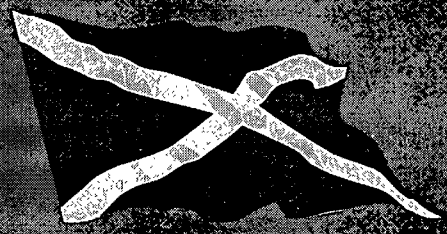

The British Psychological Society

SCOTTISH BRANCH

Mental Health Strategy for Scotland: 2011-15 A Consultation

British Psychological Society response to the Scottish Government

January 2012

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of almost 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge".

We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the Scottish Government to contact us in the future in relation to this consultation response. Please direct all queries to:-

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About this Response

This response was prepared for the British Psychological Society by Dr Frances Baty, CPsychol, AFBPsS, committee member and Past Chair of the Division of Clinical Psychology in Scotland) (DCP-S) and member of the Leadership & Management Faculty (L&MF), with contributions from:

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- Dr Belinda Hacking, CPsychol, Chair of the DCP-S and member of the Division of Health Psychology in Scotland;
- Dr John Higgon, CPsychol, member of the DCP-S and the DoN-S, and committee member and commenting on behalf of the Faculty for Psychology Specialists Working With Older People ("PSIGE") in Scotland
- Dr Ian-Mark Kevan, CPsychol, member of the DCP-S and the Faculty of Psychosis & Complex Mental Health;
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- Dr Ruth Stocks, CPsychol, committee member of the DCP-S, member of the Division of Forensic Psychology in Scotland and member of the L&MF;
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We would like to thank Jude Clarke, committee member of the Service User and Carer Liaison Committee (SUCLC) and SUCLC Representative on the DCP-S committee for advising on aspects of this response.

We hope you find our comments useful.

[redacted]

Dr E M Baikie CPsychol
Chair, Scottish Branch

David J Murphy CPsychol
Chair, Professional Practice Board

Response

The Scottish Branch of the British Psychological Society (BPS) thanks the Scottish Government for the opportunity to respond to this consultation.

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.

Comments:

As the learned and professional body for psychologists in the UK, the BPS strongly supports the greater integration of work to promote and improve mental health with the delivery work of mental health services.

Many applied psychologists work in mental health services and members of the BPS's Service User and Carer Liaison Committee (SUCLC) (please see our response to question 14 below) have had direct experience of such services. We have taken the opportunity offered by this consultation to highlight how developing and/or strengthening the psychological foundation of Scotland's NHS could further improve both the mental and physical health of the population and support the staff who provide mental health services.

We have offered some specific suggestions and examples, drawing on psychological research and our clinical knowledge base. Our response has also been informed by the NHS Scotland Quality Strategy (Quality Strategy), particularly regarding its aims that there should be clear communication and explanation about conditions and treatment and effective collaboration between clinicians, patients and others (please see our responses to questions 2, 6, 11 and 16 below). We have highlighted some gaps in key challenges around psychological needs of people with physical health problems and also people diagnosed with personality disorders (please see our responses to question 26 below).

In terms of the overall structure of the Strategy, we wonder if clarity would be enhanced by having the 14 broad outcomes grouped under headings that reflected the underlying conceptual framework, e.g. Outcomes 1, 2 and 3 refer to health promotion, prevention and early intervention; 4, 5, 6, 7, and 8 are concerned with care and treatment and the remainder appear more systemic issues.

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.

Comments:

The BPS believes that improved inter-agency working, through greater collaboration and sharing of expertise between mental health services and criminal justice agencies, would be beneficial.

This is relevant to the gaps that exist in service provision for people with personality disorder who present a risk of harm to others. This population includes violent and sexually violent offenders who tend to suffer from high levels of emotional distress and cause considerable public safety concerns. Applied psychologists have skills to address these problems but are a very limited resource.

Similarly, it is relevant to the mental health needs of Scotland's prison population where forensic psychologists, employed within the Scottish Prison Service, undertake support work on emotional regulation, assessment of personality disorders and suicide prevention.

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.

Comments:

1. A fundamental issue that the BPS believes is relevant to outcomes in mental health is the continued predominance of the medical model within specialist mental health services. This is at odds with the broad acceptance that a biopsychosocial model is appropriate for understanding mental distress. There are risks of outcomes being considerably poorer than they might otherwise be if, when working to understand a person's problems and provide appropriate treatment, not enough account is taken of information from all of these domains (biological, psychological and social).

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The disparity between access to medical treatment (primarily medication) and access to psychological or social interventions is the major reason why the medical model continues to exert a disproportionately strong influence over the culture of mental health systems. As well as the risk of poorer outcomes, a medically-dominated service offers a lower quality service for patients and carers (BPS, 2011a) and risks increased stress and burnout amongst staff (please see our response to question 5 below). This in turn can negatively influence service user experience and outcomes.

There is now a body of research that indicates the importance of psychological models to understanding and responding to mental health problems. For example, we now understand (from the findings of psychological science and research) the significance of poor childhood attachment in the subsequent development of complex mental health problems (e.g. Bentall, 2009). A mental health service which accorded appropriate weight to psychological models would ensure that primacy was given to the development of relationships between one or two key staff and the service user, and that there was some continuity within this if patients moved – for example, between in-patient, day patient and outpatient settings. This focus on the importance of the relationships within services should be made very explicit, and provide a strong framework (based upon psychological theory and evidence) within which other treatments, including specialist psychological therapy and medical if required, could be offered. The maintenance of the staff-patient relationships would, in themselves, be highly therapeutic for many patients in mental health services.

