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.

Families Outside welcomes the 14 Outcomes as identified in the draft Strategy. We are particularly pleased with the inclusion of Outcome 7, recognising the vital role of families and carers in a person's mental health as well as the impact of the caring role on their own mental health and wellbeing.

In saying this, we believe the Outcomes would benefit from the addition of an Outcome focusing on a more proactive, preventative approach. Outcome 2 touches on this to some degree, with its focus on early years and childhood. However, an Outcome such as the following may be helpful: "Key causes and triggers of mental health problems are recognised and supported from the outset to prevent the development of more serious problems." Through such an Outcome, issues such as bereavement, homelessness, imprisonment or other family trauma can be supported at the earliest possible stage, thereby preventing more embedded, longer-term difficulties with mental health and wellbeing.

The Strategy appears to have a realistic grasp of the likely challenges in delivery of the Outcomes. In our view, an important priority for meeting these challenges is ensuring that appropriate support is available for mental health problems prior to delivery of mental health services. The draft Strategy defines "faster access" to services as 18 weeks for adults and 26 weeks for Child and Adolescent Mental Health Services. Such waiting times can be unbearably long for people in need of them, particularly for children and young people, for whom six months is an unimaginably long time.

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.

In our view, an important priority for meeting these challenges is ensuring that appropriate support is available for mental health problems prior to delivery of mental health services. The draft Strategy defines "faster access" to services as 18 weeks for adults and 26 weeks for Child and Adolescent Mental Health Services. Such waiting times can be unbearably long for people in need of them, particularly for children and young people, for whom six months is an unimaginably long time. In England and Wales, the Children's Society's Good Childhood Inquiry (2009) recommended increased provision of CAMHS specifically to increase access and reduce waiting times for the children and young people who need such support.

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.

A more proactive, preventative approach would deliver better outcomes and save money in the longer term. Key causes and triggers of mental health problems could usefully be recognised and supported from the outset to prevent the development of more serious problems. Through such a proactive approach, issues such as bereavement, homelessness, imprisonment or other family trauma can be supported at the earliest possible stage, thereby preventing more embedded, longer-term difficulties with mental health and wellbeing.

An example of a proactive approach is the support that Place 2 Be provides in 18 primary schools across Scotland. Their service has been thoroughly evaluated and was highlighted as an example of good practice at the joint Cross-Party Groups on Mental Health and Children & Young People. Their approach enables children to self-refer when they feel they need support rather than having to wait until more deeply-embedded problems develop and are noticed by an adult. Such an approach may also address the call in 2011 from the British Association for Counselling and Psychotherapy for counsellors in all Scottish schools.

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

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

We believe that better recognition of the types of issues that cause distress would facilitate a more preventative approach to self-harm and suicide. Breakdown in family relationships, experiences of abuse, parental substance misuse, bullying, homelessness, imprisonment of a family member and poverty are all identifiable issues that can lead to self-harm and suicide, yet support only tends to be offered once a crisis has developed. A more proactive offer of support from the outset may prevent mental distress from becoming more deeply engrained. This may be as basic as highlighting to a family (for example at the point of a family member's arrest) that their experiences may cause difficulties for them and, if so, where they can go for help. Ready access to support such as through Place 2 Be, as noted in Question 2, would be another option.

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

Early education in schools can go a long way towards raising awareness and thereby increasing understanding and reducing stigma. For example, open discussion of mental health in broader topics about health as well as in school anti-bullying workshops can be of use, especially if they coincide with wider public information campaigns (see for example R. Scheffer (2003) "Addressing Stigma: Increasing Public Understanding of Mental Illness"). Where this has the benefit of support from well-known and well-liked public figures, such as Stephen Fry's publicity about bipolar disorder, stigma reduces even further (D. Chan and L. Sireling (2010) "'I want to be bipolar'... a new phenomenon". *The Psychiatrist* 34: 103-105).

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?

We have no specific comment on this question.

