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

Comments

You have decided on 4 areas to focus on:

- Access to therapy
- A plan for people who have dementia
- Community based services and their role
- Preventing suicide

However, a crucial area that is missing is the continued improvement of children and young people's mental health and wellbeing.

One in ten 5 to 15 year olds experience a mental health problem[1]. The lifetime costs of a single case of untreated childhood conduct disorder are approximately £150,000[2]. Investment in the mental health of children and young people must go beyond Child and Adolescent Mental Health Services (CAMHS), incorporating mental health in early year's education, early intervention programmes for parents, and early years health visitors trained in mental health.

During the lifetime of the strategy, budgets will be under greater pressure than at any time in the last fifty years. That means we need to get maximum value from every penny, so the strategy must incentivise joint work between the NHS, Local Authorities, Justice Services and the Voluntary Sector, and clearly relate to other frameworks such as GIRFEC and the ASL system.

YSIM notes the crossover period between the end of the current phase of the Choose Life, the national strategy and action plan to reduce suicide in

[1] The Mental Health of Children and Young People in Great Britain, *Office for National Statistics, 2004*

[2] Friedli, L. and Parsonage, M.: *Mental Health Promotion: building an economic case.* Northern Ireland Association for Mental Health, 2007

Scotland (2013) and the Mental Health Strategy (2015).

We believe that a national suicide prevention strategy is essential in order to inform and underpin national and local suicide prevention actions that:

- a national support function is needed to produce a monitoring framework, provide leadership and take responsibility for the implementation and monitoring of the primary objectives;
- it also provides direction for local work, e.g. on targeting, training, evaluation and acts to facilitate information sharing;
- it is crucial that the leadership body has the ability to influence action across Health and Local Authority structures, and
- it is therefore essential that the Mental Health Strategy contains a clear commitment to the continuation of a national suicide prevention strategy beyond 2013.

Around a third of GP appointments are about mental health problems[3] - yet research suggests that GP's do not feel confident in providing information on mental health. The strategy should offer GP's regular CPD opportunities in positive mental health and common mental health problems especially when relating to children.
We should also recognise GPs as part of the community in which they work. They should be encouraged to take more of a role within their local communities around the areas of mental health, but particularly suicide prevention.

The impact of bullying on children and young people, both during childhood and in later life, can be substantial. Scotland is leading the way in anti-bullying work through the work of respect*me*, managed by SAMH and LGBT Youth Scotland, and this is laying strong foundations for the good mental health of children and young people. A strategy for Scotland' mental health should include a focus on anti-bullying work.

[3] Scottish Executive Health in Scotland : Report of the Chief Medical Officer, 2003

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

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

We believe that a national suicide prevention strategy is essential in order to inform and underpin national and local suicide prevention actions that:

- a national support function is needed to produce a monitoring framework, provide leadership and take responsibility for the implementation and monitoring of the primary objectives;
- it also provides direction for local work, e.g. on targeting, training, evaluation and acts to facilitate information sharing;
- it is crucial that the leadership body has the ability to influence action across Health and Local Authority structures, and
- it is therefore essential that the Mental Health Strategy contains a clear commitment to the continuation of a national suicide prevention strategy beyond 2013.

The inclusion of self harm reduction within a suicide prevention strategy is understandable, but YSIM would seek an explicit commitment to funding self harm reduction activities nationally, and locally, in order to ensure the availability of suitable, accessible services to meet the requirements of people who self harm.

We note that most self harm occurs in younger people, but YSIM is concerned that we will continue to have an incomplete picture of the true incidence of self harm while data collection is restricted to hospital admissions and acute and psychiatric hospital settings. Incidents of self harm that result in treatment in these settings are relatively few in comparison with incidents that are self managed or less severe and many people who self harm are not in touch with any formal services. In other cases people may be receiving services that were not intended primarily to support people who self harm, such as community mental health services, but it is important that the strategy acknowledges the role these services can play in reducing self harm and takes measures to improve data collection in order that service planning is well informed.

Transitions

Young people are likely to experience a number of transitions that can be stressful, including moving from dependence to independence or from education into employment. In addition, young people who are in contact with mental health services may have to make the transition from child and adolescent services to adult services, with the attendant risk in some cases that they will left with no support or that they may receive fractured services. For some young people who disengage with services during transitions there is a risk to their mental health and they may be at higher risk of suicide or self harm. We would suggest that a strong emphasis on the need to ensure smooth transitions between services is included within the strategy.

