

CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but **we want to consult on:**

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

We would like to see a more clearly articulated vision for mental health in Scotland. We do not completely share the same degree of confidence that there is a strong consensus as to the best direction of travel for mental health in Scotland or on the ultimate aims. We therefore think there is more to do to generate a shared vision and to ensure a greater sense of ownership for the changes that may then be required as a result of this renewed vision. We would be delighted to contribute to any such process. We feel that this tradition of shared vision was a particular strength of the former National Programme for Improving Mental Health and Wellbeing. In our experience in the absence of an agreed and jointly owned shared vision change processes are harder and resistance is more likely.

Our sense is that there are perhaps some assumptions made in this consultation about a sense of satisfaction and progress and while we fully support and acknowledge the unprecedented focus on mental health in Scotland between administrations over the last decade, and the progress made, we feel there remain tensions within the mental health community as the best way to support recovery that would benefit from being more fully debated.

We would have like to have seen a more ambitious and broader set of high level outcomes and hope that any resultant strategy fulfils that wish, albeit we recognise the current economic restraints. We do though feel that difficult economic times could lend themselves to a more objective review of strengths, challenges and even the potential reconfiguration of services and spend to ensure greatest impact for recovery – perhaps in line with plans to ensure greater integration between health and social care provision (as envisioned by the Christie Commission).

We would like to have seen a broader focus within the outcome areas identified. We recognise the need to prioritise NHS services but feel the consultation would have been stronger had it been more holistic and inclusive across all aspects of mental health in Scotland. On one level we feel the strategy is limited in the extent to which it adequately addresses mental health improvement and public health approaches at the expense of focusing on mental health services and treatments. Secondly where the focus is on services we feel it is too heavily on those services provided by

the NHS at the expense of those provided by Local Authorities and their partners in the voluntary sector.

We were disappointed by the lack of emphasis on inequality and inclusion, both significant and well evidenced consequences of, and predictors of, mental health issues. In particular would like to have seen reference to employment within the strategy and feel supporting people into, and in, work should form a key part of a modern mental health strategy given its well evidenced impact upon recovery. Related to this we would also have liked to have seen reference to the Local Authorities' power to advance wellbeing' duties and to their responsibilities under section 26 of the Mental Health Act.

We would have liked to have seen a greater emphasis on early years and preventative approaches generally. We feel the focus is very strongly on working with problems as they arise rather than preventing or anticipating them.

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

We would like to have seen more explicit reference to the cross over between health and social care provision and to the potential for (and stated intention of) fuller integration. We believe there are real opportunities to realign services to better support recovery given the varied range of things that help personal recovery that don't necessarily fall within the remit of health provided treatment services. We believe that supporting people with mental health issues is of particular relevance to the integration agenda given the diverse range of elements that support personal recovery. We believe that there is a case for at least examining the potential for fully integrated health and social care mental health partnerships as one means of better realising and supporting the process of recovery which is characterised by quality of life in the presence or absence of symptoms. A more holistic and less medically dominated support system might offer greater opportunity to support all aspects of recovery.

Elsewhere we feel there is a need to review the separation of service by arbitrary age bandings. Transitioning between service types can be

disruptive and upsetting for people and also impacts on continuity of support which is an important and under recognised aspect of personal recovery.

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

We welcome the recognition of trauma within this consultation document. Increasingly strong scientific evidence is articulating the powerful and causal links between childhood experiences, including trauma (in all its forms), and the later development of mental health problems (Larkin W, Read J. Childhood trauma and psychosis: Evidence, pathways, and implications. *J Postgrad Med* 2008;54:287-93). Responding to this type of evidence calls for not only better service responses but also for a stronger emphasis on preventative approaches designed to avoid people unnecessarily becoming part of the mental health service system. We would encourage new and preventative approaches that focus on working with families and communities.

