Please tick as appropriate	x ☐ Yes	☐ No

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 See attached response

Submission from Common Wheel (Glasgow) to the Scottish Government on mental health strategy consultation 2012

1 Background

Common Wheel, a registered charity, was established in Greater Glasgow twelve years ago with the aim of providing activity for patients experiencing long term mental health problems.

Our objectives are

1 to improve the quality of life of adults with mental health problems by providing therapeutic workshops
2 to provide a workshop environment where clients will be expected to contribute to the particular activity.

Our bicycle activities are based in workshops in Maryhill and Bridgeton and offer weekly sessions to clients in the repair, renovation and servicing of bicycles.

The music arm of Common Wheel's programme operates from premises on the Gartnavel Hospital site in Glasgow. It offers workshops in hospitals, community settings and long term, community, residential units.

We also have established referral systems with hospitals, Health Board staff and general practitioners, so that local users and ex-users of a wide range of mental healthcare services can access our services.

2 Our view on future mental health strategy in Scotland

We have not followed the question/ response structure laid out in the paper.

Overall we consider that the strategy is too weighted towards clinical interventions and fails to give due regard to the importance of social interventions and the lifestyle, employment, training and educational aspects of recovery. Many of these elements were appropriately promoted in the previous strategy 'Delivering for Mental Health'[1]. and there is a risk that, if they do not feature more prominently in a new strategy, the head of steam built up to date will dissipate.

We conducted a series of focus groups with our clients to elucidate their views on how more appropriate person-centred services might be provided. Five main topics arose and are detailed below

- The importance of self-help and self-determination and of people being able to live fulfilling lives that are meaningful to them and which offer the opportunity to make real and informed choices
- The value of activities/services out-with the normal Mon-Fri, 9-5 timescale.
- The importance of employment/regular involvement in a workplace setting
- The limitation of information on services only available on the internet for adults who rarely use such a medium
- The label of 'mental health-disability' and the stigma associated with this when compared with physical disability

a) Self-help and Self Determination

Building the capacity for self-help within individuals was felt to be an important aspect of the promotion of recovery. Helping people to help themselves rather than simply being the passive recipients of 'treatment' planned and delivered by others is a key concept.

There was a full discussion in Common Wheel's client consultation exercise about various models of self-help groups and how they can help in other recovery focussed situations (e.g. A.A., Gamblers Anonymous etc) but it was felt that there would not be sufficient demand/need for a wide network of mental health specific 'affinity groups' or organisations and that people should be encouraged to use existing community resources for social, educational and recreational purposes.

Whilst organised 'affinity groups' may only suit a minority, having the opportunity to partner others or 'buddy up' to support each other's recovery was supported as a useful approach. Having more control over their life, lifestyle and care-plan is prominent in the views of most service users. Care and support strategies should be focused on what people want and not what well-meaning professionals think that they want. Wide and easy access to one-to-one peer-support was felt to be an important aspect in helping people to understand what has worked for others who have a lived experience of mental ill-health, thereby helping them to plot their own recovery journey and make choices in this regard.

Services should not be paternalistic. People should be allowed to take risks and learn from the experience where they have the capacity to do so. Paternalistic services tend to be risk-averse; they erode self-esteem, disempower people and stifle personal growth

b) Activity outside normal hours

There was a general consensus that there was an over-concentration of group/work sessions that occur Monday-Friday during the day and there needed to be a mix of activities in the evening, at weekends and public holidays.

c) Activities/ Work/Employment

The importance of meaningful activity in the promotion of mental health recovery is well documented in the literature (Goldberg et al 2008[2]); (Mee et al 2004[3]); (Rebeiro K.L. 1998[4]). People's lives can only have a sense of purpose if they have opportunities to have social contact and be involved in meaningful activities, whether they are fitness orientated, recreational, educational or vocational. In this regard the value of extending care and support services beyond traditional boundaries cannot be underestimated. Employment and meaningful activity affords most people the opportunity to regain a positive identity, including a sense of purpose and value.

There was general agreement within the Common Wheel discussions that having a regular place to attend for social/recreational/vocational purposes on a weekly/daily basis for a purpose other than discussing mental health issues was valuable. It was agreed that such opportunities should be available at weekends and evenings.

Having real training and employment opportunities are essential in promoting self-esteem and recovery. Training programmes should lead to real jobs whenever practicable. Dead end programmes can lead to frustration and erode hope.

Having 'mental health aware' employers can play a significant role in helping people to obtain, and stay in, work. It was suggested that perhaps some form of national accreditation scheme could be set up to encourage employers to become more mental health aware and to take on people who are living with mental health problems. (see also under 'Stigma' below)

d) Information

There was discussion on how people might find or collect information about support services. The over-dependence on internet based information was noted and was felt to be unhelpful to many who do not use, understand or have access to the necessary information technology.