A key change that we consider would improve outcomes in mental health services would be for services to adopt a more individualised assessment process that incorporates - and crucially integrates - bio, psycho and social factors. This can provide a service user and/or his or her family/carers with a means to make sense of what is going on. Supplying this understanding (and the hope that can follow from it) is something that service users report is often lacking in mental health services but is highly valued by those who have experience of psychological services (BPS, 2011a). As well as offering hope this process also allows a service user and/or family and carers to understand how they can influence and improve the current situation (e.g. by learning to change their behaviour or by addressing major stresses). This can assist with the maintenance of improvement following discharge. Applied psychologists all employ this approach to assessment (psychological formulation) with their individual patients and also with Multidisciplinary Teams (BPS, 2011c). The latter is effective in assisting non-psychologists to formulate mental health problems in a way that integrates a range of factors and provides understanding and a plan of treatment. Various psychological models such as systemic narrative approaches (e.g. Dallos & Vettere, 2009) can assist with this, both to facilitate learning and support a culture shift. However, a change in culture (from biomedical to genuinely biopsychosocial) is likely to require an assessment of and possible change in the use of resources.

2. This question refers specifically to patients with developmental disorders and those suffering the effects of trauma. These are two patient groups where, because of the nature of their primary difficulties, the development of services grounded in psychological models is fundamental to achieving the best possible outcomes. Similarly important is the provision of evidence-based psychological interventions that can be tailored to an individual in ways that are original and effective (e.g. Tarrier, 2006).

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3. In relation to further work at a national level to consider the delivery of better outcomes, we urge that good use is made of the skills and expertise of applied psychologists in the general area of outcome assessment. Making strategic use of the expertise of applied psychologists is in keeping with the vision for how psychologists can help the NHS in Scotland achieve its objectives, set out in the report *Applied Psychologists and Psychology in the NHS* (Scottish Government, 2010).

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?

Comments:

1. The BPS recently produced a comprehensive document outlining key psychological measures relevant to the prevention of suicide (BPS, 2011b). It includes detailed information on psychological factors relevant to reducing suicide risk in specific high risk groups such as: psychiatric inpatients; clients with mental health and substance misuse concerns; people with acute, long term and terminal illnesses; and people who self-harm.

   A major focus, considered crucial to reducing rates of suicide, is the relative neglect of the male gender as a high risk group in suicide and mental health research and practice, as well as the urgent need for male-specific psychological interventions. All of these areas are relevant to Scottish efforts to reduce self-harm and suicide rates and we would urge consideration of the document as part of this consultation.

2. A specific consideration that relates to clinical health psychology services in Scotland is the evidence that the risk of suicide in women who do not have psychological screening prior to breast augmentation is threefold that of the general population (Lipworth *et al*, 2007). This is thought to be associated with unrealistic expectations of surgery and undetected psychological morbidity. Ensuring that psychological assessment is a routine component of screening prior to cosmetic surgery in all services across Scotland would go a large way to addressing this.

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

Comments:

The BPS considers that further work to reduce stigma should occur through both community interventions and addressing issues in mental health services. In particular:

1. At a community level, greater dissemination of information amongst the public (via different forms of media) and also education within schools about the psychological factors that impact on people's mental health would help to reduce ignorance and combat stigma (e.g. Pinfold and Thornicroft, 2006; Pinfold *et al*, 2003). Sayce (2003) identified factors relevant to the effectiveness of interventions to challenge stigma, e.g. that different groups may require specifically targeted interventions, and the importance of challenging power relations underlying discrimination.

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2. There is evidence from psychological research that approaches to combat stigma within the general public are more likely to be successful in achieving desired outcomes by setting information within a psychosocial framework rather than a biomedical one (Read *et al.*, 2006; Lam *et al*, 2005; Angermeyer and Matschinger, 2005). Being clear in differentiating rare mental health conditions (such as psychoses), from common mental health problems (such as anxiety), is also important.

3. Within mental health services, stigma can originate from people's experience of having their difficulties conceptualised by use of rigid diagnostic frameworks (e.g. the effects of complex trauma being diagnosed as a personality disorder) that many find unacceptable (Johnstone 2010). Stigma can be reduced by mental health services being open to and working from explanatory frameworks that allow for a broader psychosocial understanding of mental health difficulties (e.g. bipolar affective disorder, BPS 2010; please also see our response to question 2 above).

4. Social integration and having valued roles are key outcomes of recovery (Shepherd *et al*, 2008). Loss of perceived social status through self-categorisation as a devalued 'patient' can be key to self-stigmatising beliefs and the development of further difficulties, such as social anxiety and withdrawal (e.g. Birchwood *et al*, 2006). Services can militate against this by ensuring that firstly, people are given an understanding of their difficulties that helps them to make sense of them in non-stigmatising ways and secondly offering interventions that assist people in recovery of their identity and valued roles. Applied psychologists in the NHS are highly skilled in both of these areas and are able to work with the individuals themselves as well as train and support other staff within mental health services (Scottish Government, 2010).

Although routine amongst psychology services, the adoption of alternatives to rigid diagnostic frameworks and a focus upon empowering people through helping them understand their problems will require a cultural shift in many NHS mental health services and Boards may require National support and direction in this area.

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?

Comments:

The BPS is aware, through its SUCLC (please see our response to question 14 below), of the extent to which service users can still experience discrimination within mental health services. Members of the SUCLC have made recommendations relating to improving the experience of services users in mental health settings (BPS, 2011a). These include:

- The active empowerment of service users by providing them with knowledge of relevant legislation and information about their rights when receiving mental health care. The emphasis here is on active empowerment, i.e. providing active support to help service users and carers to use the information provided and support them in interpreting the implication of such information to ensure that they can use it.
- Addressing unhelpful attitudes (e.g. SUCLC members have reported an attitude that can often prevail is one of viewing service users as irrational and/or abnormal). Addressing such attitudes, rather than prescribing behaviour change amongst staff, can help professionals to act in "as empathic, respectful and caring way as they do in other relationships" (BPS, 2011a).