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

We would encourage support for people 'where they are', such as in schools (e.g. Place 2 Be), workplaces, prison visitors' centres, job centres and benefits offices, as they will often not be aware of or seek the support they need. Equally, they may not recognise their issues as health or mental health issues (see L. Brutus 2011, *A tool to tackle health inequalities in the families of people in prison? Evaluating the Families Outside Family Support Worker role from a health perspective.* Edinburgh: Families Outside); greater awareness of these and of the support available would be of benefit through the same sources as well as through the media, as noted in Question 4 above. Support in communities must be openly accessible and non-stigmatising if they are to encourage those who need it to access it. The links between schools and specialist mental health services noted in the draft Strategy is a positive way forward.

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

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

We have no specific comment on this question.

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

We have no specific comment on this question.

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

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

We are pleased to note the access to telephone-based support and self-help therapies, as highlighted in the draft Strategy. An ongoing challenge will be raising awareness of these, as well as 'demystifying' such approaches to encourage people to use them: mental health support can be very daunting for people to access, especially where people have a limited understanding of what will be involved and how it may help.

Equally of benefit would be increased awareness regarding the types of issues that may increase the risk of mental ill health, what symptoms of mental ill health might be and the types of support available. If people are more aware that personal trauma such as abuse, divorce, homelessness, unemployment, imprisonment or poverty can affect their mental health and wellbeing, as well as that of their children and families, they may be more prepared to seek support (or ideally to access support that is readily available to them).

One practical example of this is support from health visitors and other public health practitioners in places such as prison visitors' centres. A family member's imprisonment has demonstrable effects on the family's mental health and wellbeing (Families Outside, with L Brutus (2011) "Prisoners' families: The value of family support work". *In Brief* 6. Edinburgh: Families Outside). Support in prison visitors' centres reaches vulnerable families 'where they are', when otherwise they are likely to access no support at all (G. Pugh and C. Lanskey (2011) "'Dads Inside and Out': study of risk and protective factors in the resettlement of imprisoned fathers with their families". Conference paper for *What's new in Research and Evaluation? Informing our work with prisoners and offenders and their families*. Institute of Criminology, University of Cambridge, 19 May 2011).

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

As noted above, reduction of stigma and provision of readily-accessible support (such as in schools, for children and young people, or in prison visitors' centres, for families affected by imprisonment) will help encourage people to seek help when they need it. These, in combination with greater awareness of the triggers for mental ill health, are essential elements of a proactive, preventative approach.

One further element not yet raised is the question of dual diagnosis. The combination of mental ill health and substance misuse issues often creates a barrier to treatment. The reality is that these issues often go together, and the main underlying feature may not be evident until one or both issues are addressed. We would encourage the Government to use the Strategy to tackle the issue of dual diagnosis as a barrier to treatment.

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?

As noted above, the triggers for mental ill health are often identifiable at very early stages, well before any problems with mental health and wellbeing themselves are evident. We would like to see information about risks, symptoms and supports available from the outset, for example where trauma such as bereavement, imprisonment, homelessness or abuse are identified. This means information would need to be available from schools, the police, courts, prisons, benefits offices, housing associations and job centres as well as from more conventional health-related sources. Another example is that support through midwives and health visitors will assist in identification of post-natal depression, but this could also come through nurseries, benefits offices and faith communities.

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?

We have no specific comment on this question.

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

We have no specific comment on this question.

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?

Engaging with service users for the purpose of feedback can be very challenging, especially where people have moved on from a service and would prefer to put this phase of their lives behind them. Ongoing feedback during their use of mental health services may be the most reliable option, though permission to contact them for follow-up after their departure from a service would be helpful. All such methods for user involvement can be achieved through formal evaluation as well as through less formal 'in-house' questionnaires, one-to-one discussions, focus groups and social networking.

As an organisation focused on the needs of families affected by imprisonment, we believe strongly that feedback from the families of clients of mental health services could usefully be involved in any consultation regarding service design and delivery. Families are often a key factor in successful recovery, either as a support or indeed as a barrier in some cases. Families need to understand their role in the recovery process, the supports that may be available to them and, should the primary service user agree to this, ways in which they might be more involved.

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

We have no comment about specific 'tools'. However, certain structures would be useful such as enabling access to services where service users are, such as in schools, prison visitors' centres and so on. We view engagement with families as crucial to any partnership between mental health care staff and service users. This includes engagement with and

support for families even where the primary service user does not engage with the support offered: the families will have to continue to deal with the mental health issues regardless, and the more support and information they have to do this, the better.

