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.

SAMH is pleased to have the opportunity to respond to this consultation. In recent years, mental health policy in Scotland has been directed by Delivering for Mental Health (2006) and Towards a Mentally Flourishing Scotland (2009). Both strategies are concluding in their targets and proposals, which is why SAMH campaigned for a new strategy for mental health ahead of the Scottish Parliament election in 2011, and produced the Foundation Stone: Ten Steps To a Strategy for Scotland's Mental Health.

The early publication of this consultation so soon after the May 2011 elections is welcome and demonstrates the Scottish Government's commitment to mental health. Indeed, there are many programmes across Government which are separately improving the mental health of people in Scotland: early parenting; the alcohol framework; personalisation and self-directed support; the integration of health and social care; the NHS Quality strategy; attempts to increase self-management and physical activity; and the continued focus on poverty, homelessness and substance misuse. We hope that the forthcoming strategy will bring these strands together to place a spotlight on mental health across Government and improve mental health across the country.

We also applaud the consensual approach taken by all parties within the Scottish Parliament, which unanimously passed an amended Scottish Government motion in September 2011 on the forthcoming mental health strategy. Specifically, the Parliament resolved that "in moving forward, greater personalisation, better joint working and a focus on prevention and mental wellbeing are key to achieving better, more efficient services." SAMH agrees strongly with this resolution and has sought to make suggestions throughout this response which will shape the strategy in line with the Scottish Parliament's resolution.

SAMH believes that the 14 outcomes can be supported. However, we think there are some gaps in the planned actions and a lack of an overall strategic direction which make, the consultation document more of an action plan than a strategy. Our response will set out our thinking in detail. In particular, as the draft strategy makes no reference to the 1997 Framework for Mental Health Services in Scotland[1], we are unclear whether this new strategy replaces or simply adds to it. If the former, then we believe that this draft strategy needs to be further thought through and expanded in order to meet the recommendations of the World Health Organisation, which states,

"The most important step towards providing well-considered and comprehensive mental health care is the drafting of a policy and a plan that will guide mental health system and services

[1] Framework for Mental Health Services in Scotland, Scottish Executive, 1997

development. A mental health policy is an official statement by a government or health authority that provides the overall direction for mental health by defining the vision, values, principles, and objectives, and establishes a broad model for action to achieve that vision".[2]

While there are many excellent actions within this draft strategy, there is no sense of an overall vision or strategic direction to guide systems and services development. Overall, we suggest that the strategic direction on mental health in Scotland should be to focus care within primary and community care wherever possible, and to shift to an approach based on prevention and integration between sectors.

Preparing our response

SAMH sees this strategy as a major opportunity, so we have invested a lot of time in preparing our response. We have spoken to or heard from over 600 people about the strategy, through a web survey, joint conference with Holyrood Communications, focus groups, parliamentary reception and many meetings, as well as consideration from our Trustee Board and senior managers. A detailed breakdown of our consultation work is at Appendix A, and a complete list of our recommendations is at Appendix B. Throughout our response, we have included quotes from people who took part in our focus groups or responded to our survey, as it is their voices which we seek to represent.

We asked people who completed our survey and took part in our focus groups to rank their priorities for improving mental health in Scotland. The top five were:

1. Working to reduce waiting times for those accessing mental health services
2. Providing community services to support people dealing with a mental health problem
3. More education in schools and colleges to promote good mental health and tackle attitudes of stigma and discrimination
4. Reducing discrimination in the workplace and providing initiatives to help people with mental health problems enter work
5. A Government programme to promote healthy living and the importance of good mental health

The final word in this introductory statement goes to a respondent to our survey, who told us:

"You should tell the Government that we are part of the electorate, we are human beings and that and we can be of value to society".

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.

[2] Improving Health Systems and Services for Mental Health, World Health Organisation, 2009

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

The four priority areas identified for this strategy (improving access to psychological therapies, implementing the National Dementia Strategy, community, inpatient and crisis provision and preventing suicide) are all extremely important issues. As the draft strategy makes clear, it is important to prioritise, in recognition of the fact that we cannot achieve everything all at once.

For that reason, SAMH would suggest four changes at a national level. Firstly, there are many areas of current Scottish Government policy which could contribute to the outcomes set out in this strategy, but are not mentioned here. Throughout our response, we will suggest areas where cross-departmental working on existing policy areas would help to achieve this strategy's outcomes at little or no extra cost or would achieve a cost saving.

Secondly, while we support the outcomes in the strategy, we are deeply dismayed that the actions rest almost entirely within the NHS. The people we have spoken to during our consultation tell us that while health services are very important, finding work, attaining education and living in a community without prejudice are just as important to their mental health. These aims cannot be achieved by focusing solely on treatment targets and actions. The Scottish Government has influence beyond the NHS, from other governmental departments to non-departmental public bodies, local authorities and the voluntary sector. The strategy should be rewritten to harness the power of the whole public sector as well as the voluntary sector. The NHS Lothian Mental Health and Well-Being Strategy, A Sense of Belonging[3], provides an excellent model for a new mental health strategy for Scotland. Developed in partnership with the voluntary sector, carers, service users and local authorities, the strategy sets out priority actions across all areas of mental health, with identified roles for partners where appropriate.

Thirdly, while we welcome the recognition of the Dementia Strategy's importance to Scotland's health, we are concerned that its centrality to this strategy is likely to lead to confusion and perhaps even duplication. We would suggest that links should be made between the two strategies where applicable, but that the delivery of the Dementia Strategy should not be one of four priorities in this strategy. Rather, it is a priority in its own right. We have discussed this with Alzheimer Scotland, who are in agreement. We have made limited comments on dementia in our response but have had sight of the Alzheimer Scotland response, and endorse this.

Finally, we are disappointed that there is no mention of human rights in the strategy. In particular, we believe that the Scottish Government should act on the 2009 recommendations of the UN Committee on Economic, Social and Cultural Rights, in particular that the Scottish and UK Governments should "*address, as a matter of priority, the... regressive measures taken in funding mental health services*".

Improvement Challenge Type 2

[3] A Sense of Belonging, A Joint Strategy for Improving the Mental Health and Wellbeing of Lothian's Population 2011-16, Lothian Joint Mental Health and Wellbeing Strategy Programme Board, 2011

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.

Overall, the strategy needs to incorporate the findings of the Christie Commission on the Future Delivery of Public Services and the 2011 Scottish Government budget. The four key recommendations of the Christie Commission were that[4]:

1. Reforms must aim to empower individuals and communities receiving public services by involving them in the design and delivery of the services they use.

2. Public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve.

3. We must prioritise expenditure on public services which prevent negative outcomes from arising

4. And our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible.

Following this, the Scottish Government Spending Review 2011 and Draft Budget 2012-13 set a policy direction of implementing a shift to preventative spending[5].

In order to deliver better outcomes, the mental health strategy must shape services and programmes in accordance with this policy direction.

Trauma, for example, is an area where cross-sectoral work is crucial, as people who have experiences of trauma use many different services and are found in many different areas of the public sector. A consistent approach and understanding of trauma across not only health but also justice, social work and voluntary sector services will help to direct people to the right support quickly.

International approaches to trauma should be investigated. In the USA, the Substance Abuse and Mental Health Services Administration (SAMHSA) have eight separate initiatives on trauma, ranging from support directly to children and to families, to impacting on the healthcare pathway for all people[6]. SAMHSA funds the National Center for Trauma-Informed Care (NCTIC), which is a technical assistance centre dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programmes and services. Specifically, they are promoting the screening for trauma as a result of adverse childhood experiences, just as clinicians across the world screen for physical diseases. This early identification means that early intervention can take place, routing people away from more acute services and improving the recovery journey. The expansion of existing trauma screening in Scotland and of existing services could well have

[4] Commission on the Future Delivery of Public Services, 2011
[5] Scottish Government Spending Review 2011 and Draft Budget 2012-13
[6] Leading Change: a Plan for SAMHSA's Roles and Actions 2011-2014

similar benefits.

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?

In Scotland, 781 people died by suicide in 2010. The Scottish Government has successfully reduced suicide rates since introducing its Choose Life strategy, but Choose Life ends in 2013. A strategy for suicide prevention work must continue beyond 2013.

Work must begin now to determine the follow-up to the Choose Life strategy. While much progress has been made, suicide rates continue to be persistently high, and research demonstrates an increased risk of suicide during recessions[7].

The Scottish Government must sustain its commitment to reduce suicide rates, and support work that targets those groups for whom previous campaigns have been less effective. Whilst suicide has an impact on all of Scotland's communities, statistics show that some age groups have a higher rate of suicide and deprived areas have up to twice the rate of suicide as the national average.[8] Research has shown that the suicide risk is raised for people experiencing virtually all mental health problems[9] and men are more likely to complete suicide than women[10].

SAMH welcomes the recent focus on training NHS staff in suicide prevention, but suicide affects whole communities and as such needs a response from the whole community, not just the healthcare sector. Short, straightforward training and information resources need to be immediately available to anyone who needs them: while the suicide prevention training available in Scotland is excellent, even a half-day course is not practical for some people.

There should be a focus on people within the community who come into regular contact with people under financial pressure and at greater risk of suicide. This includes CAB, Jobcentre Plus workers, employability workers, Victim Support, social workers, the police and taxi drivers. Equipping such groups with the confidence and ability to discuss suicide would increase the chances of people finding support when they need it. This is the work that SAMH's National Programme on Suicide Prevention aims to undertake, but this needs national and local support.

A major issue is the support that people receive when they attempt suicide or feel suicidal. At present, we hear from both the police and from individuals that there is no clear route to help. Too often, the police are left trying to find support for someone who has either been assessed as not having a psychiatric disorder and therefore not admittible to hospital, or who is under the influence of a substance and therefore cannot be assessed. It is not good enough to leave the police, who are often the only ones who will respond in such situations, to keep delivering

[7] Stack, S. (2000) Work and the economy.
[8] Refreshing The National Strategy and Action Plan to Prevent Suicide in Scotland: Report of The National Suicide Prevention Working Group, 2010
[9] Harris, C, and Barraclough, B, (1997), "Suicide as an Outcome for Mental Disorders", British Journal of Psychiatry, 170, 205-28
[10] Refreshing The National Strategy and Action Plan to Prevent Suicide in Scotland: Report of The National Suicide Prevention Working Group, 2010

people to their families without any support, or to put people who are vulnerable and distressed into cells for their own safety following which they are released without referral to support or information / advice.

There are some emerging approaches which can help. An initiative in West Lothian, led by Lothian and Borders Police, sees people who have attempted suicide or self-harm not arrested but instead fast-tracked to hospital for a psychiatric assessment. This is working well in West Lothian because of good relations and local support, but the police think it is unlikely that it could be reproduced in places without these. This initiative was developed in response both to a frustration that the police are often the only agency which will respond in these circumstances, but also a clear message from the Procurator Fiscal that they do not want to see people being processed under breach of the peace for attempting suicide. A similar approach has been standard practice in Tayside for over four years.

Such initiatives are an improvement, but they do not address the underlying issues. Although people are being seen by the NHS more quickly, it remains likely that they will not be admitted to hospital and will either be returned to the cells, taken to a family member or taken home. We urgently require local NHS Health Boards, local authorities and the police to pool budgets to provide an effective and properly resourced crisis service which would allow people to be taken somewhere safe and non-threatening, and then listened to and directed to appropriate support. Such services are neither expensive nor complicated, but they are lacking across Scotland.

Suicide prevention spending by local authorities must become more transparent: local authorities must be able to evidence how they are supporting and financing initiatives to reduce suicide in their local areas. Those services which received funding via Choose Life should also be held accountable for how their money is spent against the national objectives.

Stigma against people who attempt suicide remains rife, which hinders improving awareness of suicide and discourages people from seeking help. This stigma is also found within the NHS. We must ensure that NHS staff are aware of and implement the principles in the Patients Rights Charter.

