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.

Third Sector

There is little commitment to developing mental health and well-being across all ages, nor consideration given to the role of community mental health services (third sector). What is critical here is the importance of the localism agenda and how national mental health policy translates into practice within local communities, particulariy in terms of planning and designing local services, effective delivery, review and evaluation, and how resources are shared and used.

It remains the case that there is nothing more than lip service given to the inclusion of local third sector mental health organisations in the strategic planning of local mental health services – this remains with local health boards and local councils. Moreover, there is inconsistency across Scotland about how these structures may exist, or not, and how they reflect a true working partnership. It is important to note that whilst not perfect, there is much to commend the approach of the Reshaping the Care of Older People programme as local funding from Scottish Government is dependent on partnership working and is predicated ori commitments between NHS Health Boards, local authorities and the relatively new third sector interfaces.

Mental health in later life

There is little understanding of mental health in later life as this is largely seen in terms of dementia for which there is already a robust strategy and funding. The strategy dismisses how older people's mental health and well-being is not taken into account, particularly within primary care where there is stilt a predominance of ageist attitudes and practices by health care professionals. Too little is done to record older people experiencing depression, and too few older people are referred for psychological therapies.

Community mental health services operate distinct age capping demonstrating how difficult it is for people to transition from, for example, children & young people's services to adult services (these are mostly capped at the age of 65) – and in few cases it may be possible to retain people over 65, as long as they are already receiving a service. Potentially, this could be as a result of 1. How local services are organised, and 2. How funding is allocated. These features surely serve to undermine the work of the Reshaping the Care of Older People through the Change Fund – again, it demonstrates poor synergy between health areas.

Mainstreaming of mental health

"*Without mental health what have you got? It underpins everything*" Female, Stirling (Action in Mind/SAMH consultation).

It is critical that mental health is recognised in its own right, but equally that it is mainstreamed across all health – 'no health without mental health', and that it interfaces with other policy areas which have a clear impact on mental health and well-being, for example, poverty; unemployment or threat of unemployment; housing; equality discrimination and so forth. Often, it is the local third sector community mental health services which recognise the importance of taking such factors into account when supporting service users, and which often report that there is poor integration and partnership working between housing and mental health. For example the removal of ring fencing for Supporting People means that more people experiencing mental ill-health are at risk of homelessness. Third sector mental health organisations often are the catalysts for seeking better integration between different policy areas that would then produce better outcomes for service users.

Leadership is required within Scottish Government to follow through its guiding principle of mainstreaming equality.

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.

Local third sector mental health associations have extensive experience, many for more than 25 years, of delivering community merital health services. However, until the establishment of the Scottish Mental Health Cooperative (SMHC) there has not been a mechanism for bringing the majority of these local mental health associations together – where there is now the potential for sharing knowledge, experierice and resources.

The SMHC is unique because members:-

- Have close working relationships with their local authorities, health boards and have a good overview of the third sector;
- Adopt a person-centred approach and many provide a range of community mental health services within a mental health recovery model;
- Represent hundreds of staff working in mental health;
- Support thousands of service-users and have substantial potential to develop the service-user voice;
- Have increased opportunities for partnership working, across geographical

boundaries, and for transferring good practice.

It is our contention that Scottish Government need to engage more meaningfully with local merital health associations and recognise the potential that can be developed to support national policy within local communities. This does however require a much clearly defined and integrated approach to mental health in partnership with local authorities and heath boards.

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.

Questibri 2: Iri these situations, we are keen tp get your views on what needs to hapoen next to deyelpp a better undierstanding pf what changes would deliver better outcomes.

Mental health and well-being in later life is pooriy represented, other than through the staunch work undertaken in relation to dementia. As one of the key areas within TAMFS – there are clear recommendations from the working group that should be taken fonward. There is little evidence of how mental health is integral to the Reshaping the Care of Older People and Change Plan programme – an indication of poor synergy between two policy areas and more importantly joint working between health and social care.

For older people

- Better recognition of depression in later life for people living in the community, and also in residential and nursing care
- Improved access to psychological services
- Community merital support services
- Parity between physical and mental health
- Training for GPs on mental health in later life
- Review of 'old age psychiatry' – perhaps we need to review health attitudes towards ageing and older people – the clue lies in the name.

