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.

The British Association for Counselling and Psychotherapy (BACP) commends the Scottish Government on the development of this mental health strategy and appreciates the opportunity to comment.

The structuring of the strategy into 14 high level outcomes is plausible; however BACP would suggest that the strategy is broadened to include the wider landscape of mental health services, particularly in relation to the third sector, which forms an integral part of the delivery of non stigmatising mental health services. As it stands the strategy appears quite narrow in its scope and reads like a checklist for NHS services.

BACP has concerns about the lack of engagement with other relevant Government departments and would like to see a joined up cross Government mental health strategy. There are many areas that need to be considered in the mental health strategy which have a major impact on mental health issues, including criminal justice, communities, housing, welfare and education, which are not mentioned in the strategy. For example, the ongoing Welfare Reform points towards the tightening of incapacity benefit (ICB) eligibility; it is currently estimated that 44% of those on ICB in Scotland have a mental health issue, therefore welfare reform, which is not mentioned in the strategy will have a major impact on these people with mental health problems. Another area is education and how this strategy might fit alongside the 'Curriculum for Excellence', which emphasises the importance of the mental health of pupils.

In terms of gaps in the challenges identified, it is worth noting that those living in areas of deprivation are three times more likely to have mental health issues and 10 years less life expectancy than the national average. It is these people that we need to be considering in the development of appropriate services and this should be included in the mental health strategy. BACP would recommend that there is a counsellor in every GP practice across Scotland, with initial emphasis being on practices in areas of deprivation.

A priority is the provision of appropriate primary care mental health services; approximately 32% of GP consultations are for a mental health problem. BACP would suggest that there needs to be a refocusing of mental health funding from specialist secondary care services to the communities and primary care settings where mental health issues are usually identified/presented. Primary care practitioners, particularly GPs, don't have either the time or the expertise to manage patients' expectations and when they refer to Community Mental Health Teams (CMHTs) they are often 'bounced back' for not being serious enough. Whilst the HEAT target on accessing mental health services is admirable it will not

help the majority of those with undiagnosed mental health issues.

A further priority is incorporating all past and current policies and commitments on a range of relevant issues into high level outcomes. These include developing meaningful service user involvement; putting people at the heart of guiding service delivery (The Healthcare Quality Strategy for NHS Scotland, 2010); social models of health; community-led services and tackling health inequalities. This would help change the way the NHS delivers mental health services.

Finally and importantly, BACP would suggest that a priority is ensuring equal emphasis is given to both service-user data and practice-based outcome evidence to complement the current focus on efficacy, in deciding the nature of local mental health services.

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.

BACP would suggest auditing and evaluating existing services which contribute to meeting HEAT targets but which are not currently identified as evidence-based according to recommendations by the Scottish Intercollegiate Guidelines Network (SIGN). Counselling is a prime example, which is recommended by the National Institute for Health and Clinical Excellence (NICE). It would then be possible to monitor the effectiveness of these services and fund accordingly.

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.

The Scottish Government needs to consider how it can support the interface between third sector services, primary care and secondary care services for seamless care and signposting for service users. This could take the form of facilitating regular meetings between stakeholders of the various sectors by the relevant mental health leads in health boards and Local Health Care Co-operatives (LHCCs) to open channels of communication and improve ways of working, with a clear reporting structure to Government.

Additionally, there needs to be a consistent approach to measuring outcomes with data being collated centrally, that all sectors can adhere to. It is unclear whether the Scottish Recovery Indicator mentioned in the strategy would be sufficient to capture all service user experiences, nor CORE which is being proposed as the national tool to be adopted by all Scottish Health Boards for psychological therapy services.

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?

Young people are increasingly turning to self-harm as a coping mechanism and at worst some commit suicide; early intervention is critical in the reduction of self harm and suicide rates. BACP suggests that access to counselling in schools, colleges and universities can be an effective early intervention strategy to prevent mental health problems developing or becoming more serious, and can help to build up trust and confidence to enable young people to access more specialist services if required. Counselling can build resilience in children and young people, equipping them with skills to cope with problems as they occur in the future. Counsellors can also assist individuals in better understanding the relationship between suicidal thoughts and behaviours.