"I have tried (suicide) a lot of times over the years and self harmed. I don't get as many suicidal thoughts as I used to because I get a lot of support through my peer support group" Male, Greenock

"I went to the hospital and I went to the receptionist and said,"I am feeling suicidal can I see a doctor quite quickly". She said, "just wait in the queue". I sat there for fifty minutes and in that fifty minutes I could have gone to the window or walked away and done something" Female, Stirling

When people present at A&E, their physical symptoms will be addressed but usually there is no service in place to identify and meet emotional needs. There are many ways to address this: a crisis service near or in a hospital, a liaison nurse whose time is protected or a voluntary service that works with both the individual and family or friends could all be helpful. While there are resource implications to these approaches, we cannot continue to pour resources into dealing with crisis after crisis, rather than taking the time to listen to people and provide them with proper support when they seek it, thus implementing the prevention-focused approach recommended by Christie.

"I have heard colleagues in the health service say, God, we can't, [have?] another suicide attempt, can't they just pull themselves together". And that is from professional colleagues"

Support Worker, Stirling

Self-harm

'Self harm is an exercise in extreme restraint' Louis Pembroke, National Self Harm Network

SAMH understands the thinking behind placing self-harm and suicide prevention together, as self harming behaviour may indicate increased suicidal ideation. However, we strongly caution against approaching them both in the same way. Self-harm is not necessarily a suicide attempt and can be used by people as a coping strategy: as the Scottish Government's final report on responding to self-harm makes clear[11]. Taking away a person's means of self-harm can increase their emotional distress and ultimately make the situation worse.

In our focus groups, many service users spoke about the stigma they felt from NHS staff when they had self-harmed. Improved training and awareness should be delivered to NHS staff so that people who do self-harm are not made to feel worse by the people responsible for treating them. Links to reducing and helping people to manage their self-harm should be made explicit in Single Outcome Agreements and NHS targets and commitments

As the main source of information about self-harm in Scotland is currently hospital admission/discharge data, this should initially be used to measure progress and outcomes. However, this dataset must be expanded. A necessary first step is to start collating information about self-harm from a diverse range of agencies across all local authorities and sectors, since not everyone goes to hospital. Action SO8 in the Scottish Government's final report on responding to self-harm recognises the need to improve data collection but continues to limit this to hospitals. Opportunities to collect such data from schools, universities/colleges, prisons, care homes and the voluntary sector should also be explored.

We need more information about the type of support being requested by people who self-harm, and the effectiveness of the advice and support being offered and taken up. Regular engagement and consultation with people who self-harm and service providers would help offer insight into the awareness of self-harm and the available supports.

Specific responses to self-harm will also need to be accompanied by other forms of support to help address the underlying causes, such as mental health problems, homelessness, and unemployment, without which any response will be less successful and meaningful. A purely clinical response will be less effective and possibly counterproductive.

The NICE National Clinical Practice Guideline No. 16 on the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care[12] provides a thorough and well-researched approach to managing and preventing self-harm, including the need for psychological interventions. This guideline should be referred to when developing Scotland's approach.

The Scottish Public Services Ombudsman has made helpful suggestions on responding to self-harm, notably in a report following the death by suicide of a man in Tayside[13]. Some of these recommendations are relevant to other Boards and should be implemented across

[11] Responding to Self-Harm in Scotland Final Report, Scottish Government, March 2011

[12] NICE National Clinical Practice Guideline No. 16 on the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, 2004

[13] Case 201003783: Tayside NHS Board, Scottish Public Services Ombudsman

Scotland, specifically that Boards should "make the use and review of the risk screening tool to complement and inform the risk assessment process mandatory for all patient assessments following a self-harm / suicide attempt".

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

"I have seen people I know on the other side of the street, people I knew from school and they totally ignore you" (Male, Greenock)

Stigma was a key concern for the people we spoke to. The words most frequently used were "rejection, lonely, isolation", and it was clear that isolation was, for many people, the biggest challenge. As well as continuing media and education work to reduce stigma, we must take steps to help people with mental health problems to be a part of a community. Local authorities may be best placed to lead on this, given their Section 26 responsibility under the Mental Health (Care and Treatment) (Scotland) Act 2003 to provide services which promote the wellbeing and social development of people with mental health problems. However, all public authorities have responsibilities here, given that including disabled people in public life is the principle that underpins the UN Convention on the Rights of Disabled People, to which the UK is a signatory.

At SAMH's conference with Holyrood Communications, our guest speaker Graham Morgan from HUG said:

"Stigma is of course a horrible thing and it is not often the blunt crude horror of abuse and harassment that is our daily reality, it is the awkwardness, the how to speak to her now, the worry that we will be overstressed, can't cope, the wince away from what is seen as failure. We need continued work on anti-stigma initiatives both locally and nationally. We need to celebrate the power of the direct testimony of people with experience of mental illness. We need to work with young people and employers. We need to influence the professionals who work with us and who may also have mental health problems and we need to look at the emotional literacy needs of the whole population, find ways of realising that mental health is an issue that affects us all whether we have an illness or not."[14]

Inclusion London and Glasgow Media Unit evidence[15] (2011) showed increasing levels of stigma against people with disabilities, both in the media and in the general public; the highest levels of stigma were against people with mental health problems and other 'invisible' and fluctuating conditions.

There are few positive stories about mental health in the media, and mental health clinicians SAMH spoke to pointed out that most stories were inaccurate and negative. The media should be encouraged to demonstrate that everyone has mental health, and how to stay well, rather than focusing on the negative. The Culture and External Affairs division within the Scottish Government should seek to promote these messages to broadcasters and throughout the media.

At SAMH focus groups, service users praised the "see me" campaign and felt the early impact

[14] Graham Morgan, Holyrood Conference on mental health, 17 November 2011
[15] Strathclyde Centre for Disability Research and Glasgow Media Unit, Bad News for Disabled People, 2011

of the campaign was helpful and positive. They also noted that it has become, from their point of view, less visible in recent years, and wanted more work done to combat stigma.

They suggested the employability of people with mental health problems should be a main focus for anti-stigma work. Research which SAMH will publish in March 2012 will show that employers still need support to understand how to address mental health in the workplace, and that stigma associated with mental health problems is still a serious issue at work. We will expand on these points in our answer to question 26.

The Equality Act 2010 makes discrimination against people with disabilities unlawful and places a duty on public authorities to advance equality of opportunity between people from different groups and foster good relations between people from different groups. There should be training to employers, service providers and staff in public authorities about how this applies to people with mental health problems.

"I contacted my old employer and said 'I'd really like to start working again just a few shifts as relief'. I knew they were really desperate for staff and they just fobbed me off. My friend still worked there and she told me they were desperate for staff so I knew it was stigma. It couldn't have been anything else." Female, Edinburgh

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?

"You lose people from your life because they don't know how to relate to you. They know what to say to somebody who has broken their leg but they don't know what to say to someone who has broken their head". Survey respondent

Our service users told us that families are often the first source of support that they look for, and if stigma is present, this can prevent them from seeking help or managing their condition. Working with the families and support networks of people with mental health problems to both learn from them and help them understand what is happening can make a major difference to a person's experience of illness.

People with disabilities are protected by the Offences (Aggravation by Prejudice) (Scotland) Act 2009, but since its enactment there have been few people charged or convicted on these grounds. This is disappointing, particularly as we know that people with mental health problems are eleven times more likely to be victims of crime than society as a whole[16]. Training is required for staff within the criminal justice sector to help them recognise hate crime on grounds of disability, especially in terms of mental health. Equalities data should be gathered when a crime is reported, and police and justice officials should pro-actively ask whether the crime was motivated by hatred on grounds of their disability, sexuality, race, or religion.

Building mental health into education is also an essential route to preventing stigma: we make some specific proposals on this in our response to question 7.

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

[16] Psychiatric news, Volume 40, No. 17, pp16, Levin 2005

The 'assets based approach' to improving health and wellbeing should be adopted, especially in the most deprived communities within Scotland, since this population is most at risk from mental health problems and has most to gain from using existing community-based assets to develop resilience.

In his annual report in 2010[17], Dr Harry Burns, Chief Medical Officer for Scotland, made the point that health promotion campaigns often do not reach those most in need of their messages, but that empowering individuals to control their lives and circumstances is health promoting. Nor is this solely rooted in the 'health' domain. As Dr Burns states, 'Individuals trying to build lives for themselves need access to affordable housing. They need access to good education for their children. They need to feel safe in their communities. They need the chance to lead healthy lives through access to opportunities for physical activity and to buy healthy food.'[18] Tackling these issues will have the result of promoting mental wellbeing for individuals and within communities. For this reason, the final mental health strategy **must** make links with departments and services beyond the NHS.

The UK Government's Foresight Project on Mental Capital and Wellbeing was set up to advise the Government on how to achieve the best possible mental development and mental wellbeing for everyone in the UK. It proposed "five ways to wellbeing"[19] for individuals that can be used to promote public understanding and engagement with mental health improvement. These could be promoted to individuals but also to Governmental departments other than health and to services and organisations across all sectors, to help them understand how they can encourage individuals to protect their own mental wellbeing. The five ways to wellbeing are summarised as:

Connect
Be active
Take notice
Keep learning
Give

One of the most fundamental ways in which we could improve Scotland's wellbeing is by tackling alcohol misuse. This remains a huge problem in Scotland, with serious implications for the nation's mental health and wellbeing. The link between alcohol use and suicide are clear – alcohol is used in over half of suicide attempts[20]. The mental health consequences of alcohol misuse are also severe. People with alcohol-use disorders are more likely to suffer from other mental health problems.[21] The Scottish Government already has a strong policy framework on alcohol[22]; but too often alcohol misuse and mental health problems are viewed and addressed separately. Linking these two strategies together to develop joint approaches is essential.

Preventative spending

The Reform Scotland report, Radical Scotland, points out that in 2008-09, less than 4 per cent of health expenditure across the UK was spent on prevention[23]. This simply sets us up for a continued cycle of poor health and high expenditure.

[17] Scottish Government, Annual Report of the Chief Medical Officer, 2011
[18] Scottish Government, Annual Report of the Chief Medical Officer, 2011
[19] Department for Business Innovation & Skills. Foresight Project on mental health and wellbeing. London.
[20] Scottish Government, Mental health in Scotland Closing the Gaps - making a difference, 2007
[21] Briefing produced for the WHO European Ministerial Conference on Mental Health, 2005
[22] Scottish Government, Changing Scotland's Relationship with Alcohol, 2009
[23] Radical Scotland, Confronting the challenges facing Scotland's public services, Laura Bunt and Michael Harris, with Ruth Puttick, 2010

The returns on this type of investment are clear: a few are outlined below[24].

- Programmes supporting family life (parenting/home learning environment/reading): **8: 1 return on investment**
- Supporting lifelong learning (health promoting schools and continuing education): **25-45:1 return on investment**
- Improving employment/ workplace: **up to 30% saving**
- The **Place2Be** individual and group school counselling services: **£6 return per £1 invested**

There is strong evidence that mental health improvement messages work: to promote positive mental health, prevent some mental health problems and improve the quality of life for people living with mental health problems[25]. Such messages will not improve mental health in isolation as mental health is shaped by social and economic circumstances, life events and physical health. However, the evidence shows that they can make a real difference, and should be implemented alongside the other recommendations in this report as part of the new mental health strategy. This also fits with the messages of the Christie Commission on public sector reform.

SAMH recommends that NHS Health Scotland is asked to lead the development of a mental health improvement campaign that can be delivered nationally, locally and in specific settings such as the workplace, schools and advice centres.

Participation in regular physical activity can promote good mental health, prevent mental ill health and improve the quality of life of people who experience mental health problems. Through Get Active, our National Programme on Sport and Physical Activity, we are seeing first-hand the benefits of this approach. An interim evaluation of this programme found that, of 1,000 people taking part in SAMH's exercise initiatives:

- 87 per cent felt more confident
- 95 per cent learned a new skill
- 84 per cent made new friends

In our focus group consultations with SAMH service users, exercise also came out as one of the main ways that people manage their mental health.