Transition across mental health services

Access to mental health services is not seamless due to chronological age as evidenced within the NHS and also determined by community mental health service contracts where young people's services are capped at 18 (they may not have required a mental health diagnosis), but find that if they need continued support, such as befriending, they need to be referred and to have a mental health diagnosis. Similariy, a service user reaching the age of 65 may find that they cannot continue to receive the same service simply because of their chronological age.

There are too few community mental health suppbrt seryices for older people, and too few counselling services for young people.

Rurality
Action in Mind works across Stiriingshire which has many rural and remote communities. Access to any services, for many, is difficult because of the dependency on personal transport. While many mental health service users have the free bus pass, this is not particularly helpful when buses are infrequent and community mental services too few.

Action in Mind operates a rural access service from Stirling – we are looking to see how we may make this service more time effective by locating the worker in rural communities, but accessing local premises such as local health centres cap be difficult because of heavy demands by other community organisations. **O**ther locations such as libraries, church halls are not suitable.

We have also begun to look at how we introduce skype in our work seeing this as a helpful way of supporting service users (we can only use this with those already accessirig the internet and with their own computers) in these communities, and as winters can be highly unpredictable ensuring continuity of service is critical.

There is an inherent need to support community mental health services such as ours to work more effectively, reducing both time and travel costs, while enabling service users tp access good mental health support.

Inequality of access to mental health support for people living in rural and remote communities needs to be addressed as a matter of urgency.
The strategy should explicitly cover this area for development with consideration given to new resources and funding to support community mental health development; use of telehealth and telecare to augment person to person support, and development of telephone helplines.

These are all areas we have considered but have found we are making little progress so far.

Outcome **1: P**eople 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?

Reducing self harm and suicide prevention should be supported through appropriate resources, and monitored through the suicide prevention strategy. However, it is critical that nationally, and locally, we promote actions that are relevant and targeted to those at greatest risk. For example, self harm is common amongst young people and we need to develop good information and support services that have meaning and relevance for young people at risk, arid their peers. Developing peer support within local schools and youth settings would be a significant step forward in contributing to national strategies such as Choose Life, for example. From a recent consultation with yourig LGBT people it was suggested that mental health should be better represented within health and social subjects.

The strategy must address the impact of homophobia and racism on young pepple as this compromises positive mental health and can lead to self harm and suicide, for some.

Community mental health services need additional support when dealing with people who self harm as this may not have been disclosed at the time of referral, and referrers need to share information when referring their clients/patients.

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

There is much need to promote positive mental health amongst the general population whilst recognising that mental ill health is not so uncommon but can affect anyone – for example anxiety and depression which can be recognised as related to socio-economic conditions.

There is evidently a need to develop better outreach and engagement with the families, friends and colleagues of people who are experiencing, or have experienced mental ill-health to speak out in support of better understanding of mental health. For example, Action in Mind is developing a Mental Health Supporters' Scheme which seeks to bring such individuals, groups and communities into our organisation where we would promote training and suppbrt to engage people as mental health champions, service volunteers, fundraisers and which would directly involve service users (through capacity building) believing this to be an integral part of mental health recovery. Any sustainable reduction of stigma and discrimination must be driven from the grassroots where there is greater chance of changing the hearts and minds of people.

The **W**orkplace

There is a desperate need to engage Scottish businesses with the mental health agenda which would realise better understanding and response to employees at risk of, or experiencing mental ill-health whether this is work related, or not.

Employers need to be supported to develop mental health policies that reflect not only the promotion of positive mental health, but also workplace adjustment to support employees at work, or their re-engagement.

Action in Mind, as a partner tp the Scottish Pariiament's Community Partnerships Programme (2011-2012) has proactlvely sought to work with local employers across Stiriingshire to raise mental health in the workplace.

We shall shortly be publishing our employers' guide based on our work with local employers across Stiriing that includes our findings and a number of local case studies.

We do however note how difficult it is to engage the private sector in mental health which may be attributed to many reasons, some practical and others where there is clearly no wish to be identified less there is or has been some experience of one or more employees with mental ill-health; this leads us to believe that there remains a strong undercurrent of stigma attached to mental health within the workplace. Staff absenteeism due to rnental ill-health is costly to the individual business affecting the overall Scottish economy, costly to the NHS and costly to individuals affected who may lose their jobs and then find it difficult to re-engage with employment.

It is imperative that there is better working between health and Scottish business in relatiori to mental health by offering good guidance and support. When undertaken as a national strategy and approach, the pubic sector and larger private employers, as well as smaller local businesses, will benefit thereby reducing stigma.