According to the World Health Organization, 'It is important for counsellors working in schools to assist with informing and educating teachers and parents about identifying students at risk for suicide. School counsellors can also train students to detect suicidal behaviour and learn how to obtain help' (Preventing Suicide, World Health Organization, 2006).

School-based counselling is a professional activity delivered by qualified practitioners in schools. Counsellors offer distressed children and young people an opportunity to talk about their difficulties with a trusted adult, within a relationship of agreed confidentiality. Current provision is patchy across the country, with some young people in certain areas and regions having much better access to school-based counselling than others. In a UK Government commissioned Children and Adolescent Mental Health Services (CAMHS) review (2009), the independent CAMHS Advisory Group noted that if young people had equal access to school counselling, then mental health conditions could be ameliorated.

National school-based counselling services have been implemented successfully in Wales and Northern Ireland and have helped, and continue to help, thousands of children and young people. Although not yet implemented, the 2005 Scottish

Government report *"The Mental Health of Children and Young People: A Framework for promotion, Prevention, and Care"* called for the provision of confidential, accessible and non-stigmatising counselling support for all.

A recent study of school counselling, which assessed the experiences and outcomes of more than 10,000 children from across the UK, indicated that school based counselling is associated with significant clinical improvement from pre to post counselling, and more than 90% of clients reported an improvement due to counselling (Cooper, 2009). 'In relation to self harm it was found that counselling is associated with substantial improvements for clients who experience self-harm. In terms of prevalence rates, around 6% (1 in 16) of young people attending school-based counselling services were recorded as presenting, being referred for, or discussing self-harm issues. This is relatively similar to the proportion of young people across the UK, as a whole, that have been estimated to self-harm (1 in 12 to 1 in 15, www.mentalhealthfoundation.com). While this latter figure is only a very rough estimate, and while young people who self-harmed may not have reported it to their counsellor or referrer, it suggests that young people with self-harm issues are not, to any great extent, being referred or drawn into school-based counselling services. Given the apparent effectiveness of humanistic counselling with this client group, this suggests that greater efforts might be made to help such young people access these services' (Cooper, 2009).

Further evidence has shown that:

- CBT appears to establish a significant reduction in repeated suicide attempts, Van der Sande et al (1997)
- Problem solving therapy shows a trend towards reduction in repetition of deliberate self harm compared with standard aftercare, Hawton et al (1999)
- Group therapy led to a significant reduction in rates of self harm, and
- Family therapy resulted in a significant reduction in suicidal ideation, Burns et al (2005).

BACP commissioned a systematic review 'Counselling and Psychotherapy for the prevention of suicide: a systematic review of the evidence' (Winter et al, 2009), which provided evidence for the effectiveness of psychological approaches with clients at risk of suicide. There was also promising initial evidence for the effectiveness of approaches, including those informed by a psychodynamic perspective (eg Bateman and Fonagy, 1999, 2001; Chiesa et al., 2004; Guthrie et al., 2001) and personal construct psychotherapy (Winter et al., 2007).

It is also well know that rates of self harm and suicide are high within the 14-25 years age group and university and college counselling services work a lot with these students. Having counselling in universities and colleges makes it likely that mental health problems will be picked up sooner both because students have a counsellor they can consult and also because counsellors in university have a role in educating academic staff to recognise mental health issues and support students with them. Counselling in colleges and universities is designed to meet the specific needs of that age group and context; 14 years of age onwards in college and 18 years of age onwards in universities and to that extent is likely to be more appropriate and more effective. Counselling in universities and colleges is provided in a timely manner which is often not true of primary and secondary mental health services in the NHS.

BACP would strongly recommend school based counselling and university and college counselling as forms of early intervention for self harm and suicide prevention and would suggest that the Scottish Government promote counselling

services and develop national standards for counselling based upon the Greater Glasgow and Clyde NHS Counselling Services.