Having access to information is critical. This might be information about effective treatments and best practice, medication, alternative therapies, healthy lifestyles, the Mental Health Act or information about local or national resources which might support people to engage with services and offer advice.

e) Stigma

While everyone in the Common Wheel discussion groups had heard of the '*See me*' campaign nobody was clear of its role other than as a media promotion. There was a long discussion on how mental health conditions were perceived by employers who might be more used to dealing with physical disability. Improved employer education/training and accreditation to promote mental health awareness and tolerance was considered a key factor in the provision of meaningful employment opportunities. Whether quotas or financial incentives should be given to employers to employ adults suffering from mental health problems was discussed but no consensus was reached.

The role of the media and how it frequently portrays people with mental health problems negatively was felt to be a significant factor in sustaining stigmatising behaviours and attitudes among the general population and therefore needs to be tackled.

2. Music intervention

The charity has developed its approach over the last decade and entered into a partnership with Glasgow Caledonian University in research to establish the impact our activity has on service users. This joint work has allowed us to look at the effects of musical participation on particular population groups with mental health problems. This academic evaluation of our activity is considered a crucial part of our organisation.

a) Dementia

Our evaluation within our specialist dementia service has shown that participating in our music activities can enhance wellbeing, engagement and socialisation in older people, as well as helping to create a positive atmosphere in residential care settings, and proving opportunities for people to express themselves and develop and maintain skills. We have adopted approaches that extend beyond traditional boundaries of service delivery.

We currently run weekly sessions in seven care homes across Greater Glasgow and three psychiatric wards in Gartnavel Royal Hospital, as well as collaborating with Alzheimer Scotland in a pilot project to provide music sessions for people with dementia in their own homes.

The lack of purposeful activity on hospital wards for people with dementia to engage with is a significant problem. This lack of stimulation leads to agitation and challenging behaviour which results in excessive staff time primarily focused on 'control'.

A full and appropriate activity programme should be on offer for patients with dementia in institutional care. Agencies that do not provide such stimulation should be considered to be failing the person with dementia and their right to physically, psychologically and emotionally engage with family and fellow patients. We consider offering a 'non-active' environment can lead to de-skilling people with dementia and aggravating their care needs.

'24 hour' institutions need to give higher priority to personal stimulation for patients in their daily and weekly routine. The evaluation of our work and its impact, show music is an effective tool in such settings.

b) Research

There has been previous research in the field of music and its effect on mental health such as studies looking at the effect of music therapy on patients with dementia[5] or the effects of music listening in depression[6]. We consider there is a need for sustained research that measures the effects of musical participation on individuals and its impact on different types of psychosis.

Our previous work has provided evidence that a structured music programme involving participants with mental health problems can lead to health benefits. The first preparatory study looked at patients with dementia using the Mini Mental State Examination and The Communication and Assessment profile[7] to investigate the effects of musical participation on cognitive functioning. This study suggested that cognitive functioning improved in the experimental group who took part in music activities but remained unchanged in the control group who did not.

3) Conclusion

Common Wheel's experience and input from our users and partner groups suggest the proposed strategy does not place sufficient emphasis on certain factors crucial to mental health recovery (adequate housing, meaningful employment, being able to pursue personal hobbies and interests, development of a social network) and overly focuses on the stabilisation of medication and symptom interference element.

References:

1. The Scottish Government. Delivering for Mental Health. Edinburgh 2006.
2. Goldberg, B., Brintnell, S., & Goldberg, J. (2008). The relationship between engagement in meaningful activities and quality of life in persons disabled by mental illness. *Occupational Therapy in Mental Health, 18*(2), 17-44.
3. Mee, J., Sumsion, T., & Craik, C. (2004). Mental health clients confirm the value of occupation in building competence and self identity. *British Journal of Occupational Therapy, 67*(5), 225-233.
4. Rebeiro, K. L. (1998). Occupation as means to mental health: A review of the literature, and a call for research. *Canadian Journal of Occupational Therapy, 65*(1), 12-18.
5. Aldridge, D. (1998). Music Therapy and the Treatment of Alzheimer's disease. Journal of Clinical Geropsychology, 4, 17-30.
6. Lai, Y. Effects of Music Listening on Depressed Women in Taiwan. Issues in mental Health Nursing, 20, 229-246.
7. Van Der Gaag The communication assessment profile for adults with a mental handicap. Speech Profiles Ltd, London. 1988