As witnessed in recent months in the national media, notable sports personalities have presented themselves with mental health problems and in one case, suicide. These reported cases haye, in the main, been gender based – mainly men, which further begs the question about how do we address the fear of stigma within the male population?

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?

Not withstanding the progress that see me may have made in addressing stigma, what is not clear from this question is 'whose services' need to be engaged to address discrimination. Injections of small grants to successful local organisations do not necessarily lead to sustained reduction of stigma or discrimination of mental health.

Fundamentally, this is an institutionalised condition and needs to be tackled head on with leadership from Scottish Government. It falls within the disability characteristic of the Equalities Act 2010, and as such should be afforded the same degree of recognition as physical disability. Whilst equality legislation is not within the jurisdiction of the Scottish Pariiament, the Scottish Government can act on promoting equality for people at risk, experiencing or recovering from mental ill health, including the Scottish business sector.

"If you have lost a leg or something that is more acceptable (than having a mental health problem)." Support Worker, Stiriing (Action in Mind/SAMH consultation).

"I was actually quite good at my job but they said to my face that didn't want anybody working there who had been in a psychiatric hospital." Stiriing (Action in Mind/SAMH consultation).

The **M**edia

"The media can be useful if it (mental health) is portrayed accurately. But it is the headlines that tend to lead to perpetuating stigma". Support Worker, Stiriing (Action in Mind/SAMH consultation).

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

Health promotion (local health boards) and mental health should be strategically focussed within local health centres and workplaces through public campaigns. We must counter some professional attitudes that prevail which suggest that raising awareness of mental health can increase public expectations about service availability. This attitude fails to take into account that people do wish to help themselves, more people than not, may not wish to speak to health workers, rather having better access to information about where to go for appropriate support – this

particularly applies to people with mild to moderate mental health conditions and for whom stress control management, for example may be a stepping stone towards maintaining good mental health.

Public campaigns encouraging general health and well-being have a focus on initiatives to develop good physical health through taking up sport-type activities - walking, for example perhaps we need to redesign these messages by integrating positive messages of mental health for men and women. It can be argued that mental well-being has in many respects been rooted in alternative psychological therapies which could be interpreted as self-indulgent and suited to certain types of individuals or groups. As indicated earlier, we need to mainstream mental health demonstrating that mental health affects everyone and that we need to invest in everyone's mental health.

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?

There needs to be better integration with education services, and with family support workers, and the third sector who support children and young pepple through irldividual and group services.

It is important that we continue to refrain from labelling children and young people too early on recognising how difficult it is to shake that label later. It is important that consideration is given to how we use language when treating children and young people lest they build a self-image and confirmation of their identity because of a mental health condition. This is important for health workers, but also for people working in education, whether guidance or support staff. Moreover, staff in educational establishments would benefit from mental health training, particularly because they will be dealing with children and young people's behaviour in the classroom which may be symptomatic of underlying mental health factors.

Question 8: What additibnal natipnal support do NHS Boards need to support implementation bf 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?

"*Things like the mental health first aid treatment and ASSIST training are very useful. Although they are really good not enough average members of the public know about them*". Support Worker, Stirling (Action in Mind/SAMH consultation)

Increasing public information is essential if more people are to take preventative steps to reduce conditions such as stress, anxiety and depression. Nonetheless, for fear of labelling, people may be reluctant to approach health workers, although for many their local GP may well be the person they seek support from.

Giving people choice and options about what support services may be available, without the concomitant mental health labelling, through active listening may lead people to developing and improving their own coping strategies.

"*You have to give people choices. What works for some people does not work for somebody else*". Support Worker, Stirling (Action in Mind/SAMH consultation).

"*I spoke to a psychotherapist and just some of the simple coping strategies he gave me were brilliant*". Female, Stirling (Action in Mind/SAMH).

As previously indicated, many local community mental health service providers are not able to accept self referrals nor referrals from other third sector organisations; this reinforces barriers to accessing early intervention of mental health support.

We need to find a good balance of increasing the use of psychological therapies, particularly by people who may initially be sceptical of such interventions, which permits self-referrals and which can be delivered locally, ideally in non-health settings.

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

Local community mental health service providers are commissioned and/or committed to service contracts that determine sources of referral, namely health and social care. On the one hand, it is understandable that we need to be focussed on key referrers who are able to make a health assessment and then refer to the most appropriate service, on the other hand, this means that we cannot accept self-referrals. In other words, we can only accept referrals that have a formal mental health diagnosis with the exception of children and young people up to the age of 18.