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

We have no specific comment on this question.

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

We have no specific comment on this question.

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

As noted previously, the Network can support different professional groups to *recognise the triggers* for trauma and consequent mental health problems and to *know how to deal with these*. In our own field, for example, if the police are aware that a family member's imprisonment is a known cause of trauma and 'loss' for the remaining family, particularly for children, they can ensure that families have the information they need to help them cope with this (e.g. a card with details of the Families Outside Support & Information Helpline). If teachers become aware that a family is at risk of homelessness or has become homeless, they can offer additional support for children at school and ensure that help is in place (i.e. Place 2 Be) to prevent or address the emotional stress for children and their families.

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

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

We believe families need to be recognised as equal partners in the process of treatment. This includes recognising the impact on the carers' own mental health and the fact that they may well need support in their own right. The stress and worry of having a family member with mental health issues often in itself creates additional problems for the rest of the family. The family must be recognised and supported as having needs in their own right and not simply as an adjunct to the main service user, particularly if they are expected to support the service user's recovery.

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 as much information as possible about the relationships between families/carers and the service user in order to tap into this support most effectively. One means of doing this is through use of a strengths-based genogram and ecomapping. The strengths-based genogram identifies the other issues families might be facing and, importantly, where the strengths lie in terms of support for the service user as well as for the wider family. Ecomapping, in turn, identifies the agencies and support already engaging with the family in some form; this too identifies the positive supports as well as where there might be tensions.

Genograms and ecomaps are standard social work tools. The strengths-based approach and family-focused ecomaps are slightly different, however, as developed in the United States by Family Justice. An explanation of these tools as well as training videos and supporting research are available at no cost under 'Tools for professionals' at http://www.familiesoutside.org.uk/getting-involved/.

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

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

We have no specific comment on this question.

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?

Information about the source of referrals and reasons would improve monitoring and accessibility. While this information is no doubt already collated, it could usefully be used to identify gaps in referral sources. For example, how many referrals come from external agencies such as criminal justice or education? To what extent do people self-refer, and from where? To what extent do services reach 'where people are', such as in schools, social work offices, housing agencies, police stations, courts and prison visitors' centres? Services then need to target 'where people are' so that service users do not need to reach the point of crisis before accessing information and support.

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

We have no specific comment on this question.

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

Current gaps in service provision primarily relate to support prior to the point of crisis – services that identify and recognise 'triggers', as noted above, then prevent more embedded problems through early access to support, such as in schools. Other gaps relate more to the extent of service provision, such as readier access to Child and Adolescent Mental Health Services.

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?

As an organisation with an interest in this issue, we would highlight the use of prison visitors' centres as an excellent resource for identifying and accessing families vulnerable to mental health issues who are not likely to be accessing services. Pugh & Lanskey (2011, *op cit.*) found that 72% of people visiting prisons were not accessing any services, despite their higher risk and experience of multiple deprivation. Provision of proactive support to children in care would be another highly beneficial focus for such person centred care.

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?

To this we would also prioritise work with the wider prisoner population and families of prisoners, for example through access to prison visitors' centres where these exist and improved integrated throughcare (for example through continuity of service, ideally with the same worker in and out of prison custody).

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

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

We have no specific comment on this question.

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

We have no specific comment on this question.

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

We have no specific comment on this question.

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

We have no specific comment on this question.

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?

We have no specific comment on this question.

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

We have no specific comment on this question.

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?

As noted above, we commend the work of prison visitors' centres as a resource to support visitors to prisons but equally as a resource for supports such as mental health services to access the vulnerable populations most likely to be in need of them.

Secondly, we would prioritise the reduction of waiting times for access to CAMHS.

Third, we would increase the means of self-referral at an early stage in a non-stigmatising and non-threatening environment, for example through schools, so that people can access support when they first feel they need it. Such a proactive, preventative approach reduces the risk of mental health issues becoming deeply embedded and more difficult to address.

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

As noted above, we commend the work of prison visitors' centres as a resource to support visitors to prisons and as a resource for supports such as mental health services to access vulnerable populations. We would also commend work to integrate mental health services into more mainstream locations such as schools, social work and benefits offices, housing agencies and so on.

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?

We have no specific comment on this question.