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The facilitation of such changes needs to consider the models underlying mental health service provision (please see response to questions 2 and16).

In addition, consideration should be given to the complex psychological factors that can affect staff attitudes and behaviour. For example, the common phenomenon of distancing by professionals from service users, which can occur as a form of self-protection from emotional distress. This understandable phenomenon (see for example, Hare *et al*, 2007 in relation to psychiatric nurses in in-patient settings) has a potentially significant impact on the extent to which staff and service users are able to work together to develop mutually satisfactory changes and the extent to which behaviour change can be maintained.

There are currently good examples of applied psychologists applying systemic psychological interventions, e.g. facilitating reflective practice with staff on in-patient psychiatric wards (Davison, 2011) and enhancing psychological skills amongst Nurse Therapists in acute hospital settings (Cochrane, 2011), which can help staff cope better with the exposure to emotional distress inherent in their job. Although more systematic evaluation of such approaches would be required, anecdotal evidence suggests that they militate against both emotional distancing and staff burnout and lead to improved patient care.

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

Comments:

1. People have universal psychological needs as well as physical and social needs that are crucial for their health and wellbeing. However, there is as yet no public health psychology model to match that of public health medicine. There is now a large body of research (e.g. Wilson and Pickett, 2009; Friedili, 2009) that illustrates the huge role that psychological factors play in why mental health is so adversely affected by social inequalities and exclusion. The BPS believes that this evidence provides a sound rationale for the development of a public health psychological approach to work alongside public health medicine.

   Similarly, given that there is a wealth of high quality psychological research that has increased our understanding of what influences behaviour, we are in a good position to integrate these behavioural insights into public health to promote well-being. There are many good examples that demonstrate how public health interventions are more effective when behavioural research is used appropriately. For instance, relating to smoking cessation, the evidence shows how combining behavioural and pharmacological support gives smokers a greater impetus to quit.

   Research in the field of social psychology indicates that using social norms can be an important way to influence behaviour. This understanding could be used with approaches to reduce excessive alcohol use and to increase understanding of actual levels of alcohol intake, e.g. some studies have indicated that people overestimate how much others drink and this leads to greater personal use. This understanding is being incorporated into the *'Drinkaware Campaign'* (Drinkaware Campaign).

   The BPS believes that a central plank of a public health psychological approach should be the recognition of the importance, for our national health and mental wellbeing, of the quality of emotional attachments between developing children and the adults in their families and communities (e.g. Gerhardt, 2010; BPS, 2007a).

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Such psychological research, combined with clinical knowledge, suggests that key areas in which a public health psychological approach would be highly beneficial are:

- targeting work to improve childhood attachment in communities where there are higher levels of suicide, drug/alcohol misuse and antisocial behaviour;
- work to effect behaviour change related to lifestyle choices that affect health and well-being; and
- the application of community psychology to improve mental health and well-being (Orford, 2008).

2. There are already many good examples of psychology-led services overseeing and undertaking work relevant to the wider promotion of mental well-being and the prevention of mental ill-health, for example:

   - Steps (Greater Glasgow & Clyde NHS Steps Programme) is one example of a service that is well known to the Scottish Government for its population-focused approach to tackling mental distress in an area of high social deprivation. Aspects of the Steps programme (e.g. Stress control classes being offered to large groups in non-NHS venues) are now a routine part of NHS psychology services in other parts of Scotland.

   - Youthspace (Youthspace) is a preventative public health service addressing the mental health of young people in Birmingham (Birchwood, 2011). The service has a high degree of user involvement and, based on their feedback, is grounded in psychological approaches. It has been very successful in engaging young people including those from its target areas of high social deprivation. Addressing youth mental health is vital given that there is ample evidence (Birchwood, 2011) that the majority of life-long recurring mental health problems begin in adolescence.

   - Another highly successful, award-winning service focused on improving social inclusion was developed by a Consultant Clinical Psychologist in Bromley (Developing Valued Lifestyles Partnership). The service involves a range of statutory, voluntary sector and other organisations working together across eight life domains to promote and maintain social inclusion. It is very relevant to the Scottish Government's commissioned report *Developing Social Prescribing and Community Referrals for Mental Health in Scotland* (Scottish Development Centre for Mental Health, 2007) referred to in the Consultation.

   - In Dumfries and Galloway, the NHS psychology service has extended its work beyond standard mental health structures into public health and the voluntary sector (DCP-Scotland, 2010). NHS staff work with the voluntary sector staff, offering training in the use of evidence-based cognitive-behavioural therapy (CBT) resources and advising on wider psychological issues such as risk management.

The BPS would welcome Scottish Government support for further research around the development and evaluation of services that focus upon the mental well-being of communities with high levels of social deprivation and/or populations that are hard to engage in traditional services (e.g. men from socially deprived areas).

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3. A key feature of the promotion of mental wellbeing is the supply of high quality but also easily accessible information and there are many good examples of services ensuring their local populations have access to high quality psychological information (DCP-Scotland, 2010).

   Older people are one group where the demographics of the population mean that there will be a growing need for high quality information that is easy to locate. There are three factors in the older adult population that can limit ability to access information. These are:

   - high rates of physical health problems that can limit an individual's ability to access information (i.e. through impaired mobility),
   - high rates of cognitive impairment and/or mental health problems; and
   - low rates of computer literacy, compared to younger adults.

   A regularly updated website which provides information on, and links to, services within the local area would be an invaluable resource both for professionals and for those patients who are computer-literate and their carers. National support for local initiatives (such as websites detailing local voluntary groups and/or services) would be one useful area for action.