Within services we would like to see a continued development of an awareness of trauma informed practice. These practices and associated principles ask service providers to ask "what happened to you" rather than "what is *wrong* with you." An important shift in emphasis that locates the *problem* out with the person in question. We believe that the better identification and support of people who have experienced trauma within mental health services could reduce the need for ongoing services with the potential negative consequence of an identity that can become dominated by an illness worldview. We believe that this calls for a brave assessment of new and developing evidence from neuroscience and psychology that is offering new insights into the developmental impact of trauma (in all its various forms) on the brain and also, as a consequence, the most appropriate responses.

We believe that based on experience to date there is also a significant amount to be learned in relation to supporting people who have experienced trauma in a non-pathologising manner from approaches to recovery and peer support working practices, based as they are on validation of experience, mutuality and relationship development. We believe that crisis alternative models may have a particular benefit here in avoiding the need for hospital admission for people who have experienced past trauma.

Generally we would like to see outcomes improved through a reduction in the need for admissions to hospital in particular where they occur under the

Mental Health Act. While we don't question the need for the use of compulsory treatment in some instances we think it is vitally important to constantly monitor and review uses of the Act to ensure that they are appropriate and not a convenience for service providers, nor a consequence of reduced community based services. Recovery is strongly associated with empowerment and control so we have a strong interest in compulsory powers being seen as a last option and their use minimised wherever possible.

We are concerned that at a time when community based services are being cut significantly that we could, due to the reduction of support infrastructures, see a continued increase in the use of short terms orders under the Act and that statutory services in turn could be required to work more than ever in a crisis management type role. We believe that a greater emphasis upon community services and better recognition of their role and importance within this consultation might go some way to safeguarding their future.

Linked to this we recognise why there is a drive to encourage shorter admissions to hospital but are concerned that in some instances this can lead to the encouragement of short term and quick fix type approaches that could lead to poorer longer-term outcomes.

We would like to see a stronger emphasis upon ensuring opportunities for empowerment and self determination amongst people experiencing mental health problems as well as people affected by mental health issues including carers. We see very encouraging outcomes from the use of WRAP, which is one of a number of approaches to enabling people to move and assume a greater degree of control over their wellbeing and recovery. We see greatest impact where tools like WRAP are shared within group settings using peer approaches. We support the development of new learning based approaches to supporting self directed recovery and think there is much to be learned in this regard from newly developing recovery education centres in England and more widely (see, for example, South West London Recovery College - South West London and St George's Mental Health NHS Trust).

We also feel there is more to do to encourage the effective use of Advanced Statements.

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

We acknowledge the recognition of the separate yet related natures of self harming and suicide. We encourage the continued emphasis upon recognising the impact and consequences of self harming behaviours and coping strategies and encourage the increased involvement of people with

lived experience of self harming in developing and implementing appropriate responses.

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?

Stigma and discrimination is consistently identified as a significant hindering factor to personal recovery. We believe that an effective means of reducing stigma and discrimination is through sharing experiences of recovery and through people with experience of significant mental health problems having valued roles in communities and making recognised contributions. We have worked successfully with our partners 'see me' and recognise their recognition of the importance of promoting recovery approaches but think there is more could be done. We have recently worked collaboratively to commission research on the subject of self stigma which is increasingly being identified as a hindrance to personal recovery and will continue to do so. We are not convinced by the merit of challenging stigma through social marketing approaches favouring more community based approaches designed to enhance empowerment.

We welcome the distinction in this strategy between stigma and discrimination. Stigma is a complex concept and how best to address it is the subject of much debate. However, discrimination is more clear cut and perhaps calls for different strategies and approaches to those used when tackling stigma. We would like, for example, to see more encouragement and support for people to challenge the very real discrimination that exists in, for example, the employment field. This could involve specific advice and information as well as support for legal test cases and greater integration with other equalities bodies like the Equality and Human Rights Commission and the Scottish Human Rights Commission.

Allied to a new emphasis upon challenging discrimination we believe it is important to focus mental health awareness raising efforts on children and young people to ensure future generations are more tolerant and have improved mental health literacy.

