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.

We fully commend the continued commitment to mental health improvement within the Scottish Government and are particularly pleased to see the development of this new mental health strategy. The timeliness of this consultation and the timescale for implementation is also to be welcomed.

We hope that the final strategy will enable Scotland to further develop pioneering work undertaken since devolution on both mental health law and service reform, and on public mental health. We recognise that this strategy will focus on clear actions, and less on narrative, but we hope that this work, and successor activities will continue to build towards addressing longer-term objectives in relation to mental health in Scotland.

A key challenge of the new strategy will be in maintaining necessary momentum and leadership for mental health in all policies whilst making necessary savings and improvements in primary policy areas of mental health services, suicide reduction and stigma and discrimination reduction.

Tying this work to ongoing suicide prevention objectives, and the Dementia Strategy presents opportunities to learn, and drive forward a range of cross cutting mental health improvement activities. We hope that this connection will enable the renewal and evolution of both suicide prevention and dementia strategies when the current delivery cycle comes to an end.

MHF anticipates that this new mental health strategy will have the vision to make commitments that will embed mental health and wellbeing within policies that can be considered as secondary and tertiary mental health policy. These could be described respectively as areas of policy that influence mental health directly, or determine demand on primary mental health areas (such as education, health, inequalities or communities) and upstream policy areas such as economic development and social protection.

We recognise the limitations of what can be achieved by one department of the Scottish Government and do not expect that the systemic change required can be leveraged by this strategy alone. Instead we would hope that this strategy would seek to make space for discussion and meaningful partnerships, whilst producing commitments that begin to move us towards this ultimate goal.

Being subject to inequality is a major factor in the erosion of mental capital, and development of poor mental health. There is a greater risk of developing mental health problems, the experience of and treatment for which further erode resilience and life skills.

In many communities in Scotland, the prevailing climate of lack of hope, sense of purpose and agency leads to poor mental health, poor self-esteem and a learned helplessness and interdependence on multiple public services. The importance to future public services of unlocking inequality was recognised in the recent report of the Christie Commission on the Future Delivery of Public Services[1].

The challenge remains that some levers of mental health outcomes, such as access to benefits, and the protection afforded by equality legislation are outside of the current remit of the Scottish Parliament, however policy set in Westminster still has downstream effects on services and outcomes achieved in Scotland.

It will be important for this mental health strategy to acknowledge these limitations but also identify actions for minimising the impact of these on people with mental health problems e.g. mental health training for advice services that support people with disabilities to access benefits. Continued support for activities that encourage mentally healthy workplaces, and measures to improve employability for all disabled people in a mentally healthy way may help to ameliorate the effect of changes to welfare benefits in some ways.

In the context of the current economic downturn it is clear that difficult decisions on prioritisation are required. When resources are scarce a common default position is to focus on immediate need. Within a mental health context this could translate to a focus solely on service provision and a contraction of mental health promotion and prevention activities.

It is critical to continue to prioritise mental health promotion and prevention within mental health policy and there is an emerging evidence base that would support this. It is also important to understand the many impacts that poor mental health can have on a range of budgets that go beyond health and social care, including employment, education, housing and criminal justice.

Investing in mental health improvement now should generate substantial economic savings within a whole host of public policy areas and reduce future negative outcomes and failure demand as a result.

Realistically speaking, resources are scarce and we would argue that prioritisation does not need to be a choice between service provision and a preventative agenda. Instead prioritisation should be based on evidence of where investment can have the most impact and where there are the greatest inequalities (and distress).

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[1] http://www.scotland.gov.uk/Publications/2011/06/27154527/0

For example the mental health of black and minority ethnic (BME) communities (including refugees and asylum seekers) needs to be given greater prominence in both policy and in practice. Research indicates that BME communities experience significant racism and greater isolation compared to the wider majority population. Studies also illustrate examples of an increased prevalence of mental health problems, an underrepresentation in the use of mental health services and evidence of particular forms of stigma and discrimination towards people with mental health problems from BME communities.

MHF facilitated a range of consultation sessions with the Ethnicity in Mind Network in partnership with NHS Health Scotland and the Sanctuary Network and has submitted collective responses around these key areas of inequalities.

Within this response we will also give particular focus to issues relating to people in later life, children and young people (particularly) early years, people living in low income areas, people with mental health problems and people with long term conditions in recognition of the particular inequalities that they encounter. We would commend a mental health strategy that had a proportionate approach to ensuring that those who are most marginalised receive the support that they need.

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

The strategy needs to provide direction around 3 key areas:

- A proportionate focus taking account of inequalities and social justice
- A leadership function in influencing and facilitating the mental health component of wider public policy
- Achieving a balance between mental health services and legislation and public mental health

NHS Boards need to be monitored on the application of equality impact assessments and progress towards equality improvement targets (e.g. monitored on the application of ethnic data collation).