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?

Comments:

1. The Psychology of Parenting project (Psychology of Parenting Project) is a welcome initiative to ensure that the best parenting programmes are delivered to families across Scotland. It is now well established that the two main programmes, Triple P (Triple P), and Webster-Stratton Incredible Years (Incredible Years), have sufficient good quality research evidence to demonstrate their efficacy across a range of ages and stages as well as family circumstances. Over many years there have been numerous training opportunities to ensure that Scotland has a workforce of applied psychologists (amongst others) well trained to both deliver and support others in the delivery of these programmes. We would therefore advocate that they be rolled out more widely across Scotland with immediate effect.

   Support from non-health partners would be required to help vulnerable families attend these programmes. For example, the provision of community based venues, transport, and childcare for the index child and siblings.

   The BPS is encouraged that plans are already being developed to roll out parenting programmes for parents and carers of 3-4 year olds with disruptive behaviour disorders and suggest that it may be helpful to consider whether a wider roll out of such programmes would be of benefit in terms of a broader preventative approach. For older children, such programmes may be reasonably delivered on a primary school basis with out-of-hours option for working parents. A partnership approach between the NHS, social work and education would be required for such programmes to be successful. The issue of resource allocation in social work and education, for the support of such early intervention skills building and problem prevention programmes, is one that may benefit from being addressed at a national level.

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2. Early intervention is critical to preventing the development of mental health problems in children where possible. The delivery of parent training programmes (see above) has the potential to immediately improve access to specialist Child and Adolescent Mental Health Services (CAMHS) through the early identification of pre-school and primary school age children and their families who are in difficulty. This is relevant to the Scottish Government's Health, Efficiency, Access and Treatment (HEAT) target on access to CAMHS.

3. The BPS welcomes the Government's recent support for research and service development relevant to infant mental health. This is an area vital to improving the overall mental health of society. As already highlighted (please see our response to question 6) a secure and healthy initial attachment to a caregiver in infancy is highly relevant to subsequent mental health. We believe that the implications of theories of attachment for psychological health should be a key element of the training of primary care staff, health visitors, midwives and paediatricians amongst other professional groups.

   Likewise, services need to target those adults identified in the antenatal or postnatal period as being vulnerable to psychological problems, so that they can be offered support to create as healthy an initial attachment with their infants as possible. This is relevant to the mental health of the caregivers themselves (e.g. prevention of postnatal despair and suicide) but also facilitates the creation of a psychologically healthier foundation for the child. As such it is a vital area for both child and adult mental health services to undertake as joint work as well as each addressing the issue within their current services.

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

Comments:

The BPS welcomes the recognition that timely access to specialist CAMHS is needed to support good outcomes for children, adolescents and their families. However, a focus on access measured in a HEAT target time frame format alone may be limiting the possible scope of the 'increasing access' agenda.

Structures are needed to ensure that joint working arrangements with education and social work services are maintained even through times of significant financial constraints. Investment in the CAMHS workforce is to be commended, however education and social work provision to CAMHS teams is dependent on local authority finances. The result is that links between health professionals within CAMHS and education and social work partners have eroded completely in some areas and are generally less likely to be embedded within the team structure. Education and social work colleagues could contribute directly towards good outcomes for children and adolescents and their families if given the opportunity to do so, and their lack of involvement is particularly unfortunate given the evidence of the benefits of mental health promotion work in schools (e.g. Woolfson *et al*, 2009; Naylor *et al*, 2009; Neil & Christensen, 2009).

Further consideration of the relative benefits of providing specialist CAMHS services or greater specialisation within general CAMHS might be of benefit.

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?

Comments:

1. The BPS believes it would be helpful to differentiate the needs of different populations when considering this question. For example, the needs of the very small number of people who have a history of serious psychosis or chronic serious depression and who require psychiatric services will be different in some respects from those of the population at large. Many people in the general population will experience some form of mental distress but the nature of this means that a psychiatric model of understanding is not the most helpful.

   We recommend that further action should be focused on increasing people's sense that they may be able to effect positive change in their mental health, for example the Scottish Government's *Steps for Stress* programme (Steps for Stress). A key aspect of this is helping people to understand that their mental health is affected by experiences (past and present) and their reactions are understandable in terms of normal psychological and developmental processes as opposed to being an indication of a "mental illness". Having this understanding can reduce fear and stigma, both of which impede people's ability to address mental health issues.

2. If people understand that their mental health is very often affected by things that they may be able to do something about (e.g. aspects of their own behaviour or the psychological impact of experiences such as bullying, loss or trauma), then this can:
   - increase a sense of self-efficacy;
   - make self-help seem more relevant; and
   - make it easier to educate people not to immediately turn to their GPs for medication (or indeed to request psychological therapy).

   The skills and knowledge of health psychologists, e.g. around techniques of behaviour change, are relevant to this work.

3. Specific information and action should also be targeted towards groups who may struggle for various reasons to make good use of it (e.g. older people and men) and there should be a particular focus on children given the extent to which mental health problems develop in adolescence. Programmes to build resilience (some of which are currently taking place in Scottish schools) are a good example of this.

4. National support that accords the same degree of importance to mental health prevention work within mental health and psychological services, as it does towards direct clinical treatment, would facilitate the development of materials, partnerships and services relevant to the above.

5. Action to support the evaluation of services and approaches is vital if factors affecting the efficacy and efficiency of preventative mental health approaches are to be better understood.

6. Greater support for the development of independent advocacy services (e.g. by widening criteria that defines those who can access free services) could facilitate people being able to improve or maintain their mental health.