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

BACP would suggest recognising and acting upon research that highlights that stigma extends to NHS mental health services. People, particularly in more deprived areas, choose not to access such services due to, for example, their medical approach and perceived links with Social Services. Key actions would be:

- Making a social model of health in the NHS a reality – the medical model still very heavily applies in mental health settings.
- Increase support and the development of community-based/third sector organisations and NHS partnerships with them.
- Listen to relevant, community-based research evidence. For example, work by the Pathways Team, Primary Care Mental Health Team, South (West) Glasgow in 2009/10 provides useful insights.
- Normalise the use of counselling and other psychological therapies.

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?

As above (Q4).

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

There needs to be more choice of approaches for people, as per the matrix but to include counselling. There also needs to be a review of the NHS24 Breathing Space telephone CBT programme, which the Scottish Government funds. It is important to know how effective this is in reaching those on the margins and in areas of multiple deprivation, the completion rates and costs. Additionally, through formal discussions with local patient/public forums in these deprived areas, a clear strategy needs to be developed to address the community needs that are being reported to Health Boards and LHCCs.

BACP would also suggest making self referral to Primary Care Mental Health services universal.

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?

CAMHS services need to be flexible and willing to adapt to the needs and wishes of their client groups. Young people need to have a choice in their access to services, which could be delivered in non-clinical settings. In the plethora of evidence available, young people say that they value school based counselling as a non stigmatised early intervention in a location that is familiar to them. Head teachers, school staff and parents value this approach and recent studies of school counselling, including a randomised controlled trial, demonstrate that counselling significantly reduces levels of mental distress (McArthur 2011 in print). BACP would therefore suggest the universal provision of schools counselling.

This strategy stresses the need for cheaper, preventive, early-intervention mental health services; schools counselling has proved it delivers in these areas. The presence of counsellors in schools, in raising awareness of mental health and wellbeing and normalising seeking early help, also supports other key outcomes of this strategy (3,5,6,8.9.10).

CAMHS uses a medical model and requires diagnostic criteria for referral. Integration with other existing services such as school counselling may divert significant numbers of unnecessary referrals to high intensity services.

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

School counselling in other areas of the UK provides an excellent 'bridge' between distressed young people in schools and CAMHS services. Establishing a programme of a counsellor in every secondary school can reduce pressure on stretched CAMHS services, result in more appropriate CAMHS referrals (as has happened in Wales) and thus go a long way to meeting HEAT targets. Strong relationships can be built between school counsellors and CAMHS staff which can result in more streamlined and appropriate services for young people and their families.

If school counsellors were available as early intervention services in secondary schools, then young people would access assessments within weeks rather than months. Counsellors would be able to support young people with mild and moderate mental health problems in situ, whilst ensuring an early CAMHS referral for those with more serious difficulties.

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?

In general, when people feel unwell (especially with depression), they tend to withdraw from others and due to a sense of shame are less likely to ask for help. This makes it difficult to try and improve their mental health. One possible solution might be to channel further resources into the *'see me'* campaign to help reduce the stigma associated with mental health problems thus making it more acceptable.

School based counselling and university and college counselling as forms of early intervention as mentioned already would support this, as well as working with the education sector to deliver this.

BACP would also suggest making self referral to Primary Care Mental Health services universal.

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

It is important to recognise that 'one approach does not fit all'. Thus for example CBT has a robust evidence base, but it does not necessarily work for everyone. A range of interventions need to be made available; for example, some people, particularly the elderly or house-bound, might find telephone counselling beneficial and children and young people like to engage in text or on-line counselling. There needs to be a radical review of services to reduce barriers to accessing mainstream services. In order to encourage people to seek help, services need to be accessible, non-stigmatising and confidential.

More support should also be made available in primary care settings so that when people approach their GPs there are appropriate services that are available onsite that they can be referred to, rather than being bounced back to and from the Community Mental Health Teams as currently occurs. In addition, CMHTs may be working with strict criteria for accessing their services, making many ineligible for access due to non diagnosable mental health conditions (i.e. not seriously ill enough).

BACP would also suggest that counselling provision is made available in colleges and universities to provide quicker access by virtue of being in the young person's place of education and offering counselling at times when they are available to attend and in a format that is most appropriate to this group.

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?

Using a school counselling workforce, with a standardised training in mental health

assessment, would go a long way to identifying young people with difficulties early on, thus ensuring appropriate referrals to relevant agencies and services. The process and systems of referral can become streamlined with young people accessing help, support and treatment in a timely manner with relevant interventions.