Mental health and emotional well-being

YSIM believes there is a need for the strategy to recognise the importance of the development and delivery of interventions that take account of the mental health and emotional well-being of children and young people. However, it is important to acknowledge that the needs of specific groups will be different and that services are commissioned to meet these different needs. For example:

- Looked after children experience a higher prevalence of mental health problems than other children, and there are clear differences in help-seeking and attitudes and responses to services among young men and young women;
- the impact on mental health as experienced by young people within different equality groups due to direct, or indirect experience discrimination of one or more equality characteristics;
- children and young people are supported when one or both parents have mental health problems and/or alcohol or drug dependency;
- for children and young people bereaved or affected by suicide, YSIM believes that local authorities should ensure that all schools have access to information about what to do following the death by suicide of a member of the school. Schools should have access to counselling and additional help may be needed for the whole school following a traumatic death.

Social media

Many young men and women use social media to communicate and they also use online support in a variety of ways, including help seeking and advice for mental health issues. It is important for all agencies working with young people to understand the potential for positive use of the online environment, but also to ensure that there is clear risk management undertaken to ensure safe use. Funding should be made available to support organisations to respond to the needs of young people through social media and to expand the availability of sources of support to young people online.

The 'See Me' campaign should be further developed to make sure that it is reaching all at risk groups, young people especially. Work should be done to make communities aware that it even exists – e.g. TV advertisements, as there is very little out there already! We should make sure that what the government has done so far is evaluated to analyse the impact it has had on local communities. Especially those with a high number of people at risk. Choose life should be funded past the pilot years and implemented much further – developing further materials to make sure that ALL members of the community are reached: from drug users and young people, to those who are homeless.

National Coordination and greater communication in terms of new activities locally that can be used on a national level (things that work). Self harm and suicide programmes could be made more incorporated into main

modules in Universities and even 5th and 6th year pupils in a peer led approach. For older people community wardens, nurses and relevant staff within care homes should be familiar with self harm/suicide. Rurally, more community programmes and selling self help websites may reach more vulnerable people in rural settings.

Creative media campaign to highlight just what the term 'mental health' covers, (there is concern that young people don't regard depression as a mental health issue.....perhaps it is not just young people that have this misconception!)

In addition if the general publics awareness is heightened through 'early intervention' media campaigning and or policy change – ultimately it will become second nature to seek help when one needs to....much like attending the A+E department when you have had an accident.

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

Further work like the See Me campaign should be focused in schools, community venues and within hospitals etc by workers whose main focus is the reduction of suicide – maybe health promotion workers? We all know workers (sometimes CLD, sometimes NHS) who go into these sorts of places and deliver learning opportunities around areas such as Sexual Health and Relationships and drugs, alcohol and tobacco. Why can't this method be introduced to educate and reduce stigma around suicide and self-harm?

Taking advantage of the media to portray people with mental health problems in a much more positive light and not portraying them as victims or unsafe to be around. More tightening of employment legislation to ensure that mental health has no influence on capacity to carry out a particular job (unless it is clear that it is not possible). More educational programmes in schools so they understand at a younger age what stigma is. This can be peer led by those who may have experienced stigma discrimination.

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

Maybe set statutory and voluntary organisations targets relating to funding around reducing stigma of mental health and suicide. The more evidence based work that is carried out, the better. We believe that See Me needs additional funding for it to regain the recognition within local communities and between professionals that it should be receiving! Organisations should have pots of money available to them for producing and delivering learning opportunities with the help of NHS Health Scotland, SAMH, Chooselife, See Me etc...

YSIM still feel that the "See Me" Campaign is not far reaching enough and at times can be seen as a programme that is not young people friendly. Again, targeting schools regularly as well as universities and employment induction programmes might heighten people's awareness of what stigma/discrimination is.

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

Comments

We should ensure that all frontline staff (teachers, social workers, youth workers, police, ambulance, GPs, nurses etc) have the necessary skills to deal with any situation which may occur – e.g. taking part in ASIST, safeTALK and SMHFA training. Encouragement should also be made for employers to take a responsibility for their employees mental health and wellbeing (such as promoting healthy working lives further) and making sure that this scheme is properly implemented with tougher measures put in place for employers to gain the award – e.g., assigning someone in charge of mental health and wellbeing in the workplace. Maybe a scheme similar to the 'positive about disabled' people could be introduced for mental health and wellbeing?

Whenever any mental health training occurs, whether it be in the public or voluntary sector, GPs are rarely never in attendance, as well as those from the private sector. There has to be better ways of getting those who are continually absent to, at the very least, be aware of and send representation to mental health training. This would allow more individuals to be recognised and supported. In terms of communities, social prescribing has to be recognised as a valuable way forward and embraced by those who may deal on an individual basis with someone who may be struggling. We are all aware that medicating a person is not always the best way forward and social interaction and being a part of something can increase motivation and ultimately individual and community wellbeing.