7. The provision of adequate respite facilities to support carers in being better able to take care of their own mental health.

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

Comments:

1. Giving people as wide a range of options with regard to the type of available help. These need to include alternatives to the traditional model of assessment-treatment-discharge. The Glasgow Steps service (please see our response to question 6) offers such a community-based approach. It is particularly applicable to areas of high social deprivation where people may have more limited educational qualifications and require "crisis interventions/support" in the context of managing demands which are regularly having a negative impact on their mental health.

2. Increasing choice of treatments both for people accessing Primary Care and also those already within secondary mental health services. The waiting times for psychological therapies can act as a barrier to people seeking help, especially in situations where people do not wish to take medication. It is essential therefore to increase access to a range of psychological therapies that are appropriate to the complexity of presenting need, and for these to be offered within structures that facilitate appropriate governance and ensure that quality is maintained. The expertise of applied psychologists to offer training and clinical supervision to support other staff groups and ensure high standards of governance and quality has been recognised (Scottish Government, 2010).

3. Increase the capacity of all GPs and primary care staff to respond sensitively and knowledgably to people presenting with mental health issues. There are good examples of applied psychologists and other mental health staff working alongside Primary Care Teams in services in Scotland (DCP-Scotland, 2010).

4. Ensure that seeking help for a mental health problem will not result in an individual being unfairly penalised by other agencies such as insurance companies.

5. Ensure that both generic and specialist mental health services are maintained. The latter have focused strategies to engage specific populations (e.g. homeless people, refugees and asylum seekers, severely traumatised people, and young people with first episode psychosis) who can face both internal psychological and external practical factors which may inhibit or delay them receiving help.

6. Support for more research into the type of services that will best support the mental health of men. There is evidence that as early as 7 years of age, boys are already significantly less likely than girls to seek help from those around them (Benenson and Koulnazarian, 2008). Likewise men do not seek help as much as women (Perlick and Manning, 2007; Addis and Mahalik, 2003), even when they are shown to be experiencing equivalent levels of distress (Deane and Todd, 1996).

7. Further develop strategies to minimise the iatrogenic effects that can occur from the unintended negative experiences that people may have when receiving input from mental health services (e.g. traumatic pathways into care; medication side-effects and poly-pharmacy).

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?

Comments:

1. The term "mental illness and disorder" is most applicable to the small section of the population who experience problems such as psychosis.

   There is an established evidence base for early intervention in psychosis services (Bird *et al*, 2010). Such services aim to reduce the detrimental effects of duration of untreated psychosis (Crumlish *et al*, 2009) and tailor intervention to the critical period in the first 2 years after onset of psychosis to reduce long-term disability and hence service-costs (Reading & Birchwood, 2005; Mihalopoulos *et al*, 2009). This is contingent upon dedicated services adhering to this model (Fowler *et al*, 2009). A service-model developed in Greater Glasgow and Clyde (ESTEEM) could provide an early intervention template to draw-upon.

2. Considering the question in relation to the mental health needs of the wider population, the BPS believes there needs to be good systems of communication and understanding between services working within different tiers (e.g. non-statutory/community; Primary Care; Secondary care etc.).

3. There are specific issues relating to quicker access to psychological treatment in relation to older people:

   - Older adults are severely disadvantaged in terms of access to psychological therapies. The most recent workforce data (ISD Scotland, September 2011), showed that both the Scottish child population and the Scottish working age adult population had 17.5 applied psychologists per 100,000. However, for the Scottish over 65s there are just 4.0 applied psychologists per 100,000. We welcome the recent alignment to older adult services in some clinical psychology training places, the aim of which is to create interest and expertise in older adult psychology amongst this cohort of clinical psychology trainees. We hope that the Scottish Government will continue to support this initiative but that it will also examine other ways in which the disparity in staffing levels can be addressed, particularly given the demographic changes that will occur over the next two decades.

   - In many areas, adults in in-patient settings often do not have access to a psychologist at all. In some areas, however, adults under the age of 65 have access to in-patient psychology services whereas adults over the age of 65 do not. There is often a lack of psychiatric nursing staff trained in high intensity psychological interventions. Therefore high intensity therapies usually cannot be accessed until discharge.

   - We recommend that GPs and other primary health care practitioners receive appropriate education in identification of both cognitive impairment and emotional disturbance in older adults.

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- We recommend that that GPs are made aware of the evidence base of psychological therapies for older adults, so that they refer on to appropriate services. There is some evidence (Robson & Higgon, 2010) that GPs are reluctant to refer older adults for psychological therapy, despite the research evidence that attests to the effectiveness of psychological therapy across the age range.

- We believe that primary care services should become more proactive by inviting patients to attend for regular mental and physical health screening checks. Secondary care referrals should then be triggered by the outcome of primary care screening assessments. The present system is overly reliant on the patient presenting to primary care. This is a particular problem with dementia, where there may be a lack of insight on the part of the patient as to their impairment.

4. Poor psychological health can be a significant factor delaying the recovery of people with physical health problems (Hacking, 2011). Adequate assessment of the psychological health of patients within acute medical settings is important when considering the healthcare costs associated with, for example, delayed discharge. This can be a particular issue with older people.

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?

Comments:

Due to the scientific basis of their training, applied psychologists have the skills and expertise required to research and evaluate practice, and consider issues related to the evidence-base for treatment. They are therefore a resource which NHS Boards can draw upon to ensure that time is being spent most efficiently and effectively (Scottish Government, 2010). Provision of national guidance and case illustrations related to this may be helpful.

In addition, it is important to ensure that the voices of relevant service users and carers are considered when decisions are made around investment in evidence-based treatments.