Question 5: How do we build on the progress that *see me* has made in addressing stigma to address the challenges in engaging services to address discrimination?

See previous response

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

Through the innovative and ground breaking work already developed in Scotland in relation to the promotion of wellbeing (e.g. Indicators, WEMWEBS and outcomes models) we believe there is a very strong foundation for further development. While we recognise the huge complexity of promoting wellbeing and the extent to which it is a 'crosscutting issue' we would like to have seen a greater commitment to future work in this regard through for example a commitment to wellbeing measurement and the development of wider policy informed by the potential to positively or negatively impact wellbeing.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

We agree CAMHS need a stronger emphasis and that access to CAMHS services should be improved. However, we feel that any strategy would benefit from highlighting preventative approaches that focus in particular on early years support including parenting programmes and support in schools for those at risk of exclusion or bullying.

Question 8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

Comments

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

We think there is much to be learned from work related to self-management in relation to how all members of communities can become more empowered to take greater responsibility for their health and wellbeing. We also feel that we would benefit from a renewed emphasis upon mental health literacy in its broadest sense to build on programmes like mental health first aid, potentially not only increasing awareness and help seeking but also in turn impacting stigma and discrimination.

Question 10: What approaches do we need to encourage people to seek help when they need to?

We feel that one of the reasons people do not seek help is related to anticipated stigma and discrimination. We feel there is much more to do in this respect to continue existing good work to shift public attitudes. We feel there is still significant work to do to encourage people to seek help through awareness raising and the challenging of stigma. We believe that for many fear still prevents help seeking. We are also interested in how SRN can play a role in working with primary care practitioners to ensure that where people do seek help that the initial response is supportive, informed and hopeful.

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

We welcome the recognition of the value and role of early intervention (EI) services. New evidence suggests where people are helped at the earliest possible opportunity then recovery is more likely. We would like to see early intervention approaches becoming standard across Scotland, based on recovery principles and designed to make peoples interaction with services

as supportive and as brief as possible. We recognise the importance of access to treatment but feel this question is limited in that it does not emphasise the need to better evidence the outcomes of services and treatments provided.

We feel that we could do more to support good quality early intervention through better linkages between services and family members and friends to ensure people enter services (at whatever stage) in as supported a manner as possible. We worry there may be too much reliance upon the police to bring people to services during crisis which can cause significant trauma and distress and that wherever possible this should be a last resort.

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

Safety and efficiency should not be a means to an end in its own right. We feel that the primary driver for service improvement should be the experience of using the service and how recovery is supported. We also feel service users and carers are excellent sources of information when it comes to identifying and addressing non-value adding activities and should be fully linked in with initiatives like Releasing Time to Care.

Question 13: What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?

We believe that there is more to do to more fully assess how the implementation and use of ICPs may positively and negatively impact upon personal recovery and recovery focused practices and would be interested in working with partners in this review. There is a concern in the group that if badly implemented or unnecessarily prescriptive ICPs could hinder recovery and we are interested to know more about the reality of the experience within services.

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

We want to see specific reference to the creation of Peer Support Worker roles in any new strategy. From feedback we know that aside from economic restraint another factor that could hinder areas from creating peer roles is a lack of clear policy commitment and drive at a national level (this was described in the evaluation of the pilots related to Delivering for Mental Health - McLean, J., Biggs, H., Whitehead, I., Pratt, R. & Maxwell, M. (2009). Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme. Edinburgh: Scottish Government.)

SRN remain committed to the continued development and support of Peer Worker roles and see good outcomes in relation to Peer Workers, people using peer services and in the systems where Peers are employed. We feel that given the imminent availability of the nationally validated Professional Development Award, developed in partnership with SQA, that it is time for a significant push on Peer Worker roles and are keen to work with our partners in Scottish Government, VoX and more widely to support this.