This creates barriers and delays for people seeking and accessing appropriate mental health support. We can see how important mental health information is for signposting people to mental health support, but the issue remains, adults require formal health and social care referral whereas they may find it easier to speak with mental health workers in non-health settings.

Stigma of mental health is still a considerable barrier to people seeking help and we have to find ways of describing conditions such as stress, anxiety and depression as acceptable, often they may arise of one or more personal factors. Individuals may feel embarrassment, loss of self-control and so forth, we need to address a culture that, for the best part, still finds it difficult to consider mental health as a fact of life.

"I think it needs to become easier for people to say 'I'm struggling, I can't cope'. That can sometimes prevent people coming forward". Support Worker, Stirling (Action in Mind/SAMH consultation).

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?

Where there are already day resources for referred service-users, it should be that there is better understanding of the need for off-the-street information and support services for people who would rather seek help informally in the first instance at least, particulariy for first-time users. Third sector mental heath organisations will already, in large part, provide this informal support to individuals on a one-off basis fulfilling an important role in eariy intervention, but this can be labour intensive and needs suitable resourcing.

We do need to recognise that our work practices are largely regulated by employment conditions, namely a 9am – 5pm regime, thereafter we operate emergency cover. We need to develop more responsive approaches which make it easier for people to access mental health support, not necessarily because they are in crisis, but because people work, have caring responsibilities etc. and their needs might be better served in the evenings or at weekends. This approach will necessitate different means of delivering support – through telephone helplines such as Breathing Space and Samaritans, but for seryice users already using services, we also need to ensure that we have at our disposal a range of options which build on the person to person support already in place. However, service contracts specify client hours in terms of 'in-person' support, but we equally spend time speaking with service-users on the telephone whb need reassurance from time to time but not necessarily to meet in person. This does not impede quality of service but rather enhances the support within a mental health recovery approach

As a community mental service provider, we may find ourselves faced with a service-user in crisis and/or someone that is vulnerable and may be subjected to abuse or harm by others. In these situations, we need to ensure that we can access the most appropriate staff within statutory services to ensure the service user's immediate needs are addressed and, if required, they are placed in a safe environment

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?

See Question 2 re Rurality. Decentralising services wpuld enable more people to access mental health support seryices, particularly for those in rural and remote communities, thereby reducing travel time and costs for staff.

How we monitor arid report service-user information for funders needs to be reviewed as smaller third sector mental health organisations may not have the best systems for collating required data, nqr the electronic means for service-user client files. We need to ensure that where such data is required by statutory services, health and social care that the third sector community mental health services are able to access, and have the appropriate hardware and software available to them. Manual handling of data is labour intensive and can lead to increased errors.

From our own experience, we cannot accept referrals electronically because we do not have the means available to accept these securely. This leads, in many cases, to pooriy written referrals and demands more time in seeking clarity from the original referrer and which can then delay assessment for mental health support.

Questiori 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?

We need to build into the service support regular consultation and feedback from service users about their experiences at different stages of accessing and receiving the mental health support. Goal planning and care management encourages service reviews within a mental health recovery or self-management approach. The approach is person-centred - it is that person's mental health that is important and their experiences can inform ahy changes to the service overall which may benefit others. In other words, service design and delivery is best judged from the perspective of the service user as they use the service – it provides a mutually beneficial interaction between the service user and the worker.

There is merit in organised service-user feedback through discussion or focus groups but we need to ensure that there is good capacity building for such groups to give good quality responses and that the process is self-empowering for the individuals involved. When conducting mental health consultations we should ensure that we produce the materials in easily digested formats which do not undermine the capabilities of non-health people ie the general public so that they would wish to contribute.

We should be cautious that service user engagement does not attempt to be representative of all service-users, and also that we treat this as part of a mental health recovery programme for those continuing to use mental health support services ie it can be a cathartic process. When speaking from personal experience within group situations, the group facilitator must respect the confidentiality of what is being imparted but also manage this sensitively.

Not all mental health service users wish to engage in such activities, particulariy when they are now in mental health recovery. I am mindful of a person who as a transgendered woman said that, 'transgendered people may not wish to discuss transgender further as they are now where they would wish to be'. The same could be said about mental health service users.