"I play Street Soccer once a week. That is brilliant for me. I feel really good after it. It gives me

[24] Taken from a presentation by Lynne Friedli, Improving mental health through a recession: ethics, equity, effectiveness and best buys, October 2010

[25] NHS Health Scotland, Friedli et al, Mental health improvement: evidence based messages to promote mental wellbeing, 2007

a reason for pushing myself". Female service user, Edinburgh

However, limited finances and stigma prevent some people from accessing gyms and using physical activity to improve their mental health[26]. SAMH recommends greater prescribing of exercise referral schemes, such as the 'green gym' approach taken by GPs in the Link Project in Drumchapel, Glasgow. This successfully encourages physical activity and provides a space where people with mental health problems can exercise without experiencing stigma.. The GPs at the Deep End project, a group of GPs working in the 100 most deprived areas of Scotland, also explicitly recommends that general practices make better use of non-medical community resources (social prescribing)[27]. In some universities in Scotland, counsellors are prescribing exercise as part of the National Union of Students' Healthy Bodies, Healthy Minds campaign. These are inexpensive, simple, interventions that meet the aims of several policy areas, and they should be prioritised.

"If you can get something positive out of the day that helps you when you are down at night time". (Female, Stirling)

Service users also told us that they use creative therapy – art therapy, drama therapy, poetry and music – as outlets and a release from their mental health problems. SAMH is concerned that despite the evidence base for this type of work[28], these services may be reduced or stopped altogether because of lack of funding. Their value in keeping people well, engaged in the community and active should not be underestimated.

"My husband tends to take me away out (if I am feeling down). He makes sure I am up, makes sure I take my medication and we just get away. We go up to Oban and places like that so my mind is on all the scenery" Female, Stirling

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 based our answer on the definition of Child and Adolescent Mental Health Services (CAMHS) provided by the Scottish Parliament Health and Sport Committee's 2009 report on the subject. This defines CAMHS as four tiers, beginning with universal services that are not staffed by mental health specialists, including GPs, teachers, social workers, voluntary services etc, and building to services for children and young people with severe mental health problems, and include specialist units and outpatient teams.[29]

We assume that this is the definition being used in this strategy, since clearly, acute NHS-

[26] SAMH Get Active survey, 2009
[27] GPs at the Deep End, Manifesto, 2011
[28] Matarasso, The place of arts and creativity in promoting community health 1997; Scher and Senior, the use of art works in clinical settings e.g. hospitals, 2000

[29] Scottish Parliament Health and Sport Committee, Inquiry into Child and Adolescent Mental Health Services, 2009

based services cannot by themselves deliver this outcome.

In line with the messages of the Christie Commission, prevention is better than cure. In order to improve the short and long term outcomes of children and young people, there should be a renewed focus on promoting mental wellbeing and information about mental health to everyone in society, especially those who are in contact with children and young people. There is a particular link to be made here with the Scottish Government's developing Parenting Strategy, as parents need to know about positive mental health and to understand their child's illness should they become unwell.

"If my parents had known as much about my condition when I was younger as they do now then things would have been much better. They would have realised that I wasn't just playing silly buggers" Male, Galashiels

Investment in tier 1 CAMHS, Promoting Knowledge and Understanding of Mental Health Issues amongst Universal Services, will ensure that children and young people get swift intervention and referral when necessary.

The SNAP (Scottish Needs Assessment Programme) report[30] stated that there was a lack of training in the wider non-specialist Tier 1 of CAMHS. As primary care workers and teachers will be among the first to see a child or adolescent as they begin to develop mental health problems, improving their training in mental health is crucial to ensure that early intervention can be made.

Teachers need support to deliver the new health and wellbeing outcomes in the Curriculum for Excellence, which includes mental health. There are already good training and CPD programmes for teachers on mental health, but there is no strategic approach to ensuring that teachers are exposed to these. Indeed, it is quite possible for a trainee teacher to go through their entire course with almost no discussion of mental health, and then upon qualification to be expected to deliver the health and wellbeing outcomes without any prior support. The mental health strategy should commit NHS Health Scotland to working with Education Scotland to embed training in mental health and wellbeing in both teacher training and CPD.

This recommendation was also made by the Scottish Parliament Health and Sport Committee in its 2009 inquiry, which concluded "The Committee urges the Scottish Government to examine again training needs in this area, in particular how mental health and well-being are covered in initial and continuing teacher training".[31]

We also recommend that health and nutrition inspectors should be be part of each school inspection team, rather than only some teams as is currently the case. This would help to make sure that the health and wellbeing outcomes in Curriculum for Excellence are given parity with the literacy and numeracy outcomes.

One in ten 5 to 15 year olds experiences a mental health problem.[32] The lifetime costs of a single case of untreated childhood conduct disorder are approximately £150,000[33]. Investment

[30] Public Health Institute of Scotland, Needs Assessment Report on Child and Adolescent Mental Health: Final report, 2003.

[31] Scottish Parliament Health and Sport Committee, Inquiry into Child and Adolescent Mental Health Services, 2009

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

in the mental health of children and young people must go beyond Child and Adolescent Mental Health Services (CAMHS), incorporating mental health in early years education, early intervention programmes for parents, and early years health visitors trained in mental health.

The strategy should also include incentives for local authorities to work together with NHS Boards and the voluntary sector to develop mental health improvement programmes. A key part of this should be to provide schools-based interventions which can quickly address emerging mental health problems without the (often counterproductive) need to remove the child from their environment. Schools-based programmes to prevent conduct disorder through social and emotional learning programmes have evaluated as among the most cost-effective programmes available, with an economic pay-off of £48.30 per £1 invested[34]. The draft strategy should prioritise such schools-based programmes, which have the potential to bring about generational change in both health and attitudes towards mental health.

In-school support, such as that provided by Place2Be, could play a valuable role in supporting teachers and providing counselling services for young people who need to access this help.

There is of course an existing policy framework which this strategy could usefully link to. As well as ensuring the implementation of the Framework for Children and Young People's Mental Health[35] by 2015, the strategy should meet the aims of Getting it Right for Every Child.

We would also refer back to our recommendations at question 2 on trauma, since trauma experienced in childhood is often at the root of mental health problems in later life.

We would like to see specific actions for early years in the strategy. The Scottish Government Early Years Framework is piloting Family Nurse Partnerships in Lothian and Tayside[36], which look set to have positive implications across several areas, including lower incidences of depression and anxiety among children and better maternal mental health. Creating links between mental health services and Family Nurse Partnerships could add value to the partnerships.

The Centre for Mental Health is also conducting a two-year research project into improving the life chances of vulnerable children as part of its Early Years Programme[37]. The strategy should be informed by the findings of this research.

A strategy for Scotland's mental health should include a focus on anti-bullying work. Being bullied at school has adverse effects on both psychological well-being and educational attainment. There is evidence from longitudinal data that this has a negative long-term impact on employability and earnings; on average, lifetime earnings of a victim of bullying are reduced by around £50,000.[38] Furthermore, on the limited evidence available, inexpensive anti-bullying

[33] Friedli, L. and Parsonage, M.: Mental health promotion: building an economic case. Northern Ireland Association for Mental Health, 2007

[34] Martin Knapp, David McDaid and Michael Parsonage, Mental health promotion and mental illness prevention: the economic case, 2011

[35] Scottish Government , Children and Young People's mental health: A framework for Promotion, Prevention and Care", 2005

[36] Scottish Government, The evaluation of Family Nurse Partnerships Phase 1 report, 2011

[37] Centre for Mental Health, Improving the Life Chances of Vulnerable Children, project outline April 2011

[38] Hummel S et al, University of Sheffield, Cost-effectiveness of Universal Interventions Which Aim to Promote Emotional and Social Well-being in Secondary Schools. ScHARR, 2009

interventions appear to offer good value for money on a long-term perspective, based on improved future earnings[39].The 24-month evaluation of respect*me,* the Scottish Government's anti-bullying service delivered by SAMH and LGBT Youth, demonstrated that local champions are crucial to ensuring that the implementation of their plans on bullying. Practice in this area is currently too patchy and responsibilities are not defined; this is the biggest hurdle to effectively tackling bullying. We recommend a named official within each local authority who will champion anti-bullying strategies to agencies including schools, childrens' services etc.

Improving access to CAMHS is important; improving the **quality** of CAMHS services is crucial. Embedding international children's rights within Scottish law is fundamental to a shift in the culture within the NHS and childrens' services delivered by local authorities. The Mental Health Strategy should have more than due regard for the UN Convention on the Rights of the Child. The four core principles of the Convention are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. The Convention protects children's rights by setting standards in health care; education; and legal, civil and social services. The draft strategy does not currently re-commit the Scottish Government to the target set in Delivering for Mental Health, to reduce by 50% the number of children and young people admitted to non-specialist wards. While we understand that the speciality of a ward is only one of a range of factors that should be considered alongside proximity to family, we believe that the Scottish Government should commit to achieving this target, to reduce the chances of a child or young person's education or welfare being harmed by inappropriate admissions.

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

A more ambitious target for access to CAMHS is needed to send a message to health boards that this is a priority. 26 weeks – six months – in the life of a child is simply not acceptable. As a starting point, the target should be brought into line with the adult HEAT target on psychological therapies, of 18 weeks. This is an issue of equality and human rights: there is no excuse for such inequity, particularly if it is due to inadequate targeting of resources.

The provision of CAMHS across Scotland is patchy and inconsistent[40]. SAMH supports the call of Barnardo's Scotland to improve flexibility in delivering CAMHS, with more community and home based appointments.

We are concerned about the accessibility of CAMHS: for example, we hear about children with no permanent address being excluded from the service, and that children with a conduct disorder being unable to access services. We see parallels here with the old attitude towards personality disorder in adult services, where there was a perception that the diagnosis was used to exclude difficult people. Excellent progress has been made in changing this attitude and we wish to see a similar opening up of CAMHS to children and young people who need their support.

We would also like to see inclusion in the strategy of the other recommendations made by the

[39] Knapp, McDaid and Parsonage (Editors). Mental health promotion and mental illness prevention: the economic case. Personal Social Services Research Unit, London School of Economics, April 2011

[40] Audit Scotland report – Overview of mental health services in Scotland, 2009

Scottish Parliament Health and Sport Committee in its 2009 Inquiry[41], particularly:

- the Scottish Government should establish further and more detailed interim targets and milestones by which implementation [of the Framework for Children and Young People's Mental Health] may be actively measured.
- The Committee welcomes the idea put forward by witnesses to establish a bespoke service for adolescents and young adults. The Committee notes that the Scottish Government is currently considering how to approach this area and urges the Government to give close consideration to how a new service for this age group should be delivered, paying particular attention to the need for support to be determined on a case-by-case basis and for service transition to be tailored to need rather than based simply on age

SAMH also supports Barnardo's Scotland's call for a greater focus on young offenders and children in care, who are more likely to have high levels of mental health problems. There should also be more support for staff in children's homes, given the poor outcomes for young people in their care, so that early interventions can be made.

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?

Public awareness campaigning about mental health promotion is required. Making the general public aware of how they can take steps to improve their mental health will help people to stay well, and ensure that people who become unwell will know how to seek help. This reinforces the need for an NHS Health Scotland-led campaign that we outlined at question 6.

There is an opportunity to help people take action where needed on their mental health and also achieve other policy aims on keeping unemployment down. At any one time, one in six of the workforce will be affected by a mental health problem. However, 72 per cent of workplaces have no formal mental health policy[42]. The costs falling on employers because of mental health problems in the Scottish workforce are estimated at £970 a year for every employee[43]. BT has reported that the creation of an organisational mental well-being strategy led to a 30 per cent reduction in mental health-related sickness absence and a 75 per cent return-to-work rate for people absent for more than 6 months with mental health problems[44]. The better management of mental health at work undoubtedly makes good business sense, but few organisations recognise this or give it sufficient priority. Through Healthy Working Lives, the Scottish Government has the opportunity to improve people's mental health through employability.