We note that there is no reference to advocacy in the consultation and understand that at a time of reduced funding that the limited collective advocacy services that exist could be threatened by the need to prioritise individual advocacy. We believe that both elements are necessary features of a modern mental health system. We see a considerable variability in the local provision of service user and carer groups in local areas and would like to see less variability. We feel it is important that user and carer involvement groups are specific to mental health and not generic across care/health needs.

In addition to service user involvement we would encourage the inclusion of additional and separate involvement of informal carers as a central aspect of service improvement as described in policy.

Question 15: What tools are needed to support service users, families, carers and staff to achieve mutually beneficial partnerships?

This is a huge question and it is hard to know where to start answering it. SRN have been working increasingly to recognise the key role that informal carers can play as one part of a "triangle of care." We want to see a greater emphasis upon employing tools that can bring together service users, providers and informal carers in local dialogue and feel that there may be some merit in employing the triologue approach, increasingly used in German speaking countries where well over hundred groups are regularly attended by around 5000 people. The groups meet regularly in an open forum, that is located on 'neutral terrain' - outside any therapeutic, familial or institutional context - with the aim of discussing the experiences and

consequences of mental health problems and ways forward' (Amering M, Mikus M, Steffen S Recovery in Austria: Mental Health Trialogue, International Review of Psychiatry, in press.)

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

We believe that it is possible to evidence person centred and values based approaches. We feel that to better evidence these outcomes requires that services are routinely required to report on how they are realising these ambitions, as they are on other targets. We believe that there are existing tools and approaches that could be used in this endeavour, e.g. the Scottish Recovery Indicator, Talking Points, i-ROC and My View, and that it may be as much a question of promoting or requiring the use of relevant tools rather than creating new ones.

Question 17: How do we encourage implementation of the new Scottish Recovery Indicator (SRI)?

SRN is working closely with Scottish Government, NHS Education for Scotland and other partners to promote the use of the revised Scottish Recovery Indicator tool. We believe that the improvement and streamlining of the original tool takes away many of the previously cited reasons for non-engagement e.g. time commitment etc. We are also conscious that it is perhaps time to take a more directive approach to monitoring and promotion of the tool and are open to dialogue and suggestion through this consultation process, and more widely, as to how this might be achieved.

Question 18: How can the Scottish Recovery Network develop its effectiveness to support embedding recovery approaches across different professional groups?

SRN are currently undergoing a strategic review and planning process. Within the new plan we are likely to include suggestions as to how we might better engage across professional groups, albeit this may be limited by the extent to which it is felt to be a strategic priority and on available resources.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

We have seen very promising outcomes from the use of WRAP amongst carers and family members. We believe that this type of approach to empowerment and wellness planning is of merit with carers. We feel that learning opportunities can play a vital part in enabling carers to separate themselves, to some extent, from their caring duties and to offer the degree of perspective and self-care that will enable them to ultimately fulfil their recovery support role more effectively by being conscious of their own needs. An example of this is the Prospect training programme previously disseminated by NSF Scotland (now Support in Mind Scotland) and we feel there may be merit in investigating future national support to this or a similar programme of learning.

From our work with informal carers the most commonly cited problem relates to services failing to adequately share information with carers in a way that will allow them to fulfil a recovery supporting role. We recognise that in some instances it may not be appropriate to share information but are concerned that confidentiality is used too often as an excuse not to better engage carers and family members. Carers should be better consulted about the role they play and should not be expected to perform roles that they do not necessarily want to perform. Rather they should be asked about how they could offer support in collaboration. Linked to this we would like to see the more routine use of carers' assessments across Scotland.

We believe that there remains an attitudinal problem with some professionals and professional groups regarding the role and influence that informal carers play in the delivery of care and treatment. Improved information and training may enhance a better level of awareness.

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

We feel that this should be a standard and routine practice for staff. Perhaps what might help is to raise awareness in staff teams of carers' experiences and potentially key role as recovery supporters.

We believe dedicated time should be factored in during pre registration

training and in the work place to hear about carers, needs, experiences and views. Carers views should be taken seriously and where appropriate acted upon. We understand that the opportunities for carers views to feed into training and education programmes have become more limited through budget cuts and are concerned that this will reduce the understanding of mental health professionals as to the key role of informal carers.