School staff are very experienced in knowing when their young pupils are having difficulties and readily refer to school counsellors. They know that school counselling services are accessible; trusted by staff, pupils and parents alike; have the ability and infra-structure to liaise with and refer to other services; and demonsrate results in behavioural and clinical terms (Evaluation of the school-based counselling strategy, Welsh Government, 2011; Cooper, 2009).

Again as suggested above, counselling provision should be made available in colleges and universities to provide quicker access by virtue of being in the young person's place of education and offering counselling at times when they are available to attend and in a format that is most appropriate to this group.

In the NHS, evidence shows that many people fall through the gap between primary and secondary care, which causes delays or prevents access to treatment. There is a need to 'blur' the boundaries by providing potential for a greater number of sessions of psychological therapy within primary care teams.

There is also a need to improve service information, particularly on-line, and encourage self-referral (by trialling its appropriateness if necessary).

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?

NHS Boards could do with support and guidance to help them work more effectively and collaboratively with the third sector so that the third sector and NHS services work in partnership and become more efficient and effective.

It is unclear what is meant by non-value adding activities. BACP guidance on hours worked in the NHS are 60% client contact, 40% other supportive activities focusing on the clients (preparing and researching between appointments, case conferences, making referrals, record keeping), the organisation (meetings, preparing reports/papers, audit and evaluation, collaborative working with other disciplines) and the therapist (supervision, peer support, CPD) (Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, BACP 2004, p.25). All these activities add value. The Greater Glasgow & Clyde trust has also produced its own guidance.

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

Support is required to ensure, as the ICPs state, that all mental health services provide a choice of psychological therapies, and that patients are given adequate information about the range of therapies available so that they can make an informed choice. 'Informed choice' is a key issue; even those services with a range of modalities may not inform or engage with those referred about what their choices are.

Beyond CBT, a number of Community Health Partnerships are providing a choice of therapies, for example, person centred (which has a long and well established record of effective and efficient outcomes within NHS and other settings) and psychodynamic therapy. NHS Lanarkshire has recently appointed a large number of person centred counsellors on permanent contracts within their psychological services teams. The patient rights agenda makes this universal provision of a range of therapies even more important. The 'We Need to Talk' Coalition's 2010 survey of over 500 users of NHS psychological therapies shows that people offered a full choice of therapy were five times more likely to report that therapy definitely helped them back to work and three times (91 per cent compared to 28 per cent) more likely to be happy with their treatment than those who did not. The 'Getting the right therapy at the right time' survey report can be found at http://www.mentalhealth.org.uk/our-work/policy/policy-archive/we-need-to-talk/

A further survey by the BACP Scottish Counselling Reference Group asked psychological therapy service users what improvements they felt would make the most positive difference to them. Service users suggested a choice of therapy and an increased number of sessions. Further results from the survey can be found at http://www.bacp.co.uk/admin/templates/abstractpopup.php?abstractId=184

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?

BACP would recommend that all services have service user representation in terms of wider service planning, good practice and evaluation. BACP would suggest that service user representatives should be provided with training, for example, in the workings of meetings to maximise their input.

Examples of good practice are outlined in the 2010 service report of the Pathways Team (PCMHT, South (West) Glasgow), '"...not for me..."? Reaching out & meeting needs: With particular reference to disadvantage & socio-economic deprivation.'

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

BACP would suggest that there needs to be a strand of *see me* (anti stigma campaign) that helps to break down the barriers of "them and us" attitudes that can prevail amongst secondary care services and which would bring together the various stakeholders to have more healthy dialogues about the levels and quality of care that is provided, beyond it being about formal complaints, which seems often to be the case.

All Primary and Secondary Community Mental Health Teams could have a 'community skilled' practitioner within their team to lead on partnership/service user engagement.

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?