Working with employers and trade unions to disseminate good information on mental health and improve workplace training will mean that people can take action quickly, maximising their chances of remaining in work, with all of the attendant mental health benefits. Employee

[41] Scottish Parliament Health and Sport Committee, Inquiry into Child and Adolescent Mental Health Services, 2009

[42] 'Mental Health: Still the Last Workplace Taboo?, Shaw Trust 2010

[43] What's it Worth Now? SAMH 2011

[44] Wilson, A (2007) The Commercial Case for Health and Wellbeing. Presentation to the National Employment and Health Innovations Network, 20 July 2007, London.

assistance programmes should support people to seek early help within and outwith work to manage their mental health

Mental health needs to become far more accessible. SAMH is rolling out resource centres across Scotland, with three currently situated in Glasgow, Galashiels and Montrose. We intend to build on this model which we believe brings mental health to the high street and removes many of the barriers and stigma associated with seeking help for a mental health problem. We would urge the Scottish Government to consider rolling out such an approach more widely.

The strategy also needs to work closely with GPs to help people self-manage. GPs at the Deep End report that "current NHS initiatives concerning patient self-help and self management appear to have poor penetration in deprived areas and were not recognised by practitioners"[45]. We would suggest that the voluntary sector could act as a bridge into these communities, to help in promoting self-management approaches.

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

"You just think you will be alright and pull through it. You are scared of what people will think" SAMH Service user, Edinburgh

People need to know that if they seek help for a mental health problem, they will be supported, not stigmatised or turned away. We make suggestions later in this response on helping GPs to provide an appropriate response on mental health. The anti-stigma and mental health improvement work discussed earlier is also crucial so that people are not afraid to ask for help: the people we spoke to said that they either did not know what was wrong or felt ashamed or guilty, so they waited until crisis point to seek help.

Public awareness about mental health needs to begin with parenting strategies, continued throughout school and supported in the workplace. The Scottish Government is currently taking forward such initiatives, yet none are mentioned within the mental health strategy 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?

SAMH sees three key opportunities to redesign services in order to deliver this outcome:

- integrate NHS, voluntary sector and local authority services
- create nationwide crisis services that are well integrated with both the police and NHS
- improve the support that GPs can offer

[45] GPS at the Deep End, Summary of fifteen meetings, March 2011

Currently, NHS, voluntary sector and local authority services tend not to be well integrated. This is unsatisfactory from the point of view of the individual, who may well have to seek help several times from several sources which do not talk to each other, of the taxpayer, who is paying for services that can duplicate and perhaps even undermine each other, and of the staff involved, who have to work within an unhelpful framework.

The integration of health and social care is a major Scottish Government policy, so we are surprised that there is little reference to it in this strategy. Given the financial climate, creating incentives for services to work jointly is essential. There are examples of good practice to draw on; Clackmannanshire Integrated Mental Health Services provides a model for joint working between health and social care, with impressive results in reducing readmissions and misdirected referrals, as well as improving staff morale and ability to meet targets. Pooled budgets, high levels of user and staff involvement and the third sector being treated as an equal partner all contribute to better delivered services. SAMH recommends that this model be investigated and implemented more widely during the course of the strategy.

Integrating health and social care commissioning provides an opportunity for people with mental health problems to be 'passported' into community help much more quickly, but there needs to be commitment between the NHS and local authorities to make this work, and an awareness of the voluntary sector services available. Again, the resource centre model is relevant here.

Crisis services

'They should treat mental health as an emergency. Don't leave people to sit for weeks or months'. Male service user, Greenock.

"You have to give people choices. What works for some people does not work for somebody else" Support Worker, Stirling

As we made clear earlier, there is a desperate need for effective and properly resourced crisis services. Gaps exist when people are not assessed as needing psychiatric intervention or are under the influence of alcohol: the NHS currently has no place for these people. Yet these are the people who may attempt suicide unless they get urgent, expert help. The successful model of crisis services in Edinburgh should be extended across Scotland.

As the police are often the first to see people in crisis, fostering good links between the police and NHS services is crucial so that people can get appropriate care and support as a matter of urgency. There are a number of initiatives across Scotland where this takes place. For example, in Tayside, there is an ongoing pilot on diversionary alcohol intervention. An early Tayside Police report[46] recommended that the Community Justice Authority (CJA) note the arrangements for the provision of health care services in police custody settings in Tayside, and stated that this initiative is meeting and exceeding expectations in both Tayside Police and NHS Tayside.

A two year evaluation of the project funded by the Association of Chief Police Officers of Scotland (ACPOS) commenced in November 2009. SAMH has had informal discussions with the research team and understands that the pilot provided greater opportunities for early intervention and engagement of traditionally harder to reach groups. Following the evaluation, we hope that the strategy will recommend an extension of this initiative across Scotland. We

[46] Report No: TCJA18-2009, NHS Services in a Custody Setting, Detective Superintendent Roderick Ross, Tayside Police, 17/06/2009

believe that the collaboration between the NHS and the Police could save money and ultimately lives.

As Graham Morgan from Highland Users Group stated, "If we are in such a mess that the police feel the only way we can be dealt with safely is by arresting us for breach of the peace then we need the world to grow up a little and understand that there are human rights issues involved when we are put in the police station as a direct result of illness and crisis."[47]

"Listen to people and treat them as an individual. Everybody's mental health is different. Don't look at me as my illness. Look at me as a person". SAMH service user, Elgin.

GPs

First contact services are mostly with the general practitioner, so their role is vital. The World Health Organisation recommends a focus on primary care, stating:

"Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need[48]."

Many other countries have taken steps towards integrating mental health more fully into primary care, to reduce waiting times, keep people within their communities and begin treatment and support as quickly as possible. For example, the World Health Organisation (WHO) describes an initiative in Neuquén Province in Argentina.

"Primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Patients receive outpatient treatment in their communities. Psychiatrists and other mental health specialists are available to review and advise on complex cases. A community-based rehabilitation centre provides complementary clinical care and serves as a training site for general medicine residents and practising primary care physicians. The programme has increased demand for mental health care and allowed people with mental disorders to remain in their communities and socially integrated. Because psychiatrists are used sparingly and institutional care is avoided, costs are lower and access to needed services is enhanced".

We would suggest that the overall strategy for mental health in Scotland should be to focus care within primary and community care wherever possible, and that the models and guidance provided by the WHO should be studied with a view to implementation and to developing creative approaches to care.

Within each area, there should be a mental health co-ordinator who ensures that primary and other levels of care are integrated with each other and with other services. The integration of health and social care provides an opportunity to do this, potentially through CHPS. This would fulfil the WHO's statement that: "A mental health service coordinator is crucial.

The WHO further states that "Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required" in integrating mental health into primary care: supporting our argument that the focus of this strategy must be broadened.

SAMH focus groups suggested that more time should be given people who wish to speak to

[47] Graham Morgan, Holyrood conference on mental health, November 2011
[48] Integrating Mental Health into Primary Care: a Global Perspective, World Health Organisation, 2008

their GP about mental health. GPs at the Deep End recommended that additional consultation time is needed to address the needs of patients with multiple health and social needs, and recommended that 15 minute appointments should be standard[49]. Other research has also found that extended GP appointments lead to reduced GP stress and increased patient enablement[50].

"Eight minutes with a doctor is impossible for them to tell you that it is this or that." (Male, Galashiels)

Services should also adapt to the demand for certain interventions – GPs at the Deep End recommended that 'Every Deep End practice should have an *attached mental health worker*, capable of helping patients with psychological, alcohol and/or addiction problems'[51] This could be replicated across the country where GPs are dealing with a high volume of people with mental health problems. Such mental health workers need not be based in the NHS – voluntary sector organisations could work with the NHS to create this role. The cost saving achieved by addressing a person's needs correctly at the first time of asking should be investigated: we believe it would demonstrate that the GPs at the Deep End suggestion is worthwhile both financially and on health grounds.

In our consultation, we met with representatives from the Royal College of General Practitioners. Around a third of GP appointments are about mental health problems[52] - yet research suggests that GPs do not feel confident in providing information on mental health[53]. A 2010 report of an independent Commission for the RCGP and the Health Foundation recommended that training for GPs should increase to five years, to reflect their increasingly complex role and ensure that all patients received high quality care; and that the training should be more generalist, with a specific focus on disciplines such as mental health[54]. SAMH strongly supports these proposals, and given the volumes of patients with mental health problems, recommends extended training for GPs on mental health within their qualification period, as well as regular continuing professional development opportunities in mental health.

GPs must be aware of the range of treatments available in their area and know how to direct their patients to get help. The new strategy should include a commitment to work closely with the RCGP to develop ways of informing GPs locally of what is available, especially as we progress towards the 2014 HEAT target on psychological therapies. This target will not be achieved if GPs are not confident in making referrals for talking therapies.

"*If you go to the doctor then you are looking for a bit of reassurance, that there is hope at the end of that tunnel. All that happens is that they give you a standard drug whether you need it or not".* Survey respondent

"There is too much of a tendency for GPs to assume a problem has gone away if you don't

[49] Glasgow Centre for Population Health, GPs at the Deep End – Connecting with General Practice to improve public health, September 2011

[50] More time for complex consultations in a high-deprivation practice is associated with increased patient enablement, Stewart W Mercer, Bridie Fitzpatrick, Glen Gourlay, Gaby Vojt, Alex McConnachie, Graham CM Watt, Br J Gen Pract 2007 December 1; 57(545): 960–966.

[51] GPs at the Deep End, Manifesto, 2011

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

[53] Mental After Care Association First National GP Survey of Mental Health in Primary Care. London: MACA, 1999 and Rethink survey of GPs, 2010

[54] Guiding Patients through complexity; modern medical generalism, Report of an Independent Commission for the RCGP and the Health Foundation, October 2011

keep nagging, which is hard when ill". Survey respondent

In our surveys and focus groups, a poor experience was more common at the start of treatment and support, either when presenting at a GP for the first time or when being admitted to hospital. We recognise that mental health problems can be difficult to diagnose and that it is not always helpful to begin a course of treatment immediately, since people may well be able to manage their own recovery. However, people should not leave a first consultation feeling that they have been dismissed. It may be that further implementation of Integrated Care Pathwayss provides an opportunity to develop ways of ensuring that first consultations are helpful.

It is worth noting that where people have received good help at primary care level, this has made a big difference. The rewards for getting it right in terms of improved individual mental health are substantial.

"*The GP was willing to listen and was very helpful with the side effects of different medications. My psychologist does his best to make me feel comfortable, is willing to listen and offer support in any way he can".* Survey respondent

"The medication has definitely helped the anxiety side. I have valued the counselling appointments highly as they gave me a specific time and place to speak about how I was feeling to someone who I feel has a grip on my situation". Survey respondent

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?

"*You feel as if you are just going around in circles all the time*" Male, Galashiels

GPs at the Deep End identified health care fragmentation as a barrier to improving the health of their patients. As we have already argued, NHS boards and key partners need to work together to improve services and prevent both patients and professionals spending frustrating weeks and months trying to source appropriate treatment. The voluntary sector should be a key partner in this, as should the patients themselves and their families and carers.

Unlike many conditions, much treatment in mental health is recurring. Most waiting times targets focus on time to first treatment but in mental health, we consistently hear of long waits between appointments with psychiatrists and other mental health professionals, as well as frequent changes in personnel. Little data is available on these types of waiting times or their effects on patients[55]. Ensuring that clinicians take previous interventions into account, and directing NHS Boards to ensure consistency of psychiatric staff wherever possible, may reduce the amount of time spent on non-value adding activities.

"In between referrals for further treatment I was left for four months. In the meantime I deteriorated due to having more awareness but little support and coping skills". Survey respondent.

The speed of diagnosis and treatment was one of the main issues raised by people we spoke

[55] Audit Scotland report – Overview of mental health services in Scotland, 2009

to. They reported being moved around the system, forced to wait for a long time and trying numerous different medications. While it is well-known that it can take a long time to find the right treatment for individuals, this process does not always seem to be well explained. People said that the whole process was slow and at times lacked direction or clarity.