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

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

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

Breathing Space opening hours should be made longer so the helpline is available at all times. TV adverts from 'Healthier Scotland' should be produced aiming at all people, but particularly day time viewers who may be off work due to mental health issues – adverts should include helplines and other information with maybe a very real movie like scenario. As said above, See Me campaign should be re-established with more money behind it so it reaches more of an audience than it has already (which is not many people) – maybe this could be the drive of the TV advert / radio ads?

All this can't happen however if Scotland doesn't have a strong enough workforce to support the people who self-identify themselves as having mental health issues. We need to make sure that our professionals are trained to the standard required and not let the cuts affect the general public in this way (which could be difficult). This goes for staff within local government and NHS. The Chooselife TV advert should be reintroduced also – but this does not cover ALL people as someone with a severe mental health problem may not be suicidal.

Better and more effective media campaigns that appeal to everyone of every age as well as community mental health delivery programme and leaflets that allow people to firstly understand what mental health is and how it relates to them personally. If someone doesn't understand what mental health is, how can they try to seek support for it. Although there has been a lot of work done (Breathing space, Self help CBT, NHS living life etc) if these services are unable to be recognised or understood as positive means of support they will not be used as much as they could be (these could and should be readily available in all GP surgeries).

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

Comments

A friendly, accessible, non-judgemental and supportive approach should be taken. This could be in a variety of formats: telephone, face to face, text, internet chat etc. It doesn't always have to be a face to face approach. I think sometimes people need to 'think outside the box' in order to reach all people of the community who may have issues. What about the homeless? Street workers should be introduced to build connections with Scotland's homeless – maybe could be linked to our Community Learning and Development or Social Workers. The WISH model sounds really good but

should be developed to a service that isn't primarily telephone – what about the people that are even too mentally ill to talk to someone on the phone. It would be great if NHS 24 or a new provider could provide an online based service – similar to a chat room?

Promoting understanding of mental health alongside reducing stigma programmes, and encouraging local people in communities to undertake and deliver this training within their community (Champions).

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

Focus groups should be developed with local communities to see what is working well, what isn't working at all and what should be improved. This will provide key information to professionals about what areas need to be worked on. The focus groups should be organised in sex and age groups for a more precise understanding of what works for who. This could also be done by professionals working with people who have already self-identified as mentally ill to see what has worked best for them in the current system, and what hasn't.

There are loads of possibilities here for development! A solution may be to work more closely with local council's Community Learning and Development teams.

Part of a front line workers task while consulting with a patient, client, pupil etc would always be to consider the mental health of the person concerned. A simple tick box exercise with a simplified, well staffed team to pick up clients through a referral system, more community nurse practitioners and staff with qualifications in mental health and counselling support.

For young people who are 16 – 18 years but are not in full time education getting access to children's services can be extremely difficult. This criterion has to change as it feels discriminatory that because a person is not at school when they are 16 they are not deemed to meet the criteria to access these young people's services. The system may also benefit from a clear path from primary school through secondary school and continuity of care from the transition between primary/secondary school. Much more mental health awareness training for all teachers, as well as community involvement between parents and schools may help more people to recognise when something is not right with their child or pupil.

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

It is important to encourage focus groups of experienced service users and their families and carers to influence the systems of service and delivery and in care based on their own experience. Peer education in a sense.

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?

Comments

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

All public and voluntary services to have a basic awareness of what specialist services are available. A national training programme that allows not just those within the NHS to understand more about recognising and supporting young people with learning disabilities, but should also be targeted via the social prescribing model, as well as support sessions to the general public, educational bodies, the voluntary sector.

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
Possibly non statutory bodies going into prisons to provide awareness raising sessions around mental health patterns. Encourage mental health Champions amongst staff who can deliver SMHA and other relevant training to staff and the prisoner population.

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
A recognition that many staff have the relevant skills/training to deliver psychological therapies but are unable to do so due to job descriptions, for example, trained counsellors cannot utilise their skills due to the inflexibility of many services to allow this to happen within existing contracts. A **psychological therapies workforce budget** that can support staff in key areas and that can support and compliment community based therapies to reduce the burden on CAMHS services can be positive way forward. A support/supervision structure could also be put in place from these delivering the training.

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

Asking staff who are interested to get the time and financial backing with support from managers and chief executives to undertake appropriate training and can be delivered within existing job descriptions and contracts.

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?

Comments
First and foremost staff have to be given the time/training to understand the nature and implications of legislative requirement.