We recommend that boards are provided with guidance and a framework for working with equality target groups including addressing multiple discrimination and undertaking their obligations under equality law as well as mental health law.

Undertaking a competency survey in relation to equalities and providing training and ongoing support on equality impact assessment would be a key action in helping to shift the culture within services.

NHS NES need to use their role in workforce development to embed equality within all training resources and where progress has been made ensure that this is fully implemented (we would support wide roll out of the 10 Essential Shared Capabilities training).

Embedding mental health within wider public policy and practice is a challenging agenda but if we are to make progress in mainstreaming mental health then central leadership will be required. MHF recognises that one strategy cannot achieve everything and this kind of society wide change will take many years. However we would anticipate that a new mental health strategy would provide clarity on the direction of travel alongside some commitments that make a good start on this agenda.

Time and again we are told of the value that clear central policy has had in driving local action, down to the inclusion of mental wellbeing in single outcome agreements (and therefore its consideration at every level of local government). We would be concerned that the momentum would be lost in operationalising this work if the drivers were absent.

Scotland has made positive progress in mental health improvement through developing activities and programmes with a focus on mental health promotion, prevention of mental illness and recovery. This mental health improvement work has been developed in parallel to service redesign and creation and implementation of new mental health legislation. Although these elements have not always sat together comfortably, the Scottish Government should be commended for the continued high priority given to mental health.

This strategy provides an opportunity to bring these elements together under one banner. It is hoped that this will produce a cohesive strategy and prevent the creation of artificial boundaries. Our key concern remains that at a time when financial constraints are tightening we avoid defaulting to focus all of our resources on services. The Christie Commission report recommends a preventative approach in order to address failure demand, and we would therefore seek strong commitments within the strategy that show progress toward promoting wellbeing and preventative approaches for at risk groups (although it is accepted that these may at times be the same actions).

This notwithstanding, it is vital that we do not lose sight of the service redesign and employability agendas as there is still a huge amount to be done to get us to the position where those with mental health problems enjoy the same life chances as others in society. MHF regards people who are affected by mental illness to be a distinct inequality group, and services to support mental health need to provide examples to other services about how best to meet the needs of this group.

Overall, this strategy has a responsibility to contribute to the wider agenda of addressing Scotland's unequal society. Universal approaches to mental health improvement and services can often still prevail and we recommend that this strategy provide clear guidance on proportionate approaches.

We know who does least well therefore we need this strategy to be courageous and send a clear message that we will use our scarce resources where there is the greatest need.

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

Comments

People who experience developmental disorders and those who experience trauma, especially complex trauma, are among those most subject to inequality, and least able to advocate for themselves. We know that there are substantial unmet needs in this population, but that these are poorly scoped. The most obvious means of understanding what change would deliver better outcomes would be to engage with these populations in an accessible and appropriate manner.

Both developmental disorders and trauma share aspects of difficulty that can cloud assessment and prevent needs being met.

Firstly there are concerns about the extent to which problems are diagnosed and assessed, particularly in adults. With complex PTSD in particular there are few centres that specialise in working with those people with dissociative disorders and complex trauma. Both communication challenges and stigma often prevent disclosure of concerning symptoms, and diagnosis of personality disorders with associated stigma (both self-stigma and from health professionals) further confuses matters.

Because complex PTSD is not a widely accepted term in practice, it is possible that changes in care teams or geographical location may mean different 'attitudes' to symptoms from care professionals and changes in treatment and support. A common, shared understanding of the effect of complex trauma across public services would greatly assist in developing approaches to treatment and support.

Both trauma and developmental disorders present challenges in relation to communication of need, and understanding and engagement in treatment for both mental and physical ill-health. Careful development of crisis cards and advance planning might be helpful in these situations, and Lothian and Borders Police and the National Autistic Society have recently launched a 'crisis card' system for people with Aspergers Syndrome to quickly notify the police or emergency services that they are autistic.

We recognise on a population level that many people with trauma histories do not need support, and do not wish to revisit past experiences with which they have learned to live. Equally though, it is possible to surmise that supporting people affected by complex PTSD more effectively might reduce the call by them on health, social, criminal justice and welfare services.

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?

Self-harm and suicide should be addressed as separate issues and strategic work on self-harm needs to continue in parallel to suicide prevention initiatives.

Based on evidence of risk, we would recommend a stronger focus on key risk groups who experience multiple disadvantages. This would include: ex-service personnel and their families, LGBT and BME communities, students, disabled people, refugees and asylum seekers, and older people.

Work to address the needs of these communities should include developing a better understanding of the barriers to support. Choose Life should build stronger links with these communities and see me should concentrate some of the focus on stigma within these communities to promote early help seeking.