BACP suggests that to offer a choice of psychological therapies, including ones that allow for the exploration of life events/experiences, would ensure a range of treatments to meet varying individual needs. Additionally, the term "person-centred" has both a generic and a specific meaning. In general terms it refers to an approach to treatment which focuses on the individual needs of the client. From a more technical perspective it is a model of psychological counselling developed in North America by Carl Rogers (Client-Centred Therapy, 1951), which holds the client's own subjective reality at the centre of the therapeutic process. Many counsellors in the UK have been trained in this model over the past 30 years and it is the most common single therapeutic model used by BACP counsellors. These counsellors are trained in person-centred values and philosophy and are experts in delivering this type of therapy to clients. An additional factor is what these counsellors can bring to multi-professional settings in promoting such philosophy and values among other health professionals, hence meeting the objective of embedding a person-centred approach in mental health care settings. There is already a large fully-trained workforce of counsellors available to take this work forward.

It is also known that there is an indirect effect of having mental health workers on-site in GP practices; they may increase referral rates to certain mental health services, possibly through sensitising the GP to psychosocial problems that cannot be managed in the practice (Bower, P, 2000). Providing therapy on-site in primary care can reduce consultation rates, psychotropic prescribing and mental health referrals, although the effects are modest (Harkness, E. F., & Bower, P. (2009).

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

BACP would suggest having an annual awards ceremony that celebrates services that consistently score highly on the SRI and which would then engender a climate of excellence.

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

The Government could consider financially supporting the roll out of pyramid training across all the services that SRN would be relevant for, by provision of continued increased support to sustain their vital work.

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?

There is a growing awareness of the burden of care which is shouldered by family members of those with mental health problems. Where this network of support breaks down, the cost to health and social care services is significant. This is perhaps best exemplified with the case of dementia, a mental health problem increasing commensurately with the ageing of the UK population. The National Dementia Strategy (Department of Health, 2009) reminds us that there are over 500,000 family members in England who care for a person with dementia, and that carers provide over £6 billion a year worth of unpaid care. Additionally there is evidence that counselling and psychological therapy can prove effective in supporting the wellbeing of carers and can in some cases improve outcomes for the person being cared for who is suffering from mental illness (Gallagher-Thompson, D. & Coon, D. W. 2007, Evidence-based psychological treatments for distress in family caregivers of older adults. *Psychology and Aging, 22*(1), 37-51; Pinquart, M. & Sörensen, S. 2006, Helping caregivers of persons with dementia: which interventions work and how large are their effects? *International Psychogeriatrics, 18*(4), 577-595.). A fully trained counselling workforce already exists, capable of offering this type of care.

In the Welsh Government's school counselling evaluation report (Welsh Government, 2011), interviews conducted with parents found that some schools offer interventions to the family. Parents are informed of what the service offers and the purpose of counselling and in some schools parents have access to support from the counsellor themselves.

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?

Staff need information to sign post families and carers to relevant support services as required. These services should include counselling provision. BACP has commissioned a research review on the effectiveness of psychological interventions for care givers of people with dementia, which will be published later this year.

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?

No comments.

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?

BACP is aware that providing counselling services to those living in rural areas comes with different considerations to provision in urban areas. Research conducted in Scotland (Kirkwood, 2000) regarding the development of counselling in Shetland was the first UK example of research about counselling in a specific geographical area. One example of the findings from the research is that in a rural area, assuring the confidentiality and anonymity of the relationship between counsellors and their clients can be challenging.

Counselling and psychotherapy can offer many benefits to people living in rural areas in Scotland. Specifically:

- **Improving people's quality of life**
- **Helping to manage long term conditions:** counsellors and psychotherapists can offer support for people suffering from long term conditions
- **Counselling for the elderly:** BACP has previously commissioned an external review of counselling older people, which concluded that counselling is effective with older people, particularly in the treatment of depression, with outcomes consistent with those found in younger populations, suggesting that old age is not a barrier to being able to benefit from counselling.
- **Counselling for suicide prevention:** (A particular problem in rural areas) BACP has also commissioned a systematic review into suicide prevention, which has found that people at risk of suicide should have access to psychological interventions.
- **Counselling for depression:** Counselling for depression has been found to be effective, as shown in research (King, 2000) and recommended in NICE guidelines for depression.

BACP members have a wealth of experience in service provision and the Association is keen to use this experience and knowledge to help support the delivery of improvements, in particular to improve the accessibility of counselling and psychotherapy where it is needed.