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

Building trust and honesty is essential betweeri all parties thereby ensuring that the person experiencing mental ill-health receives the most appropriate support; that there is common understanding by everyone of their respective roles, and that the needs of families and carers are all taken into account.

While good information should be available to service users, families and carers by multiple means – the most critical tool is service management. This is predicated on good communication and person-centred care planning that is developed with the service-user, and includes families and carers. Having an identified key worker is important – to manage and monitor the support service ensuring that case reviews are held at regular intervals and personal outcomes appraised.

What service-users value the most is being treated as individuals, possessed of their own hopes and aspirations and seeking tp achieve positive mental health outcomes or self-management in order to lead a good quality of life. This is the fundamental of any service support provision

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

Through effective monitoring and reporting of approaches which are outcomes focused and person-centred.

As a small local community mental health provider, we can demonstrate personal outcomes for our service users – from the person who was at rock bottom and who has now managed to sustain his employment and is enjoying his life to the person whose self-confidence was severely diminished through discrimination at work suffering depression as a consequence, and who has not worked for many years, speaking publicly about the importance of good mental health in the workplace.

Mental health recovery is a slow trajectory and can incur relapses in the process, but with the right consistent support people can continue to rhake improvement.

Mental health recovery is an individual process – unlike the prognosis of physical health which can, in the main, be calculated tpo some degree, we support person-centred, personal outcome approaches but we are also mindful of the growing demand by funders to see that people are 'moved on' lest they become service dependent.

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

Comments

Question 18: How can the Seottish 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.

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

See Question 15. Through care planning and management, regular seryice reviews and information sharing. Recognising that families and carers can also reach breaking point is critical for their own mental health and well-being, also when there are children or young people who may be affected by this experience.

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?

This is not solely about information but rather about building up good trusting relationships with families and carers (see Question 15). Staff would benefit from training in working with families in crisis, and case management.

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?

The agenda is focused on moving people away from inpatient services to the

community, and it is unclear to me how we measure 'balance' in this context.

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 pf services?

There is a huge amount of work to be done within equality groups, particularly BME and LGBT communities where stigma of mental health is high and/or mental health awareness/ support is underdeveloped.

Action in Mind is now completing a short project ' With *L*GBT *in Mi*nd' and one of the singularly important findings is how important an LGBT infrastructure is to developing not only social networks but, in particular, social support. What social networks exist, with the exception of support from LGBT Youth Scptlarld and both Clackmannanshire and Stirlingshire councils for young people, these are largely unfunded grassroots initiatives that are self-help and dependent on mutual support. Their fragility is that they are dependent on one or two people usually to keep the momentum going.

We take our responsibilities in pursuing equality of outcomes serlously, and from this work we will be oetter informed about how we can make our services more responsive to equality groups.

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

The Scottish Government could perhaps utilise the expertise of both their Equalities Unit, and the Equality and Human Rights Commission (EHRC) based in Glasgow, to disseminate good practice in making services accessible to equality groups.

Where Scottish Government has funded mental heath demonstrator projects eg LGBT it would be helpful to disseminate findings nationally to support similar initiatives locally.

Why not ask the third sector local mental heath service providers?

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

- Mental health within refugee communities;
- Postnatal depression;
- Looked after children;
- Dual diagnosis;
- Prlsoners;
- LGBT and mental health;
- BME community and mental health;
- Mental health in rural communities;
- Telehealth and telecare for mental health.

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?

- Long term physical health conditions and mental health;
- Mental health and domestic abuse;
- Health inequalities and mental health;
- Equalities and mental health.

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?

Action in Mind is currently negotiating with Glasgow Caledonian University to establish a student counselling placement service. We appreciate the need for students to access practice hours as part of their training, but equally we feel we benefit because we can offer this provision thereby creating a good partnership as well as reducing our waiting times for counselling.

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.

Questipn 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?

Health boards and local authorities are already bound by public duties across a range of legislation from mental health, equalities, children and adult support and protection, for example. It is their responsibility to ensure that they comply fully and can demonstrate that they meet their requirements when discharging their service roles and functions.

All staff should be familiar with the legal requirements when delivering services. Services should be monitored to ensure that there is equitable access across all individuals and communities. Where there is evidence of low referral or access, this needs to be reported and actions taken to increase uptake, where required. Similarly, in addressing inequalities it is critical that different approaches are adopted to ensure that targeting is suited to the groups in question.