"It is a struggle because nothing is working. You go from A to B back to A back to B until you find something that works". Survey respondent

The most effective way of reducing time spent on "non-value adding activities" is to ensure that people are listened to properly in the first instance. The points which we make later in this document about carers, families and rights are relevant here, as is the need to improve access to advocacy services. A strong theme within our focus groups was that many people felt they were not being listened to or that their views or concerns were not being taken seriously.

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

We would support Bipolar Scotland's assertion that Integrated Care Pathways implementation is patchy. More awareness is needed amongst clinicians of the various pathways and individuals receiving care should be made aware of the ICP to help empower them to ask for support and make them aware of what they can expect from the NHS and other care partners.

Again, the integration of services between different sectors is needed if ICPs are to be implemented.

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?

Again, there are existing policy directions which support the achievement of this aim. The integration of health and social care should put the person at the centre of their care, as should the Scottish Government's forthcoming Self-Directed Support Bill, which will facilitate personalised services. It is disappointing that there is no reference to personalisation in this strategy, as it is a huge opportunity to promote self-management and help people to be truly at the centre of their care.

Beyond this, the strategy should direct NHS Health Boards and local authorities to train and support staff working at the delivery level of health and social care services to embed service user involvement into their everyday practice. While service users and the organisations that represent them may well be consulted on strategies and policies, it is equally important for them to have input into the day to day activities of the services that they use or the staff who support them.

Taking a human rights approach to service development can facilitate service user involvement. The FREDA human rights approach (fairness, respect, equality, dignity and autonomy) lends itself well to including service users appropriately.

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

The Patients Rights Charter will provide a framework which should ensure that patients will be aware of the treatment that they can expect from NHS staff. NHS staff will need training and an awareness of their patients' rights in order to successfully uphold the Patient Rights Act. The Act is also relevant to question 19.

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?

As mentioned above, the Patients Rights Act produced a charter to ensure that patients are treated with dignity and respect. Training for NHS staff is needed to help embed the person-centred and value-based approach across the NHS. This should also be the case for mental health settings.

We also need to think about long term conditions and people with more than one health condition: our survey of 250 people found that 23% of respondents received treatment for a long term physical condition as well as for their mental health problem. Experience varied. For some, both treatments were linked and 'joined-up', whilst others had different staff and different locations with poor linkages between the two.

Some concern was expressed around the awkwardness of being treated for two conditions at once and a perception that any physical illness was not treated seriously as a result of a mental health problem:

"I feel as soon as anyone hears you've got/had a mental health problem any physical problems are not dealt with the same way as others without mental health problems. Most of the time it's very frustrating as I'm told whatever symptom I have is because of my mental health and that it's 'all in my head".. I am not taken seriously with any physical problems." Survey respondent.

This underlines the need for all NHS staff to understand mental health and receive regular training or resources in the need to avoid stigma. Such work should not be confined to those working with people who have exclusively mental health problems.

A strategy for Scotland's mental health should implement the Long Term Conditions Alliance Scotland's (LTCAS) recommendations for:

- **Mental health and emotional support to be embedded** as a core element of long term conditions care.
- **Increased access to psychological and emotional support** to be provided, including NHS services, complementary therapies, community-based provision and peer support.
- **Improved signposting and referral** from NHS services to voluntary sector organisations to be developed[56]

It is notable that neither complementary therapies nor peer support would be classed as psychological support under the Matrix[57]. The recent Action Plan for Allied Health

[56] Long Term Conditions Alliance and SAMH, Policy Briefing: Long Term Conditions and Mental Health and Wellbeing, 2010

Professionals in Mental Health, which set out a plan for staff such as dieticians, speech and language therapists and occupational therapists to further develop their role in mental health, provides a model for other areas of the NHS[58]

Person-centred care needs to provide ways for NHS, voluntary sector and local authority staff to link up, without budgets or structures presenting a barrier. This is why it is essential that the mental health strategy recognises and builds links to other areas of Government policy such as personalisation, employability, health and social care integration and alcohol.

Person-centred and values-based treatment and support must also be rights-based and recognise the right of the individual to be involved in their treatment choices. This does not appear to be consistently taking place across mental health: in our online survey, 43% of people said they felt they'd had a choice in their treatment but 48% did not. There is more cause to be positive about people being given information about their treatment, with 58% feeling very well or well informed: however 38% did not feel they were well informed. Only 13% were offered help, such as independent advocacy, to help them get the right treatment and support. As everyone with a mental health problem has the right to advocacy, this figure is disappointingly low and suggests that further investment in and promotion of advocacy is required.

"You give into them because you are desperate" Survey respondent

"I just felt that my doctor was telling me how it was going to be. I never got much of a say. You just do what they say". Survey respondent

In our survey, almost a quarter of people did not feel that they were treated with dignity and respect: reinforcing the need for a human rights-based approach.

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

There is not enough awareness about this. The Scottish Recovery Network can only do so much in promoting it. Wherever possible SRIs should be embedded within existing structures and systems, such as care plans, referral documents, advance statements, ICPs and the Quality Strategy. The key to its successful implementation is to see it as a part of existing planning and care, not as something new and separate. The Scottish Government should consider making SRIs a performance monitoring outcome between the Government, Local Authorities and Health Boards.

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

The Network can no doubt learn from its previous experience in embedding recovery approaches, but if this is to be achieved fully, then the responsibility for doing so must lie not

[57] NHS Education for Scotland, The Matrix: a guide to delivering evidence-based psychological therapies for Scotland, 2011

[58] Scottish Government, Realising Potential: An Action Plan for Allied Health Professionals in Mental Health, 2010

with the Network but with the professional groups concerned. NHS Boards, local authorities and the voluntary sector should be encouraged and where appropriate directed to review their practice, in partnership with service users, to make it recovery-focused. Although the recovery concept is well understood in some areas of mental health, it is still not well embedded or grasped among some professional groups, and this should be addressed.

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?

Our focus groups expressed mixed views about their support from their family and friends. Some found it positive:

> *"I was very lucky. My mum and dad were very supportive. They went to a lot of support meetings with me and read up on mental health. I just like talking things through with them. It helps you."* Male service user, Greenock.

However, a number of respondents stated they could not talk to their family as a result of lack of understanding or experience of stigma: this supports our earlier argument for increased mental health education and anti-stigma work.

Carers need support to look after their own mental health, and the mental health strategy must interact with the Carers and Young Carers Strategy to ensure they get it. The strategy should consider ways to overcome artificial structural barriers such as those based on age. We have experience in Dundee of providing a service for carers that is much in demand by referrers, but we have not been permitted to accept referrals for people aged over 65, because that would need to be funded separately. This kind of short-sighted approach is focused on service structures, not on people's needs, and needs to be overcome.

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?

During the consultation period, SAMH held a discussion with NHS mental healthcare professionals working in rehabilitation. They reported that they managed to build stronger relationships with families and carers because patients tend to spend more time recuperating than in other areas. By the time a person reaches the rehabilitation centre, they may have been in the system for some time, and arrived at a point when their mental health was very fragile, which can shape the attitudes of the patient, as well as the family and carers to the clinicians providing treatment. Medical staff need to be sensitive to this and work to improve relationships.

The healthcare professionals we consulted told us that clinical staff would appreciate training to give them the confidence to include families and carers in their relative's care, without breaching the confidentiality of their patient. They were very concerned about confidentiality and data protection and wanted reassurance that they could work with families and carers

without breaching their obligations. They agreed that more involvement with the patient's family and carer would improve the outcomes; families are often expected to take on a caring role immediately after discharge, so preventing them from engaging with clinicians is counterproductive. Systems should be developed to ensure that where there is a family member or carer who is interested and/or is likely to be responsible for care after discharge, and the patient is happy with their involvement, they are involved in discharge plans and given as much information as possible about likely outcomes and support available.

SAMH also consulted the Princess Royal Trust for Carers, and heard a similar concern about data protection, underlining the need for increased training. The Royal College of Psychiatrists and the Princess Royal Trust for Carers has produced Carers and Confidentiality in Mental Health[59], which includes a good practice checklist for health professionals. This should be developed for a specific Scottish context and rolled out through NHS systems and practices.

Carers also feel staff should consider that a young person may be providing care for the individual, and see them in this role rather than as a son / daughter who doesn't need medical information. A positive development here is the Young Carers Authorisation Card. We hope that if it pilots successfully it will be rolled out quickly and that health care professionals will be given training about how to appropriately support young carers when they produce their authorisation card.

There should be a drive to include the names of carers in advanced statements; support should be offered to help patients complete these after a first incident of mental illness.

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 balance of community and inpatient mental health services will be determined by a range of factors; government policy, demand for services, integration of health and social care, and the impact of self-directed support. The overarching aim of reforming the public sector as per the Christie Commission's recommendations on better joint working and more preventative spending should also contribute to the balance of care.

The previous HEAT target, to reduce psychiatric readmissions was met in 2010. There were around 20,919 inpatient admissions to mental health hospitals during the year ending 31 March 2011. This continues the downward trend seen in recent years and represents a 17% fall in the number of admissions since year 2006/07[60]. Readmissions also continue to fall. Mental health care is increasingly provided within the community and budgets and services should reflect this.

Personalisation offers scope to give people control of their own support and bring together

59 Royal College of Psychiatrists and Princess Royal Trust for Carers, Carers and confidentiality in mental health, 2010

60 ISD, Mental Health (Psychiatric) Hospital Activity Statistics – year ending March 2011, published December 2011.

budgets without structural reform to local authorities and NHS Boards. However, progress in providing mental health services via self-directed support has been extremely slow: less than 3% of direct payment packages in 2009 were for people with a mental health problem.[61]

The Scottish Government must invest in training in the safe implementation of personalisation for social work, NHS and voluntary sector staff, so that they can advise service users on the options that are open to them.

In our consultation with hospital staff and some of their colleagues from the local authority, we were told that services have undergone redesign in recent years and their good practice should be cascaded throughout health boards. Reversing the proportion of acute / rehabilitation beds was suggested to improve throughput and approach by hospitals.

As a fundamental point, a strategy for Scotland's mental health should set out a timescale to bring all mental health NHS services, not just psychological therapies, into the 18 week time to treatment guarantee.

Clinicians expressed a desire to do more community focused work, but this was dependent on resources. Their council colleagues were clear that they found it easier to move people with mental health problems back to the community than older people, or people with learning disabilities. The difficulty in moving people back to the community occurred when an individual had complex needs.

Housing people within the community remains a huge issue – especially in parts of Scotland such as West Dunbartonshire with high rates of homelessness. The fixed period that a resident can stay in supported accommodation was credited with creating throughput in the system, but more accommodation is necessary, and increasing social housing provision should be considered as part of the mental health strategy. However, the clinicians and council staff were clear that a house was not a solution in itself. The support the individual received must be included in the thinking behind their discharge.

Primary Care

In 2007, the Scottish Development Centre for Mental Health produced a report for the Scottish Government on social prescribing and community referrals for mental health in Scotland. It found that social prescribing had the potential to strengthen considerably the links between primary health care providers and community, voluntary and local authority services that influence the wider determinants of mental health, such as leisure, welfare, education, culture, employment, and the natural environment.

Social prescribing can rebalance care so that people are treated effectively in their community, and the mental health strategy should act on the recommendations of the 2007 report:

- Increasing awareness in primary care of the potential effectiveness and feasibility of non-medical resources and supports
- Encouraging CHPs to support primary care partnerships with the community and voluntary sector to work towards improved mental health outcomes for their patient populations
- Situating social prescribing in the context of greater choice for patients and a stronger

[61] Scottish Government, Self-directed Support (Direct Payments), Scotland, 2009

focus on enabling patients to participate in their own care

- Practical support with data, referral criteria, evaluation and accountability.

