.

Integration White Paper and Commissioning Mental Health Social Care

- **System' integration should be the vehicle, not the ambition**; the narrative needs to prioritise the vision and outcomes i.e., personalised care, premised on prevention and wellbeing; not structures and means.

- **Behaviours and culture are important and need to be recognised as both enablers and barriers to service transformation** concerned with advancing personalisation, developing wellbeing communities and investing in prevention.

- **Parity of esteem and preserving the Mental Health Investment Standard must be a priority** in the establishment of NHS led Integrated Care Systems and for their Boards.

- **Integrated local commissioning for mental health, informed by active Joint Strategic Need Assessments**, capable of identifying shared populations that need support, will help ensure less fragmentation of mental health systems and services and the effective implementation of community mental health transformation.

- **Commissioning must be re-engineered, with a greater emphasis on its role facilitating partnerships and co-production for better service design**. It should prioritise collaboration and disincentivise competition, in the pursuit of person-centred care outcomes. Specifically, procurement should reward innovation, flexibility, partnerships and place a premium on personalisation and tackling inequalities and help nurture and sustain a diverse mental health social care provider sector capable of responding diverse needs.

- As an organising principle, **commissioning must, therefore, be at the required level for arranging support for people and securing the most effective outcomes for them**. Sometimes this will be at an individual level through direct payments/PBs; sometimes at locality and/or place overseen by Health and Wellbeing Boards; and sometimes at a system/regional/national level.

- Commissioning should also seek to **operationalise the principles for effective mental health social care that this paper has identified e.g. coproduction, personalisation and a social model of mental health and wellbeing.**

- At whatever level **commissioning is undertaken, its architecture and footprints should be aligned with the importance of local authorities** as a place shaper and with responsibilities for the essential public services that contribute to improved mental health and wellbeing.

- A **more developed understanding and knowledge of the breadth, skill set, expertise and roles within the mental health social care workforce and the recruitment and retention challenges it faces, is required to inform planning at all levels**. This is essential if the unique and essential contribution of that workforce, one that is often overlooked in strategic planning, is to be realised, sustained and maintained. The Group would suggest that councils might be enabled to have greater oversight of mental health social care workforce planning, capacity and development, to ensure that integrated local strategic planning is inclusive of the breadth of the that workforce and its needs.

- **Transparency is essential, particularly in relation to investment, resource allocation and funding flows.**

- **The dynamics of differing local authority structures and their impact on commissioning and provider footprints**, need to be considered e.g., upper tier/county (district) vs unitary–unitary authorities often exhibit the ability to be more agile and are co-terminus.

- **There is a need for greater uniformity of and integrity in the data collected across NHS/LA and VCSE mental health provider sector**. Crucially, this data must be allied with drive to shared outcome measures and be sufficiently transparent and comprehensive to evidence the investments in mental health social care and its impact.

- **Examples of good practice and partnership working (Turning Point, Rethink) between VCSE, Local Authorities and NHS (especially with Clinical Commissioning Groups) are important illustrations of strategic intelligence possessed by VCSE organisations and of their value, to both system transformation and assurance**. However, there may be challenges for specialist VCSE sector providers to engage in local ICSs because they have national management structures, and where ICSs do not explicitly develop means of engaging local VCSE organisations.

- **Local systems must both acknowledge and engage meaningfully with VSCE sector as an essential strategic partner.** The sector is a critical part of the continuum of support that flows from individual and family, community through to formal statutory support-LA and NHS and in arrangements for ICSs.

- **The Group endorses a coproduction approach to system improvement across all levels from locality up to national**, including significantly giving voice to people with lived experience of mental health distress and of being unpaid carers.

[i] The Mental Health Social Care Policy and Oversight Group brings together partners from across the statutory and VCSE sectors, people with lived experience of mental illness and unpaid carers, to consider the strategic priorities for social care and support services for people who live with mental illness or experience mental distress and those people with relevant other needs e.g. related to alcohol and substance misuse and homelessness. Facilitated by the Association of Mental Health Providers, it meets monthly and is co-chaired by the Association of Mental Health Providers and the Association of Directors of Adult Social Services. The group has provided several reports for and ongoing advice and intelligence to DHSC, which attends meetings in an observer status. The Group's reports, papers and recommendations reflect its collective assessment of and perspectives on relevant issues and do not necessarily represent the views of its individual members.

[ii] 'What Do Service Users Want from Mental Health Social Work? A Best-Worst Scaling Analysis' Mark Wilberforce et al, British Journal of Social Work 2018 0, 1-21

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