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

Question 21: How can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

We feel that there needs to be a stronger direction from Government as to what the preferred make up of a service system might look like. We see considerable variation in provision across the country with well recognised centres of progressive practice and service design. We feel that some parts of the country continue to be too heavily reliant upon inpatient beds with inadequate provision of community based and crisis alternative support services that could prevent the need for a disruptive and potentially traumatic hospital admission. We believe that future discussions on integration offer one means by which the Government may be more prescriptive in relation to expected provision and design. We also feel there is a strong potential within the voluntary sector to assume greater responsibilities for a wider range of service provision including the provision of crisis alternative options. This may provide a better balance on strength based approaches against the predominant focus on risk management.

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Comments

Question 23: How do we disseminate learning about what is important to make services accessible?

The Scottish Recovery Network is one of a number of vehicles that could be used to help disseminate information on the accessibility of services.

Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

In our work we hear about considerable differences between the quality and types of services available to different age groups and feel that there should be greater consistency as well as smoother transitions between age limited services. This would help promote continuity – an important recovery supporting element in services – and reduce the potential for service discrimination on the grounds of age.

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

We would like to see some of the existing tools and resources that have been designed to support person centred approaches being more effectively used. For example, the further promotion and dissemination of the 10 Essential Shared Capabilities and Realising Recovery training materials. The further promotion of the Scottish Recovery Indicator should also help towards this aspiration as would an increase in the number of Peer Support Workers within multidisciplinary teams. Additionally we think there is useful learning in relation to shared decision making models that could be investigated particularly in relation to the effective and informed use of psychiatric medication.

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

As previously stated we believe that the increased integration of health and social care services offers real opportunities for service improvement and the development of a more holistic recovery focus within services.

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

We feel that service user and carer involvement is crucial to all mental health training delivery and that it must be supported, guided and encouraged at a national level.

Question 28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

Comments

Question 29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

In addition to a renewed push to ensure existing values based and recovery focused training is used more widely (10 ESCs and Realising Recovery) we would like to work in partnership with the Scottish Government and VoX to ensure that the Professional Development Award in Mental Health Peer Support is delivered, potentially linked to a new programme in local areas to develop roles. We believe that without this national push role development will be slow and significantly hampered by economic circumstances.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge?

While we recognise the burden on service providers in relation to providing data and how this can get in the way of care and support we believe that it would be helpful to more routinely gather information about the experience of using services across Scotland, directly from the people who use them and from their carers and family members. Given the drive to ensure recovery focused and person centred services we feel there is a need to gather new data using innovative methods and would be delighted to contribute to any such developments.

Question 32: What would support services locally in their work to embed clinical outcomes reporting as a routine aspect of care delivery?

Comments

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

In our experience the extent to which service improvements are adopted and good practice promoted is highly variable across Scotland. As far as we can tell this is significantly linked to the extent to which there is good leadership in an area. Given this we feel there would be merit in revisiting some kind of leadership development programme. However, we feel that leaders are to be found in all relevant stakeholder groups so would encourage approaches that brought together leaders from service providing, service using and carer and family backgrounds. These leadership sets could be focused around how best areas can lead the development of recovery focused and person centred services.

Question 34: What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?

Comments

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

As described earlier we are concerned that at a time of service reduction, particularly in relation to community based social care services, that the use of Compulsory measures under the Mental Health Act may increase and feel that it will be important to more closely monitor for this eventuality and respond appropriately if needs be. We are concerned that in these circumstances the Act could be used as a convenience to allow greater access to pressed services. We also would like to see closer connection between the functioning of the act with the principles of recovery, for example in relation to the training of tribunal members which to date we

have been unable to influence. Elsewhere we would like to see a renewed emphasis on sections 23-26 of the Act which potentially affords a powerful means to ensure that people are able to access a range of supports in their local areas to ensure inclusion.