One specific aspect of improving efficiency and effectiveness is to consider the 'health' of the system (e.g. teams; workforce). This will impact on service-improvement, delivery, productivity and efficiency. Promoting the adoption of practices that enhance the functioning of teams delivering mental health services can address some of the factors that may be hindering the functioning of the system (BPS, 2007b).

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

Comments:

At local level, we recommend the identification of bottlenecks in Integrated Care Pathways, and the tackling of associated resource issues. This may have implications for national funding of 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?

Comments:

There are some key differences between the people using the services within each tier of a mental health service. For example, people who engage with primary care-based mental health services may well see only one mental health professional for a relatively short period of discrete care, whereas those engaged with secondary care psychiatric services are more likely to see a number of mental health professionals for what can be very long periods of care. It is more likely that those in the former group (while being a large number in population terms) will have less personal investment in the nature of mental health services compared to some people in the latter group, but the experience and views of the latter may not reflect those of the former. Different forms of involvement and methods of consultation may therefore be required in order to ensure that the opinions of a range of service users are heard.

The BPS believes that the role of service users and carers in the design and delivery of services needs to be carefully considered. Service users and health professionals have different but complementary areas of expertise, and meaningful engagement can be of significant mutual benefit. However, there are a number of issues, such as how to ensure engagement is meaningful and sustainable, that need to be considered.

The BPS has a formal Service User and Carer Liaison Committee (SUCLC) within its Division of Clinical Psychology, and its members play a very active role within the Division, sitting as full members on a range of committees (including the Executive of the Division of Clinical Psychology in Scotland) and contributing to policy documents. In order to ensure that SUCLC members were able to play a meaningful role in BPS business (and so reduce the likelihood of tokenism) the decision was taken to recruit via adverts in specific national newspapers and using a formal interview process. Similarly, in order to address issues of equity and facilitate active involvement, all SUCLC members are paid a daily rate as well as expenses. Our experience is that this has been a very successful model resulting in meaningful engagement between professionals and service users/carers. We suggest consideration is given to how similar approaches could be applied within the NHS.

Meaningful engagement can also be supported by means of a formal buddy system with specific staff supporting specific service users and carers. There also needs to be an understanding (where applicable) that service users and carers are full members of any committee and that this brings with it certain responsibilities for both sides. The Chairs and admin staff for the relevant committee and working groups may need guidance or support to facilitate active engagement.

Clearly there may be some service users and carers who either do not wish to, or are unable to engage with services over a period of time, but whose views and experiences are potentially very important for a service to hear. The expertise of the users/carers who are able to participate more fully could be drawn upon to learn how best to involve such individuals and learn from their experiences.

We suggest that the Scottish Government's *Better Together* (Better Together) programme could adopt a specific focus upon mental health services.

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

Comments:

Independent advocacy can ensure that service users, carers and families have access to relevant information. This is of particular benefit to people who are actively unwell and/or without access to the internet.

Ensuring that there is clarity about confidentiality, the limits of confidentiality and the right of the family member or carer to be aware of some aspects of the patient's treatment/condition is vital. Where possible, we recommend that staff obtain a clear indication from the patient as to what information is permissible to share with their carer/family.

The BPS believes that consideration should be given to the careful and appropriate sharing of some information with non-NHS organisations (e.g. social services and the voluntary sector). For example, advice given to an in-patient medical ward team on the management of a patient's challenging behaviour might later be very useful for an Alzheimer Scotland day-care centre, but at present this level of information sharing is not permitted. There are ethical questions that need to be considered regarding the kind of information that is shared, and the purpose of sharing that information. However, the current situation is that the voluntary sector is moving into areas of care traditionally provided by the NHS, but without the benefit of relevant clinical information that is available to NHS staff. This makes it more difficult to provide 'seamless services'.

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?

Comments:

The approach to care adopted by applied psychologists is congruent with the tenets of the recovery model, person-centred and values-based approaches. As such, psychology services in the NHS have these outcomes as core aspects of their service provision. However, many mental health services continue to adopt a primarily medical model (with the main treatment being medication) where professionals may be less likely to adopt a collaborative approach. This can make the embedding of person-centred and values-based approaches more of a challenge.

In order for person centred and values-based approaches to become more routinely embedded in mental health services, we believe there needs to be a greater culture shift within such services. This could be facilitated by the development of a more relational model of care within inpatient mental health services, one which accords equal weight to psychological as well as physical safety (Seager, 2008). Psychological safety is related to issues of attachment, relationships and engagement. Problems with attachment can develop as the result of childhood abuse or neglect and these are very significant for many people with severe and/or complex mental health problems (Gerhardt, 2004).

An in-patient service based on a relational model of care would facilitate the establishment of therapeutic attachments between patients and staff. It would also respect the need for continuity of attachment throughout the care pathway (which is different from continuity of care) (BPS, 2011b). Due in part to the priorities and underpinnings of a medical model, staff on psychiatric wards often have no time or support to adopt a more relational approach to care. This could be addressed by setting standards for psychological communication and relationships within services. For example, one standard is that vulnerable people need continuity of relationship and a secure attachment with at least one person within the health care system (Seager, 2008).

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

Comments:

The BPS has no comment to make to this question.

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

Comments:

The BPS has no comment to make to this question.

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?

Comments:

The BPS believes that asking this question of an individual (and/or his/her family/carers as appropriate) should be a routine part of the assessment process. Involvement can be facilitated by services providing, or sign-posting to, information relevant to an individual's condition.

Family/carer involvement is especially relevant in complex mental health difficulties such as psychosis. In this context, carer/family needs should be considered from point of entry to mental health services, to demystify mental health issues and the system of services, and foster alliance building.. Liaison with families/carers on a recurring basis should be routine and not the exception, including access to psychological assessment of adjustment to a 'caring' role. Services should aspire to develop a hierarchy of levels of support and interventions for family members/carers, ranging from provision of information to formal family interventions, such as behavioural family therapy (BFT) (Pearson *et al*, 2007; Lobban & Barrowclough, 2009).