GPs at the Deep End are piloting social prescribing within some of the most deprived parts of Scotland[62]. These pilots should be evaluated and rolled out to other communities who could benefit from this approach. They have made some recommendations on ways to increase GP social prescribing which the strategy should implement. They include:

- An internet directory of community resources, if user friendly, locally relevant and kept up to date

- More medical and nursing time in consultations to respond to very challenging needs by clear explanation and guidance

Where people do need to access acute or tertiary care, they should be able to do so quickly. However, the 2009 Audit Scotland report highlighted a lack of mental health professionals generally. This undoubtedly contributes to the long waits people often experience between appointments with their psychiatrist, which is a source of great distress for many of the people SAMH supports.

The people we spoke to reported frustration that the staff with whom they dealt changed frequently. NHS Boards should be directed to minimise the use of locums or frequently changing staff in mental health, since this is particularly unhelpful in this area of health. We also need to consider the support that people who have enduring mental health problems receive between appointments, when they can feel isolated and forgotten. Strong, accessible community services and effective, properly resource crisis services are key here.

"You get pushed to different people all the time and you have to start telling them your story over again. That really annoys me. I don't like getting pushed from pillar to post". Survey respondent

Meeting the HEAT target on psychological therapies depends on the existence of sufficient staff. But there is not enough capacity in the NHS to meet demand, and insufficient data on current waiting times.

Some of our service users expressed frustration with the limited amount of treatment available, because of the lack of NHS capacity:

"The first CBT meeting I asked the woman how long I was getting it for and she said "as long as you need it", and I thought that was wonderful. The next week I went back she said "by the way there have been horrendous cuts and we can give you 8 weeks and that is it, but we will try to do what we can in 8 weeks". The problem is to actually get comfortable with the person and for them to get to know you can take a wee bit of time. You get to a point when you have worked through some stuff and you are just left hanging with no help to sort it out. It is almost worse than not having started" Female, Edinburgh.

SAMH wants to see an audit of current provision and waiting lists for psychological therapies in each health board. The new strategy should include provisions to audit capacity within the voluntary sector, and use this to provide more people with faster access to psychological

[62] GPs at the Deep End, Manifesto, 2011

therapies. While the Psychology Workforce Planning Project has been assessing capacity, this has only focused on NHS provision: given that much psychotherapy takes place in private and voluntary sector settings, this is short-sighted. In the current economic climate, we cannot afford to ignore so many potential contributors.[63]

"There is too much reliance on drugs rather than exploration of other options eg talking therapies and counselling" Survey respondent

It is estimated that 10.4 per cent of the Scottish population aged 15 and over make daily use of antidepressant drugs. There is no method to ensure that the treatment of people in this group is regularly reviewed to ensure that it is still the best way to help them towards recovery. This is important not only because people deserve the right treatment but because continued high prescription rates are expensive: the gross ingredient cost of antidepressant drugs in 2009/10 was £32.2m. A strategy for Scotland's mental health should make clear that people receiving mental health treatment should have regular reviews of their treatment to ensure a focus on recovery.

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?

Good progress has been made in some areas of the NHS in carrying out Equality and Diversity Impact Assessments, in accordance with Equality Act provisions. This progress should be maintained and a particular focus placed on it within mental health services, so that the collection of data on who is using a service is built in at the planning stages.

We are aware that the Mental Health Foundation has submitted a thorough response focused on the needs of BME communities. We endorse this response and do not intend to reprise its detailed points, but in particular support the recommendations to:

- include equality indicators on all HEAT targets
- train interpreters in mental health awareness to ensure that they are provide sensitive and appropriate services.

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

SAMH would suggest that, given that staff across all sectors are stretched and that carers and families are unlikely to have much spare time to attend courses, presentations etc, the mental health strategy should identify the networks and channels which already exist to disseminate learning. For example, the Knowledge and Policy in Education and Health Sectors project conducted useful mapping of the policy-making environment[64]. This could be built upon to provide a picture of the networks which exist across the NHS, voluntary sector and local

[63] ISD, Psychology Workforce Planning Project, Characteristics of the Workforce Supply, 2011

[64] Knowledge and Policy in Education and Health Sectors, The Social and Cognitive Mapping of Policy: Scottish Mental Health Policy: Context and Analysis, 2008

authorities, and information could then be disseminated across these channels. This could be created in partnership with other Scottish Government departments as it would no doubt be invaluable across government.

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

We have already discussed the gaps in provision on trauma, suicide prevention, crisis services, children and young people and education.

The accessibility of services needs to be improved. Opening times and location is critical to this, as is raising public awareness about the availability of services. The Sandyford hub and spoke model has been successful in sexual health services, with ad hoc clinics working in the community; the same model could be applied to mental health services. Linking up with mosques, churches and other community focal points such as libraries and leisure centres would improve people's ability to seek help for their mental health, at times and locations convenient to them.

Our service users tell us that they do not always become unwell between 9am-5pm, and that a physical service that was available during the night would be helpful if they were in crisis or feeling suicidal. While Breathing Space does excellent work, they could help more people if funding was made available to extend their operating time past 2am on weekdays. As well as this phone service, drop in centres where people could access crisis support, other than A&E, would be welcome. Our earlier point regarding the urgent need for crisis services is relevant here.

There are also gaps in services for people who are deaf, deafened or hard of hearing. Research commissioned by Action on Hearing Loss made many recommendations on filling this gap[65]. SAMH would particularly suggest that the strategy should act on the following recommendations:

- Scottish NHS Boards should be required to develop action plans for improving mental health services for deaf / deafblind users.
- Mental health staff should be trained in deaf awareness
- A high level review should be undertaken to set national priorities and strategies to improve the quality of mainstream and specialist care provided to deaf / deaf blind mental health service users within Scotland.

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?

[65] Action on Hearing Loss, Scottish Mental Health Services: the Experience of Deaf and Deafblind People, 2009

Given the links between mental health and alcohol, the strategy should incorporate relevant aspects of the Alcohol Framework and fully implement Closing the Gaps. Sustained investment in alcohol prevention and treatment services could make a huge difference to Scotland's mental health.

As we have already discussed, our experience is that substance misuse and alcohol services are not well integrated with mental health services, with people routinely turned away from NHS services because they are under the influence of a substance. Given that provision of substance misuse and alcohol services often sits with the local authority, the strategy should set a clear expectation that every local area will submit to the Scottish Government its plan to ensure that there are no gaps between these service areas.

Indeed, the strategy could be far more radical in this area. In United States and New Zealand, as in many other areas, mental health and substance misuse services are funded and commissioned together, which reduces the silo mentality. In the light of health and social care integration, this might well be worth considering.

Criminal justice should be a national priority, and needs to take a much more broader approach than simply concentrating on the work with female prisoners. People with mental health problems are disproportionately found within the criminal justice system. The Scottish Prisons Commission has found that about one in nine young men from the most deprived communities in Scotland will spend time in prison before they are 23, highlighting substance misuse and mental health problems as contributory factors[66]. As the NHS is now responsible for healthcare within prisons, the mental health strategy should take the opportunity to improve mental healthcare in prisons and young offenders' institutions. This will need to be a priority within the strategy to send a clear message about the imperative from Government for agencies to work together. This includes health, prison staff, advocacy services, and housing, local authorities and employability services after release.

Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system in England and Wales holds many lessons for Scotland[67]. The new strategy should include a commitment to adopt those of the Bradley Report recommendations which apply in Scotland, and to undertake an additional review of specifically Scottish areas relating to criminal justice and mental health.

The new strategy should also include a plan to maximise the potential of Community Payback Orders to route people with mental health problems away from prisons. The mental health treatment requirement provides an opportunity to begin to address some of the underlying causes of offending behaviour and to improve mental health and wellbeing among particularly high risk groups. So far, their uptake has been low: of 4,265 CPOs imposed over February 2011 – September 2011, only 29 involved a mental health treatment requirement[68].

Research conducted by Capability Scotland in partnership with SAMH found that people with mental health problems had also experienced prison staff failing to recognise mental health problems and recommended that staff throughout the justice sector should receive mental health awareness training[69].

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[66] Scottish Prisons Commission: Scotland's Choice, 2008

[67] Department of Health, The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, 2009

[68] Scottish Court Service MIS team monthly CPO table, 2011

[69] Justice Disability Steering Group, Report of SAMH Involvement Event: Friday 18 September 2009, October 2009

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?

We have already suggested that alcohol, education, personalisation and health and social care integration should be priorities over the next four years. We have one further suggestion: employability.

"The manager at my work told everybody what my diagnosis was. And I lived in a small village so not only was I working with these people I was living amongst them as well. I spent a long time not wanting to leave the house." Survey respondent

Meaningful work is good for your mental health. Towards a Mentally Flourishing Scotland included workplace promotion of mental wellbeing and this work must not be lost. In recognition of the economic climate, welfare reform and the increasing amounts of sickness absence on grounds of mental health, the Scottish Government's strategy for mental health must have a focus on employability.

SAMH has signed up to a detailed statement from Ingeus, which has been submitted as part of this consultation and which sets out several recommendations on the inclusion of employability in this strategy. We will therefore not repeat these here but instead will highlight a few key points on the issue.

SAMH's What's It Worth Now research[70] demonstrated that £2 million is lost to the Scottish economy every day as a result of sickness absence from work. Combined with other output losses, such as worklessness and presenteeism, £3.2 billion is lost to the Scottish economy each year.

Under Section 26 of the Mental Health (Care and Treatment) (Scotland) Act 2003, local authorities are required to help people with mental health problems with employment. Some local authorities are reducing funding to these services; this will result in fewer services being offered to fewer people, at the very time when benefits are being cut and demand for help is increasing. The strategy should take the opportunity to establish who is responsible for monitoring local authorities' implementation of sections 25 and 26, as this has never been resolved.

Appropriate work can promote good mental health. SAMH is piloting an Individual Placement and Support programme with three health boards and their local authority partners in Scotland, whereby an employment specialist is placed with the community mental health team to improve communication and referrals, and help people to recover from mental health problems. Employment support is offered to the individual at an earlier stage to speed their recovery, increase meaningful activity, and improve their employment prospects. Innovative projects such as this should be rolled out across Scotland.

There is compelling evidence to show a positive link between employment and mental health. People enjoy better mental health when they are in work and poorer mental health when they are out of work. For people with mental health problems, work can be therapeutic and reverse the adverse health effects of unemployment. Some aspects of the work environment can pose

[70] SAMH, What's it Worth Now? 2011

a risk to mental health and well-being, for example excessive hours, work overload or lack of control, but the overall balance of evidence is not in doubt: work is good for mental health.

Furthermore, there are existing services which could be directed to have a specific focus on mental health. Many local authorities provide some kind of welfare benefits or advice service, and the Scottish Government funds much of the excellent work of Citizen's Advice Scotland. The people we have spoken to told us that they sometimes needed help with paying bills and form filling, and that where such help was provided, it was invaluable. They also said that having money was important to remove worry and to be able to undertake activities to improve mental health. Advice services should be directed to have a particular focus on mental health and to target people with mental health problems.

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?

No 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?

"For a long, long time I just kept things inside of me. For the last few months I have been actually telling people how I feel. It is like a burden has been taken off my shoulders. Talking to people actually gets your feelings out. You are expressing yourself" Male, Glasgow

Meeting the HEAT target on psychological therapies depends on the existence of sufficient staff. In total there were 744 (629.8wte) Clinical & Other Applied Psychologists employed in NHSScotland as at 30th September 2011. This is an increase of 1.7% Clinical & Other Applied Psychologists from 30th September 2010.

This total of 744 (629.8wte) equates to 688 (580.1 wte) Clinical Psychologists plus 56 (49.7wte) Other Applied Psychologists. This represents a national staffing level of 1 wte Clinical Psychologist per 9,002 of the general population of Scotland. Figures from NES show that 253 people are currently in training.[71]

Despite this increase, there is still not enough capacity in the NHS to meet demand, and there is also insufficient data on current waiting times. SAMH wants to see an audit of current provision and waiting lists for psychological therapies in each health board, building on ISD's audit of current workforce figures in each area. An audit of voluntary sector capacity would be helpful, as it could be used to help provide more people with faster access to psychological therapies. We have not yet seen a level of investment comparable with that made in England, where upwards of £400m has been made available to expand the availability of services.