Other suggestions to improve the accessibility of services that might be considered are:

- The potential for on-line and telephone counselling provision (BACP has published guidelines – give reference.). On-line counselling provides particularly good access for children and young people, whilst telephone counselling is good option for the housebound elderly and those in rural communities.
- Self referral to primary care and to school counselling services.
- Audit what currently goes on: does it include socio-economic status? Information should include drop-out rates, client satisfaction measures and self-assessment. Also for centrally funded programmes which are based on evidenced approaches, follow up samples should be taken after treatment ends to make it clear that effects are transferable. It would also be valuable to monitor co-morbidity with other conditions.

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

BACP would suggest pooling all the learning and relevant research on accessibility so as to produce guidance, which could be disseminated at a high profile event, targeted at primary and secondary care team leaders and staff. This would allow for dissemination and the identification and commitment to key actions that all such teams could sign up to. This could be followed up by a review and monitoring of commitments being met.

There could also be a dedicated national advocate that acts as a conduit for this information.

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

Socio-economic status is a key issue:

- Gap in *amount* of provision - The well documented 'Inverse care law' (whereby the greater the need, the fewer the services) applies particularly to Scotland's mental health provision in more disadvantaged areas. There needs to be more targeting of NHS/community mental health resources to those communities in greatest need, for people without the resources to pay for, or travel to, alternatives.
- Gap in *type* of provision - The Pathways Team report (see above) evidences the fact that current NHS psychological therapies provision does not (and perhaps cannot) provide services that meet the needs of large numbers of people in more disadvantaged areas. There is a need for community provision (or NHS/third sector partnerships) offering more flexibility over the number of sessions and choice of therapy that provides space to explore past life events and deal with current pressures/stressors; that is holistic and offers a social model of health.

LGBT provision:

The Glasgow Anti Stigma Partnership research 'There's more to me' shows Scottish LGBT people remain reluctant to use NHS mental health services. Support needs to be given to community sector organisations that, for relatively small amounts of money, can and do provide vital, early interventions. Some existing organisations such as Strathclyde Lesbian & Gay Switchboard, the only regular Switchboard left in Scotland, is under threat of closure due to loss of central funding.

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?

The concept of person-centred care is not sufficiently defined here. The document reads as though it suggests that you can only have person-centred care if you tick one of the diagnostic boxes for mental ill-health. More needs to be done to educate and enthuse professionals on all levels about what person-centred care involves and how it can benefit the patient and the service.

BACP would further suggest that all mental health screening should link up with social support that may alleviate practical stressors/anxieties, for example as modelled by some Community Health and Care Partnerships (CHCPs) such as SW Glasgow CHCP (Pathways Team).

In prisons BACP would advocate the universal provision of counselling services in partnership with the community and third sector. Useful Sainsbury Centre research that has looked at what prisoners needed is outlined at:
http://www.centreformentalhealth.org.uk/news/2008_from_the_inside.aspx

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?

BACP would suggest looking more holistically and creatively at how psychological therapies can be applied to people with long term conditions and medically unexplained symptoms (MUS). As suggested in 'No Heath Without Mental Health' (HM Government, 2011), 'getting better diagnosis and treatment of mental health problems for those with long-term physical conditions, and getting identification and treatment of anxiety or depression for those with medically unexplained symptoms' is key.

'Medically unexplained symptoms have been shown to directly cost the NHS in England £3 billion every year with additional associated costs through sickness

and decreased quality of life totaling a further £14 billion a year. A review of a large number of studies has found that cognitive behavioural therapy is very effective for those with identified mental health problems' (HM Government, 2011). There are cost savings across the NHS if the psychological needs of patients with physical health problems are taken into account e.g. diabetes and co-morbidity of depression, if depression is untreated then the costs of treating diabetes are 250% what they would be if depression was treated.

MUS may present in admissions to A&E, as does self-harm (not just injury but drug and alcohol related A&E admissions). It is not always a mental health diagnosis that we should be looking for or looking to treat, sometimes people are distressed by their situation and/or a physical health problem and some counselling support to help alleviate their psychological distress can bring benefits to their physical health (for example through improved medication adherence, more appropriate use of NHS services, reduced stress and better self care) and thus reduce the cost of their care overall and improve their quality of life etc.