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?

Comments:

1. Confidentiality issues. In adult mental health services, some circumstances (e.g. involuntary admission) and the person's current psychological state and preferences (e.g. declining that anyone contacts their family) can lead to dilemmas for staff in the provision of basic information and education for families. All staff require clear guidance on managing issues of confidentiality and how to negotiate information sharing dilemmas to maintain working alliances with both service users and carers/families. An example of training resources is provided by RETHINK (RETHINK Interactive Course). Clear operational policies and guidelines for staff to follow will prevent family/carers being unnecessarily excluded from provision of education and information about mental health.

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2. Staff require training in providing evidence-based family interventions that reduce family/carer stress and enhance their role in supporting a relative with mental health problems. This is especially relevant in mental health problems towards the more severe end of the spectrum, including bipolar affective disorder and psychosis. There are evidence-based family interventions (Pilling *et al*, 2002). To date, in Scotland at least 462 staff (predominantly working in adult mental health in the NHS) have been trained to deliver behavioural family therapy and there are at least 41 staff who have been trained to deliver BFT training to staff groups (Meriden Family Programme). Nevertheless, there are often barriers to implementation of this evidence-based therapy in clinical practice. This highlights the importance of systematic organisational support for the training, supervision and delivery of formal family interventions (Fadden, 2009). Inclusion of a recommendation that staff training in family interventions is to be supported within NHS health boards would assist in supporting implementation of family interventions in clinical practice.

3. Involving users/carers in staff training (pre and post qualification) has the potential to increase staff understanding of how better to engage families/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?

Comments:

We suggest that the Mental Welfare Commission for Scotland looks at specific areas and produce a report on areas of good practice.

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:

The governance structure of NHS Boards is relevant to both regular audit and reporting on this topic.

The BPS agrees with Boddington (2011), Broomfield & Birch (2009), and Robson & Higgon (2010) that regular audits regarding uptake of services by various age groups should be undertaken and the results disseminated. Variation in uptake of services between age groups is a major issue for older adult services. It is clear that older adults tend not to be referred in the same numbers as younger adults for psychological therapy, despite there being high levels of psychological need amongst the older adult population.

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This population is growing, older adults are frequent users of the NHS, often experience complex co-morbidities, often are carers for others, and are also at high risk of suicide. Despite this, there is a perception within Community Mental Health Teams that older adult psychology services exist to aid in the identification of cognitive impairment, and not in the context of their emotional problems, suggesting that there may be a gap in care

Please also see also our response to question 11 above, regarding staffing disparities between older adult psychology services and psychology services for other age groups.

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

Comments:

While dissemination of learning (e.g. via published guidance, conferences, websites) is important, giving people information alone is unlikely to be enough. Instead, we feel that a more comprehensive approach that takes into account, for instance barriers to change at a local level, will be required to effect changes necessary to make services more accessible to older people, older teenagers/young adults and other target groups.

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

Comments:

1. Services for people under the age of 65 who have early-onset dementia are very patchy. Diagnosis could be conducted by existing memory clinics but there would be associated resource implications. Post-diagnostic support for this group is more difficult to achieve within existing models of services because the needs of this group differ in some respects from the needs of the more typical dementia population, which tends to be older.

2. Services for people diagnosed with personality disorder (please see our response to question 26, below).

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?

Comments:

The BPS believes it is important to ensure that NHS Boards are making best use of the skills and expertise of their applied psychologists (as per the report *Applied Psychologists and Psychology in the NHS*, Scottish Government, 2010).

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Applied psychologists have an extensive knowledge of psychological processes and responses relevant to improving patient care. As well as using this as a basis for their collaborative, person-centred approach to clinical work, they have the skills and knowledge to apply this understanding to organisational structures, teams and services.

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?

Comments:

The BPS suggests three key areas for further work, over and above the further development of services related to tackling the impact of social deprivation outlined in our response to question 6, above.

1. Work to promote physical and psychological wellbeing for those with medical conditions.

   Psychological distress is a key driver in increasing healthcare costs in those with physical health problems and there is a growing body of evidence that highlights the health-economics benefits of addressing psychological issues in people with physical health problems. Activities undertaken by applied psychologists working in the area of physical healthcare (including specialist assessment and interventions with individuals, families and groups; supervision of and joint clinical work with other professionals; clinical consultation; training; strategic work to e.g. enhance quality; and also research) has been shown to improve health outcomes and reduce costs (Hacking, 2011).

2. Work to develop a psychological assessment and intervention strategy for patients with medically unexplained symptoms.

   We believe there is the potential to improve patient care and services and to reduce healthcare costs by considering the area of medically unexplained symptoms. In working age adults, patients with such symptoms (also known as somatoform disorders) have been estimated to account for 22% of all primary care consultations, 7% of all prescriptions, 25% of outpatient care, 8% of bed days and 5% of A&E attendances (Knapp *et al*, 2011). Psychological therapies and approaches are known to be effective in addressing medically unexplained symptoms (Knapp *et al*, 2011) but are under-utilised and largely unavailable across Scotland.

3. Work with people who suffer from personality disorders to reduce the risks that they may present to themselves and others.

   Expertise is available in the NHS and other agencies employing applied psychologists that could help the criminal justice system to manage offenders in the community more effectively and prevent re-offending. For example, people with personality disorder tend not to respond well to traditional treatments for offending behavior and need treatments to be geared more specifically to their needs. NHS staff in forensic mental health services, particularly applied psychologists, can do this through assessments, and then provide the courts, criminal justice staff or police with advice and consultation. We therefore suggest a broad outcome in the area of improved inter-agency working for people diagnosed with personality disorders who are at risk of offending.