[71] ISD Scotland Psychology Services Workforce Information, November 2011

A survey about the perceived quality of tiers 3-4 CAMHS treatment by patients and their families would be valuable; there has been, rightly, focus on improving access to CAMHS, but the quality of the service provided to vulnerable children and young people by CAMHS must also be considered. Engaging young people and their families about what support they would appreciate / would have appreciated will help to improve the quality of the service in the future.

Measuring the impact of anti-stigma messages is crucial. While some of the questions in the "Well? What do you think?" surveys on Scottish opinion on mental health are being built into other surveys, we must ensure the reducing frequency of this specific survey does not mean that we cannot measure change. Measurement is difficult but essential.

SAMH would be interested in a study of health professionals which would capture how well-equipped they feel about treating and supporting people with mental health problems, in terms of their professional development and their access to other health and social services.

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

Based on the suggestions we have made throughout this response, we suggest that following are priorities

- mental health awareness training
- suicide prevention training
- self-harm training
- data protection training
- human rights and equalities training
- awareness / compulsion to work in an integrated way with social care services?
- Self-directed support / personalisation training with regard to mental health

In order to maximise the effectiveness of workforce development and training, wherever possible the potential of staff in local authority and voluntary sectors should also be considered.

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

As we have said elsewhere, an audit of capacity across Scotland on ability to delivery psychological therapies would give a clearer picture of the level of access that can currently be achieved.

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 need to collect data on outcomes. Currently, data is mostly focused on processes rather than outcomes - there is very little available on whether people actually felt better at the end of all the processes.

Local authority recording needs to improve. We still don't know how much each council spends on mental health, and the resource transfer issue remains pertinent.

A key step in facilitating better joint working is to link and where possible share information sources. The 2009 Audit Scotland review of mental health services pointed out,

"Different information systems are used by NHS Boards and councils and this limits their ability to deliver joined-up, responsive services"[72].

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

[72] Audit Scotland report – Overview of mental health services in Scotland, 2009

Local authorities should be included in setting indicators on mental health, in order to give them a sense of ownership in service provision. Many local authorities measured their commitment to improve mental health through a single outcome agreement which was measured by training NHS staff in suicide prevention – this was outwith their budgets and responsibilities. Therefore, the development of datasets, indicators and objectives shared across CHPs wherever possible would improve the reporting of outcomes.

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?

Service users must be viewed as experts in mental health services and their experiences used as the main source of evidence to evaluate the effectiveness of mental health services. Detailed monitoring of outcomes as well as processes is required for effective assessment of services in mental health. Therefore, systematic monitoring based on user outcomes is crucial.

A board by board analysis of financial investment in mental health services should also be conducted and reviewed regularly.

Across the public sector in Scotland, there is also an absence of evidence that human rights have been used as an ethos and as a way of working to improve the delivery of public services[73]. Where human rights are integrated into the delivery of public services, the benefits are clear. The Scottish Government, local authorities and the public sector need to adopt a human rights framework for mental health laws, policies and services to ensure that effective treatment, prevention and promotion programmes are available to people when and where they need them.

An example of good practice in this regard is the recently developed 'Human Rights in Healthcare' project, which specifically aims to support the NHS in using a human rights based approach to improve service design and delivery. Running since 2006, it is led by the Department of Health in conjunction with the British Institute of Human Rights (BIHR) and five NHS trusts in England. A key resource developed from the project is "Human rights in healthcare – a framework for local action". This is a practical guide to assist people working in NHS to put human rights principles into practice. The five pilot NHS trusts engaged in the project have been road-testing the framework by looking at human rights in different aspects of their work, including learning, service user involvement, strategic planning and risk management.

[73] Delivering Human Rights in Scotland, SAMH, SWA, SRC and AI, February 2011 & Public Authorities and the Human Rights Act, Scottish Executive Central Research Unit, 2001

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

The strategy has to sit across Government and be carried out at all levels of Scottish society – mental health has a significant impact on justice, education, local services, employability, housing, poverty, alcohol and substance misuse, homelessness, and many other areas.

In the development and delivery of publicly-funded services, government along with voluntary and community sectors have distinct but complementary roles. There is added value in working in partnership to common aims and objectives and, while the public and voluntary sector have different forms of accountability and are answerable to a range of stakeholders, common to both is the need for integrity, objectivity, accountability, openness and honesty.

There is a need to ensure consistency in the scrutiny of social care, social work, and healthcare services, across the public, private and voluntary sectors. It is important that scrutiny bodies work together to support improvement and that the skills and expertise existing in the current bodies is brought together, not diluted or lost.

It would be useful to create a central repository of core information for each service provider that regulators, local authorities and other government bodies can access. This would prevent multiple requests for the same information, which can be a considerable drain on providers' resources.

Current scrutiny processes often rely too heavily on measuring input-based compliance and the views of professional staff; as opposed to the views of people who are actually using services and progress in achieving the outcomes that are important to them. SAMH believes that the needs and views of service users should be placed firmly at the heart of any changes involving public services. We would like to see a situation where service users are empowered to determine their own needs and outcomes and where providers are able to respond appropriately with innovatively designed local services.

SAMH believes that a review of the National Care Standards is necessary in order to ensure that service inspections are undertaken in the context of recovery and a person-centred model of delivery: currently, inspections can seem very focused on a medical model.

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?

The Patients Rights Charter will provide a framework which should ensure that patients will be aware the treatment that they can expect from NHS staff.

The Mental Health (Care and Treatment) (Scotland) Act 2003 is rightly seen as one of the most advanced pieces of mental health legislation in the world. However, areas of the Act have never been fully implemented while others require review. Any review of

the Act must be grounded in the context of the new mental health strategy, so this should be considered as part of the consultation.

The Mental Welfare Commission and NHS Quality Improvement Scotland have undertaken valuable work in reviewing Intensive Psychiatric Care Units (IPCUS)[74]. The strategy must include targets and incentives for NHS Boards to act upon the recommendations made in these reports.

As we have stated earlier, under the Act, local authorities must provide services not only to care for and support people with mental health problems, but also to promote their well-being and social development. No evaluation of local authority success in meeting these duties has ever been carried out. The new strategy must set out how local authorities will be assisted to meet these duties, and who is responsible for assessing whether they have been met.

In Session 3 of the Scottish Parliament, the Equal Opportunities Committee looked at the Mental Health (Care and Treatment) (Scotland) Act 2003. The Committee made a series of recommendations to improve access to advocacy, and SAMH believes these should be urgently implemented.

Concerns were also raised in the Committee's report about the lack of data monitoring. A first step, therefore, to ensure that information is used to monitor who is using services would be to improve the collection of this information. The Committee highlighted particular gaps in ethnicity data and a lack of awareness that monitoring this was a legal requirement, as well as the lack of data on religion, sexual orientation or disabilities (other than learning disabilities). It recommended greater flexibility about the timing of data collection, to overcome barriers about asking for sensitive data when a person is distressed. The Committee also believed that NHS Health Scotland initiatives on equalities training should be further encouraged and asked the Scottish Government to consider the scope for capturing more data regarding all the equality strands.[75]

SAMH welcomes these proposals on information gathering and calls for their urgent implementation.

[74] NHS Quality Improvement Scotland, Intensive Care Psychiatric Units, Overview Report, 2010 and Mental Welfare Commission, Great Expectations Revisited, 2008

[75] Scottish Parliament Equal Opportunities Committee, Report on post-legislative scrutiny: the Mental Health (Care and Treatment) (Scotland) Act 2003, 2010

Appendix A

List of events, surveys and organisations consulted in preparing SAMH response

We received about 250 responses to a web survey aimed at the general public about how they look after their mental health and their experiences of seeking and receiving care.

A joint conference which we held with Holyrood was attended by over 100 people working in mental health, education, criminal justice, social care, voluntary sector and employability services. We also held a parliamentary reception, attended by over 80 people, gained an audience of around 80 people at our SNP conference fringe event and attended the official Scottish Government consultation on 7 December 2011.

We held focus groups with 109 participants across Scotland, including Glasgow, Elgin, Edinburgh, Galashiels, Stirling and Greenock. Our Board and CMT has also discussed the strategy.

Organisations consulted

Action in Mind
Action on Depression
Addiction Support & Counselling
Alzheimer Scotland
Angus Mental Health Association
Barnardo's Scotland
Bipolar Scotland
BPS Division of Clinical Psychology - Scotland.
DAMH (Dundee Association for Mental Health)
General Teaching Council Scotland
GPs at the Deep End
International Initiative for Mental Health Leadership CEO Group
Ingeus Ltd
Kildean Day Hospital
Lothian and Borders Police
Mental Health Foundation
National Union of Students
NES
Scottish Prison Service
NHS Greater Glasgow and Clyde – Gartnaval Royal Hospital staff
Place2Be
Princess Royal Trust for Carers
respect*me*
Royal College of General Practitioners
Royal College of Psychiatrists
Samaritans
Scottish Commission for Children and Young People
Scottish Health Council
Stirling Users Network
Stirling Employability Service

Appendix B

Full list of SAMH recommendations on the draft Mental Health Strategy

Overall Approach

1.1 The Scottish Government should clarify whether this strategy replaces the 1997 Framework for Mental Health Services in Scotland

1.2 Overall, we suggest that the strategic direction on mental health in Scotland should be to focus care within primary and community care wherever possible, and to shift to an approach based on prevention and integration between sectors.

Improvement Challenge Type 1

1.3 The strategy should seek cross-departmental working on existing policy areas wherever possible

1.4 The strategy should be rewritten to harness the power of the whole public sector as well as the voluntary sector.

1.5 Along with Alzheimer Scotland, we believe that the Dementia Strategy should be a priority in its own right, and not one of the four priorities in this strategy

1.6 The strategy should incorporate a human rights-based approach.

Improvement Challenge Type 2

1.7 Overall, the strategy needs to incorporate the findings of the Christie Commission on the Future Delivery of Public Services and the 2011 Scottish Government budget.

1.8 International approaches to trauma should be investigated, such as SAMHSA's eight initiatives.

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

1.9 A strategy for suicide prevention work must continue beyond 2013.

1.10 The Scottish Government should support suicide prevention work that targets those groups for whom previous campaigns have been less effective.

1.11 Short, straightforward training and information resources on suicide prevention need to be immediately available to anyone who needs them, in any area of the community.

1.12 We urgently require local NHS Health Boards, local authorities and the police to pool budgets to provide an effective and properly resourced crisis service which would allow people to be taken somewhere safe and non-threatening, and then listened to and directed to appropriate support.

1.13 Suicide prevention spending by local authorities must become more transparent: local authorities must be able to evidence how they are supporting and financing initiatives to reduce suicide in their local areas.

1.14 NHS staff must be aware of and implement the principles in the Patients Rights Charter.

1.15 Models of meeting the psychological and emotional needs of people who self-harm should be considered and implemented.

1.16 Self-harm and suicide should be understood as different issues and not approached in the same way.

1.17 Improved training and awareness should be delivered to NHS staff so that people who do self-harm are not made to feel worse by the people responsible for treating them.

1.18 Links to reducing and helping people to manage their self-harm should be made explicit in Single Outcome Agreements and NHS targets and commitments.

1.19 The dataset on self-harm must be expanded and opportunities to collect such data from schools, universities/colleges, prisons, care homes and the voluntary sector should also be explored.

1.20 Specific responses to self-harm will also need to be accompanied by other forms of support to help address the underlying causes, such as mental health problems, homelessness, and unemployment.

1.21 The NICE National Clinical Practice Guideline No. 16 should be referred to when developing Scotland's approach.

1.22 The Scottish Public Services Ombudsman's recommendation to NHS Tayside on risk screening tools and processes for people who self-harm should be rolled out to all NHS Boards

1.23 Local authorities should fulfil their duties under Section 26 of the Mental Health (Care and Treatment) (Scotland) Act 2003 to help people with mental health problems to be part of a community.