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?

It is important to take into consideration changes currently being made in relation to the 'health and social care workforce'. With the release of a command paper, *'Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff'*, in February last year, statutory regulation no longer remains UK Government policy for unregulated professions (such as counselling and psychotherapy) apart from in exceptional circumstances. Instead, the UK Government wishes these professions to join voluntary registers. Unfortunately, the term used in section 11 'allied health professionals', does not include unregulated professions, such as counselling and psychotherapy. This is a serious omission.

With statutory regulation no longer an option, BACP would like to see any new relevant policy regarding allied health professionals amended in order for the proposed Professional Standards Authority (PSA) approved voluntary registers to be accepted by the NHS as a satisfactory level of quality assurance.

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?

BACP agrees with the idea of piloting a workforce survey of people delivering psychological therapies in Scotland and would suggest that the survey includes the modality of therapists, so that the range of psychological therapies offered is monitored; their client base and the scale of referrals from the statutory sector or community organisations. It would also be useful to include in the survey

community and third sector organisations offering psychological therapies, to include their experience of what gaps they fill in service provision and demand.

BACP has 1,500 members working in Scotland as counsellors and psychotherapists across the public, private and voluntary sectors. It is imperative that these professionals are included in the survey to ensure a comprehensive picture of services is drawn up.

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

In developing priorities for workforce development it is important that patient choice is taken into consideration; specifically ensuring that the different needs of the Scottish people are met by the presence everywhere in the Scottish NHS of a range of therapists, not just CBT practitioners.

BACP would recommend a survey of patient choice in primary care to find out what their needs and preferences are and collating outcome measures and patient satisfaction measures from existing therapy services.

As suggested in response to question 28 a survey of the existing workforce would be useful, keeping in mind that many psychological therapists may not be coded as such; for example a survey of the workforce in the community sector, building on work previously done by Bondi (2004, 2005). Bondi was commissioned by the Scottish government to research voluntary sector counselling in early 2000. She found that the majority of informants who were volunteer counsellors in voluntary agencies believed that the 'free' aspect had an important positive impact on the relationship and therapeutic work.

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

BACP would suggest considering relevant training strategies, which would re-skill the existing workforce in nationally approved therapies, for example counselling for depression (CfD), which are not currently available in Scotland. CfD is a NICE recommended form of psychological therapy for the treatment of depression specifically devised for counsellors working in the IAPT programme. CfD targets the emotional problems underlying depression along with the intrapersonal processes, such as low self-esteem and excessive self-criticism, which often maintain depressed mood.

In England there is a growing network of Higher Education Institution (HEI) /Professional Body approved providers for National Institute for Health and Clinical Excellence (NICE) recommended therapeutic interventions. This partnership approach could enable delivery to large numbers through established, reputable HEIs with a track record in a particular modality and offers more consistent standards, than a model that accredits individual trainers.

BACP has accredited courses in Scotland who would only require familiarisation

with the training materials to be able to deliver according to agreed standards. BACP quality assures the training through its CPD endorsement scheme. BACP is currently developing a quality assurance visit process to enable standardisation and consistency of the Counselling for Depression training, which is being rolled out to Strategic Health Authorities across England where IAPT sites exist.

BACP would also recommend making links with Scottish training providers, including the Universities of Strathclyde, Edinburgh and Abertay.

Finally, BACP would suggest spreading funding beyond training in CBT for psychology graduates to include a wider range of evidence based approaches and a more diverse workforce of therapists.

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

BACP would suggest the inclusion of patient outcome measures and the use of IAPTus, a system for patient case management and reporting. It offers the possibility for health care providers who are providing different services across the community to collaborate. It also allows the NHS, charities and other third sector organisations working together to combine data. Further information about IAPTus can be found at: http://www.iaptus.co.uk/.

It is imperative that a standard outcome measure is applied nationally to enable standardised outcome monitoring and the possibility of a national evaluation of services. BACP would also suggest the inclusion of a patient satisfaction component.

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?

No comments.

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

No 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?

No comments.