

## 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.

### 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.

Mental health for folks in the outer districts of Glasgow that come under other councils, is hardly helped by their arbitrary exclusion from the Arc, which has caused a lot of evil mental pain, as those of our members who attend SASN with Glasgow folks have heard about.

## 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

**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

**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

**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?**

A member who survived being in a traumatically and frighteningly authoritarian child psychiatry unit, its hard man nurse chillingly talking of "to get you in here and change you", for the effects of traumatically and frighteningly authoritarian schooling, was missed from recognition as aspie at the time when the name had already been coined by Lorna Wing in the 80s. From the English site AS support group online, a quote from a Tony Attwood interview: "1. When did you first hear about Aspergers Syndrome?

I first heard about Asperger's syndrome in the mid-1980's when fellow clinicians in the UK were starting to use the term 'Asperger's syndrome' from the work of Lorna Wing".

Yet our member, at that time totally isolated in the aftermath of extrication from that unit without its approval or endorsement of his health, could not go anywhere near mental health services for any reason. An aggressive posture of outstanding threat had remained from that disastrous unit, indicating a wish to fault his future coping with life and find an opportunity to force more of the same treatment, which was conformist and a violation of his democratic liberties seeking to destroy every distinctive feature of his personality. In the period of the earliest AS diagnoses in the 90s, they were generally for the younger among us who were lucky to have non-confrontational contacts with the mental health system then, while the member described continued to miss out on recognition, when the aspie community's support would have made a big beneficial difference to his quality of life.

After this member caught up with the aspie scene in 2002 when it was becoming self-advocating and separated from the mental health scene, in order to get an aspie diagnosis safely he needed to make up a cover story about safety fears in responding to some university research going on then, in order to get agreement to not having to talk to the psychiatrist at all about his period of life that included the episode with that unit. It is only after discussion at the SASN's recent conference, that this member has been able to put an end to the threat feeling left by his teenage psychiatrists nearly 30 years before, and in safety to challenge the NHS about what that unit did and to lobby that its conformist and high handed attitude was damaging and must not be the practice now.

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

Comments

**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

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

Comments

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

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

Comments

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

Comments

**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

**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

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

Comments

**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

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

Comments

**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?**

A member placed by the jobcentre in a mental health project for work experience and supposedly to lead to opportunities (it never did), experienced the institution closing ranks in favour of emotional exclusion and pushing around, and to cover it up. In a project claiming to be a safe community some of whose clients were potentially suicidal, the incident involved gender discrimination by telling the project's men that their inclusion in the community's life should be subject to veto by the women, even over which public events they should attend in their own time. 3 years after it happened, and months after an advocated meeting, social work is still dragging its feet over an answer about prevention of corruption of services like this. This shows a serious lacking in the safety from harm, in using services claimed to be suitable for us as a socially vulnerable group.

Social work know from the paper record that the organisation running the project concerned blatantly whitewash complaints, ignoring most of their content then telling the victim that if they do not like this answer they must appeal it. They upheld the complaint against an innocent helpful third party who it had not been made against, because as a student on a short placement instead of permanent staff she made the most convenient target, and this behind her back without ever hearing any defence from her. The complainer was then bullied with a time limit ultimatum of, appeal the first stage within a week or else we will close the case and not acknowledge you any further. This was taken up as a case of unacceptable bullying by the mental health users' forum, who this organisation made as many repeated efforts as it could muster to fob off with noncommittality and described the bullying as their constructive way of helping the case to progress!

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

Comments

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

Comments

**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

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

**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



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

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

Comments

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

Comments

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

Comments

**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

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

**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

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

Comments

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

Comments

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

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

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

Comments

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

Comments

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

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

Comments

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

Comments

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

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

Mental health law includes a right to advocacy for the reason that it helps to ensure that the affected person is heard in what they want to say and their views are heard a tall times of decision. If the affected person has difficulty with communicating then proper advocacy is a very necessary safeguard whose first winning was an advance in democratic standards: a party, outside the person's own situation, watching that they are listened to properly. But the whole point of it is to hear what the person actually wants to say, so it is frustrated and corrupted if the advocate seeks to manipulate the message. There is a mental health advocacy service that will always declare it has the final say over any message content written under its name, and when you are composing a message with them thy will keep sending writes of it back to you that repeatedly keep putting back in a change they know you do not want, but only if you are strong enough to ask them about it will you even find out why they are doing it. Then they will tell you, oh we don't think it sounds diplomatic to talk about any service having threatened you, threat is too strong a word and we decline to use it. But that may be what you need to say, that you had been threatened, so a diplomatic policy like that is manipulation of the client. Or, you may need to assert that as your

good health is recognised and witnessed to, that you have proved that mental health services have been proved to have no power of compulsory treatment over you in retaliation for raising an issue about a past wrong: and you find these advocacy folks will say, oh no we won't say that for you, it's not diplomatic to make any demands upon a health service, including to "demand inaction" by it, and it is their policy never to do it, so all they are willing to write instead is a kowtowing request for you not to be compulsorily treated. The difference between a request and an assertion that the power does not exist, is so total that it makes all the difference to your personal safety in sending or not sending the message at all.

So it is a serious breach of advocacy's entire purpose as stated by law for any advocacy provider to be allowed to have policies like those. Many clients are witnesses to it and have shared their thoughts at the local collective advocacy level.

The same provider has also told one of our members when making an "advance statement", that it had all the wrong type of content and he must delete 80% of it or he would never get it signed: he got it signed by GP with no trouble at all, and the point of advance statements, again stated in law, is for them not to be influenced or vetoed by anyone helping with making them.

We are pleased at the emergence of Partners in Advocacy with a specific brief for autistics, and 2 of us have had good experiences with them already.