1.24 The Culture and External Affairs division within the Scottish Government should seek to promote positive mental health messages throughout the media.

1.25 There should be training to employers, service providers and staff in public authorities about how the Equality Act applies to people with mental health problems.

1.26 Training is required for staff within the criminal justice sector to help them recognise hate crime on grounds of disability, especially in terms of mental health.

1.27 Equalities data should be gathered when a crime is reported, and police and justice officials should pro-actively ask whether the crime was motivated by hatred on grounds of their disability, sexuality, race, or religion.

1.28 The 'assets based approach' to improving health and wellbeing should be adopted, especially in the most deprived communities within Scotland.

1.29 The "five ways to wellbeing" developed by UK Government's Foresight Project on Mental Capital and Wellbeing should be promoted to individuals but also to Governmental departments other than health and to services and organisations across all sectors.

1.30 The mental health strategy must make clear links with the Scottish Government's policy framework on alcohol.

1.31 NHS Health Scotland should be asked to lead the development of a mental health improvement campaign that can be delivered nationally, locally and in specific settings such as the workplace, schools and advice centres.

1.32 SAMH recommends greater prescribing of exercise referral schemes, such as the 'green gym' approach taken by GPs in the Link Project in Drumchapel, Glasgow.

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

2.1 Child and Adolescent Mental Health Services (CAMHS) should be defined as per the Scottish Parliament Health and Sport Committee's 2009 report on the subject: as four tiers, beginning with universal services that are not staffed by mental health specialists, including GPs, teachers, social workers, voluntary services etc, and building to acute services.

2.2 The Mental Health Strategy should be linked to the Scottish Government's developing Parenting Strategy.

2.3 The mental health strategy should commit NHS Health Scotland to working with Education Scotland to embed training in mental health and wellbeing in both teacher training and CPD.

2.4 Health and nutrition inspectors should be part of each school inspection team, rather than only some teams as is currently the case.

2.5 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 years education, early intervention programmes for parents, and early years health visitors trained in mental health.

2.6 The strategy should prioritise schools-based programmes, which have the potential to bring about generational change in both health and attitudes towards mental health.

2.7 As well as ensuring the implementation of the Framework for Children and Young People's Mental Health[76] by 2015, the strategy should meet the aims of Getting it Right for Every Child.

2.8 Creating links between mental health services and Family Nurse Partnerships could add value to the partnerships.

2.9 The Centre for Mental Health is also conducting a two-year research project into improving the life chances of vulnerable children as part of its Early Years Programme[77]. The strategy should be informed by the findings of this research.

2.10 A strategy for Scotland's mental health should include a focus on anti-bullying work. We recommend a named official within each local authority who will champion anti-bullying strategies to agencies including schools, childrens' services etc.

2.11 The Mental Health Strategy should have more than due regard for the UN Convention on the Rights of the Child.

2.12 The strategy should re-commit the Scottish Government to the target set in Delivering for Mental Health, to reduce by 50% the number of children and young people admitted to non-specialist wards.

2.13 The CAMHS HEAT target should be brought into line with the adult HEAT target on psychological therapies, of 18 weeks.

2.14 There should be greater flexibility in CAMHS, with more community and home based appointments.

2.15 The Scottish Government should establish further and more detailed interim targets and milestones by which implementation of the Framework for Children and Young People's Mental Health may be actively measured.

2.16 The strategy should act on the Scottish Parliament Health and Social Care Committee's recommendation to consider establishing a bespoke service for adolescents and young adults.

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[76] Scottish Government , Children and Young People's mental health: A framework for Promotion, Prevention and Care", 2005

[77] Centre for Mental Health, Improving the Life Chances of Vulnerable Children, project outline April 2011.

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.

3.1 Working with employers and trade unions to disseminate good information on mental health and improve workplace training will mean that people can take action quickly, maximising their chances of remaining in work, with all of the attendant mental health benefits. Employee assistance programmes should support people to seek early help within and outwith work to manage their mental health

3.2 The Scottish Government to consider rolling out a high-street based Resource Centre approach more widely.

3.3 The strategy needs to work closely with GPs to help people self-manage, using the voluntary sector as a bridge where required.

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.

4.1 The Clackmannanshire model of integrated mental health services should be investigated and implemented more widely during the course of the strategy.

4.2 The successful model of crisis services in Edinburgh should be extended across Scotland.

4.3 Current pilot initiatives, such as the Tayside pilot on diversionary alcohol interventions, should be considered for wider applicability.

4.4 We would suggest that the overall strategy for mental health in Scotland should be to focus care within primary and community care wherever possible

4.5 Within each CHP area, there should be a mental health co-ordinator who ensures that primary and other levels of care are integrated with each other and with other services.

4.6 GPs should be able to give an extended consultation time to people with multiple needs.

4.7 The attached mental health worker role within GP surgeries should be considered, and need not be employed within the NHS.

4.8 Training for GPs should include mental health within their qualification period, as well as regular continuing professional development opportunities in mental health.

4.9 The new strategy should include a commitment to work closely with the RCGP to develop ways of informing GPs locally of what is available.

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

5.1 Ensuring that clinicians take previous interventions into account, and directing NHS Boards to ensure consistency of psychiatric staff wherever possible, may reduce the amount of time spent on non-value adding activities.

5.2 The most effective way of reducing time spent on "non-value adding activities" is to ensure that people are listened to properly in the first instance.

5.3 More awareness is needed amongst clinicians of the various pathways and individuals receiving care should be made aware of the ICP.

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

6.1 The strategy should include an understanding of personalisation and self directed support as an opportunity to promote self-management and help people to be truly at the centre of their care.

6.2 The strategy should direct NHS Health Boards and local authorities to train and support staff working at the delivery level of health and social care services to embed service user involvement into their everyday practice.

6.3 Taking a human rights approach to service development can facilitate service user involvement. The FREDA human rights approach (fairness, respect, equality, dignity and autonomy) lends itself well to including service users appropriately.

6.4 NHS staff will need training and an awareness of their patients' rights in order to successfully uphold the Patient Rights Act.

6.5 The strategy for Scotland's mental health should implement the Long Term Conditions Alliance Scotland's (LTCAS) recommendations on mental health

6.6 Person-centred and values-based treatment and support must also be rights-based and recognise the right of the individual to be involved in their treatment choices.

6.7 Further investment in and promotion of advocacy is required.

6.8 Wherever possible SRIs should be embedded within existing structures and systems, such as care plans, referral documents, advance statements, ICPs and the Quality Strategy.

6.9 The Scottish Government should consider making SRIs a performance monitoring outcome between the Government, Local Authorities and Health Boards.

6.10 NHS Boards, local authorities and the voluntary sector should be encouraged and where appropriate directed to review their practice, in partnership with service users, to make it recovery-focused.

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

7.1 Carers need support to look after their own mental health, and the mental health strategy must interact with the Carers and Young Carers Strategy to ensure they get it.

7.2 The strategy should consider ways to overcome artificial structural barriers such as those based on age.

7.3 Systems should be developed to ensure that where there is a family member or carer who is interested and/or is likely to be responsible for care after discharge, and the patient is happy with their involvement, they are involved in discharge plans and given as much information as possible about likely outcomes and support available.

7.4 The guidance developed by the Princess Royal Trust for Carers, and the Royal College of Psychiatrists should be developed for a specific Scottish context and rolled out through NHS systems and practices.

7.5 The Young Carers Authorisation Card should be rolled out quickly and health care professionals should be given training about how to appropriately support young carers when they produce their authorisation card.

7.6 There should be a drive to include the names of carers in advanced statements; support should be offered to help patients complete these after a first incident of mental illness.

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

8.1 Mental health care is increasingly provided within the community and budgets and services should reflect this.

8.2 The Scottish Government must invest in training in the safe implementation of personalisation for social work, NHS and voluntary sector staff, so that they can advise service users on the options that are open to them.

8.3 As a fundamental point, a strategy for Scotland's mental health should set out a timescale to bring all mental health NHS services, not just psychological therapies, into the 18 week time to treatment guarantee.

8.4 Social prescribing pilots should be evaluated and rolled out to other communities who could benefit from this approach.

8.5 NHS Boards should be directed to minimise the use of locums or frequently changing staff in mental health, since this is particularly unhelpful in this area of health.

8.6 SAMH wants to see an audit of current provision and waiting lists for psychological therapies in each health board.

8.7 A strategy for Scotland's mental health should make clear that people receiving mental health treatment should have regular reviews of their treatment to ensure a focus on recovery.

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.

9.1 Progress in carrying out EQIAs should be maintained and a particular focus placed on it within mental health services, so that the collection of data on who is using a service is built in at the planning stages.

9.2 We endorse the response of the Mental Health Foundation on the needs of BME communities, particularly its recommendations to include equality indicators on all HEAT targets and to train interpreters in mental health awareness to ensure that they are provide sensitive and appropriate services.

9.3 The mental health strategy should identify the networks and channels which already exist to disseminate learning.

9.4 The accessibility of services needs to be improved. The Sandyford hub and spoke model has been successful in sexual health services, with ad hoc clinics working in the community; the same model could be applied to mental health services.

9.5 The recommendations made in research commissioned by Action on Hearing Loss should be acted upon.

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.

10.1 The strategy should set a clear expectation that every local area will submit to the Scottish Government its plan to ensure that there are no gaps between substance misuse, alcohol and mental health services.

10.2 As the NHS is now responsible for healthcare within prisons, the mental health strategy should take the opportunity to improve mental healthcare in prisons and young offenders' institutions.

10.3 The new strategy should include a commitment to adopt those of the Bradley Report recommendations on criminal justice which apply in Scotland, and to undertake an additional review of specifically Scottish areas relating to criminal justice and mental health.

10.4 The new strategy should include a plan to maximise the potential of Community Payback Orders to route people with mental health problems away from prisons.

10.5 Staff throughout the justice sector should receive mental health awareness training.

10.6 Employability should be a priority in the strategy.

10.7 The recommendations in the response from Ingeus, to which SAMH is a signatory, should be accepted.

10.8 The strategy should take the opportunity to establish who is responsible for monitoring local authorities' implementation of sections 25 and 26 of the Mental Health (Care and Treatment) (Scotland) Act 2003, as this has never been resolved.

10.9 Advice services should be directed to have a particular focus on mental health and to target people with mental health problems.

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.

No recommendations

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.

12.1 We need to collect data on outcomes. Currently, data is mostly focused on processes rather than outcomes - there is very little available on whether people actually felt better at the end of all the processes.

12.2 A key step in facilitating better joint working is to link and where possible share information sources.

12.3 Local authorities should be included in setting indicators on mental health, in order to give them a sense of ownership in service provision.

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.

13.1 Service users must be viewed as experts in mental health services and their experiences used as the main source of evidence to evaluate the effectiveness of mental health services. Detailed monitoring of outcomes as well as processes is required for effective assessment of services in mental health.

13.2 A board by board analysis of financial investment in mental health services should also be conducted and reviewed regularly.

13.3 The Scottish Government, local authorities and the public sector need to adopt a human rights framework for mental health laws, policies and services to ensure that effective treatment, prevention and promotion programmes are available to people when and where they need them.

13.5 It would be useful to create a central repository of core information for each service provider that regulators, local authorities and other government bodies can access.

13.6 SAMH believes that a review of the National Care Standards is necessary in order to ensure that service inspections are undertaken in the context of recovery and a person-centred model of delivery: currently, inspections can seem very focused on a medical model.

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.

14.1 The strategy must include targets and incentives for NHS Boards to act upon the recommendations made in recent reports on IPCUs.

14.2 The new strategy must set out how local authorities will be assisted to meet their duties under the Mental Health (Care and Treatment) (Scotland) Act 2003, and who is responsible for assessing whether they have been met.

14.3 The recommendations of the Scottish Parliament's Equal Opportunities Committee on the Mental Health (Care and Treatment) (Scotland) Act 2003 should be implemented.