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?

Comments:

The BPS has no comment to make to this question.

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:

1. In order to identify the workforce's capacity to deliver interventions in respect of complex adult mental health difficulties (e.g. psychosis), it would be helpful to undertake a survey of both staff training, and the implementation of family interventions.

2. A survey of the long-term impact of the delivery of training in psychological interventions would be useful. There is a perception that, because training is not followed up with appropriate on-going supervision, practitioners may tend to drift back to 'practice as usual' following training events. The BPS recommends that the requirement for supervision is factored in, prior to any training being agreed. In some areas, there is a feeling that many people go on training, are not supported afterwards, and so the training resource/opportunity has been wasted: both in terms of the actual cost, and in terms of subsequent utilisation of the trained professional's latent skills.

3. Related to this, surveys of clinician confidence in the delivery of psychological therapies may be useful. Local audit within a Community Mental Health Team (CMHT) for older adults in Glasgow has highlighted that clinician confidence is separate from skills/knowledge. This has implications for training and supervision. Staff may attend training events that equip them with knowledge and a level of skill, but they may lack the necessary confidence to integrate training into their day-to-day practice. Increasing staff confidence in managing psychological aspects of their work can however be a lasting outcome from training if the course is designed to facilitate this (e.g. *The Developing Practice Course*, Cochrane, 2011).

4. A survey of the training routes for applied psychologists with a view to being able to meet demand within the NHS.

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

Comments:

1. Older adult psychology: The profound disparity in staffing levels between older adult psychology services and psychology services for other age groups could be seen as a form of embedded ageism and severely curtails the ability of psychologists to provide services to this age group.

   The BPS believes that the Scottish Government, through NHS Education for Scotland (NES), should continue to support the cohort of mental health professionals working with older adults who have been trained in Interpersonal Psychotherapy (IPT), to enable them to reach supervisor status and thus be in a position to extend the availability of this therapy to older adults. This would require funding for supervision and support from management to dedicate the time required to this.

2. Clinical psychologists in acute in-patient settings: A shift in the culture of mental health services to a genuinely biopsychosocial model, which has implications for improving outcomes and reducing stigma and discrimination (please see our response to questions 2 and 4, above), requires a greater psychological presence in acute mental health settings. Work is required to ensure that the necessary skill mix of professionals is available within all acute mental health services in Scotland. This would involve on-going consideration of resource allocation, service redesign and workforce training issues.

3. Development of a range of applied psychology training routes: there is the potential to increase access to psychological therapies and interventions through the support for training routes of a range of psychological specialisms such as forensic, counselling, health, and sport and exercise psychology.

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

Comments:

Applied psychologists have considerable skill and expertise in developing and delivering training programmes (Scottish Government, 2010), of doing so in a manner that is sustainable within services (e.g. offering regular "bite-sized" chunks of training that staff can integrate into their working week), and which address issues related to staff confidence (please see our response to question 28, above). They also have skills in providing consultation and clinical supervision around psychological therapies and in other activities related to clinical governance in this area.

However, the priority given to direct clinical work, particularly in services for working age adults, means that applied psychologists are often constrained by their own workloads. It is also the case that the relevance of such training is not always appreciated by other professionals and there needs to be time for appropriate discussion with relevant stakeholders, especially managers of potential course participants, so that the purpose and target outcomes of training are agreed and explicit. This work is necessary if services are going to be able to further embed and consolidate the tiered model for the delivery of psychological interventions.

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We believe that the development of training and its sustainable delivery by NHS Board's applied psychologists should be accorded the same degree of importance as direct clinical work with patients. Appropriate outcome measures and methods of recording such work are required.

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.

Comments:

The BPS has no comment to make to this question.

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

Comments:

Ensuring that measures used are appropriate to capture outcomes relevant to the clinical work. For example, decisions have been taken to use the Clinical Outcomes in Routine Evaluation (CORE) as an outcome measure within psychological services. CORE is a well evidenced outcome measure for use in one-to-one mental health services, and was designed with this in mind. It has a place in older adult psychological therapy services, but it does not capture some of the information relevant to this client group; for example, results from neuropsychological assessment and the impact of consultation and indirect working.

There is a lack of clarity about which outcome measures are subject to copyright restrictions and which are free to use. Funding should be made available for those measures for which a charge is payable. It may be appropriate to consider instituting a HEAT target regarding use of outcome measures.

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?

Comments:

The report *Applied Psychologists and Psychology in the NHS* (Scottish Government, 2010) details ways in which Scotland's NHS could make better use of its applied psychologists. This includes making use of psychologists' skills and expertise relevant to the section on "*Development, organisation and management of healthcare systems*". Taking a more radical look at how best to use the expertise of the psychology profession in Scotland and supporting NHS Boards in relation to the recommendations made in the report are two actions that are relevant to meeting the above challenge.

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

Comments:

We believe there is a need to:

- ensure that both national and local plans cover all tiers of service and all age ranges;
- support local services by providing access to good practice exemplars with free resources as appropriate.

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?

Comments:

Supporting staff to ensure care and treatment are delivered as required involves consideration of factors that affects staff attitudes and behaviour as well as facilitating access to relevant information and resources:

- Actively supporting reflective practise as a core part of the job (see our response to question 5, above) is one way of supporting staff and developing a culture in which service users' rights are fully understood and supported.
- Improving staff access to relevant information, e.g. via a programme of targeted CPD delivered using methods such as e-learning, and ensuring management buy-in to this.

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