For some groups much of their daily support is provided by organisations working within their local communities. Examples of this include community resource centres in low-income areas, youth groups working with disadvantaged young people and equality groups working within BME communities. To reach these groups it will be essential to build capacity within these organisations to enable them to identify community members who are at risk and to offer support and signpost where appropriate. These preventative actions should prove to be a cost effective approach in the longer term.

There is also still considerable work to be done in terms of supporting GPs to better identify and monitor suicide risk, specifically when antidepressants are first prescribed.

Poor ethnicity data collation makes it difficult to gain a clear picture of the numbers of BME community members in distress and this needs to be improved if we are to learn how to respond effectively.

It is essential that equality impact assessment on suicide prevention training is undertaken to ensure that the efforts to improve responses also enable wider services to take account of different expressions of distress e.g. children and young people and people from BME communities may communicate and frame their distress in different ways and may not be explicit.

There is scope for developing understanding about the role of technology and the internet for assisting those at risk of suicide and self-harm (both risks and opportunities should be explored). In a 2009 survey for MHF of people who had used the internet in relation to their mental health (to be repeated in 2012) 40% of respondents had used the internet to reach out in a crisis. The role played by networks of friends and papers on social media sites in assisting people to stay safe, get help, or consider self-help strategies is not understood, and is worthy of close consideration.

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

MHF has been closely involved in stigma and discrimination activities at a European level over the last three years, providing scientific support to the European Commission's high level conference on stigma and discrimination as part of the implementation of the European Pact for Mental Health and Well-being and acting as a key partner in the EU Public Health Programme project ASPEN.

Drawing principally on the work from ASPEN we have a number of recommendations around the future direction of stigma reduction work in Scotland.

These recommendations are based on the existing evidence base from the ASPEN pan-Europe literature reviews, best practice in stigma reduction programmes across Europe and consensus on best practice developed by MHF with our 27 ASPEN partners.

Future directions should :

- **Be based on sound theoretical principles**. Much of the work to date has focused on social interactionist theories around labelling and stereotyping and as a result has prioritised information provision activities. This approach assumes that providing information will lead to behavioural change. However recent theorists have challenged this and have instead focused on structural stigma and discrimination. This places a spotlight upon legislation and empowering those who experience mental health problems. Link and Phelan (2001)[2] reconcile these different approaches in their modified labelling theory and identify stigma as a process involving labelling, stereotyping, separation, status loss and discrimination. Thornicroft (2006)[3] provides a clear framework for stigma programmes that can be translated to our work in Scotland, that programmes should contain 3 key elements for focus: knowledge, attitudes and behaviour.

- **Operate on different levels** recognising different forms of stigma including self-stigma, associated stigma, social stigma in the community and structural discrimination for example within the

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[2] Link BG &Phelan JC (2001) Conceptualising stigma.*Annual Review of Sociology* **27** 363-385

[3] Thornicroft G (2006) *Shunned: Discrimination against people with mental illness.* Oxford:Oxford University Press.

media, employment, health services or the legal system. 'see me's Stigma Stop Watch is a good example of one way we can challenge structural discrimination and these kind of activities should be given a greater prominence in coming years. It is likely that instant feedback using online social media may assist with snowballing responses to episodes of stigma.

- **Be targeted on areas of need**, as a focus on the general public is a very ambitious goal and often programmes aimed at the whole population do not reach marginalised social groups and can be financially unsustainable. There is therefore a strong economic and moral imperative to focus where the most damage is located and where it is possible to achieve the greatest impact. The work of the Glasgow Anti-stigma Partnership (GASP) provides some positive direction in relation to targeting. Stigma and discrimination in relation to employment is still seen as being a significant barrier, and a key component of anticipated discrimination. It is likely that alternative approaches will need to be taken to engage SME employers, and those who do not subscribe to Healthy Working Lives Award schemes and similar. Equally, there is good practice to be seen in employability success stories.

- **Have specific strands that are focused on depression** to ensure that messages are specific enough to challenge attitudes and stereotypes (as beliefs around depression differs from stigma related to psychotic illnesses with ideas of blame being more dominant rather than concerns around unpredictable behaviour).

- **Use methods that are evidence based/known to be effective, including a combination of protest, education and contact** (Corrigan et al, 2007)[4]. Positive personal contact has the most promising evidence-base, including proxy contact for example narrative through film (Quinn et al, 2011)[5]. Messages must be carefully targeted for different audiences (Byrne, 2000)[6].

- **Be rights based** so rather than mainly aiming to change beliefs and attitudes programme messages should consider how to tackle discrimination and be clear that stigma is a human rights issue.

- **Use positive recovery messages by focusing on promoting positive messages and strengths rather than dispelling negative beliefs**. Being clear that people recover and make positive social contributions. The media volunteers working within See me and the user led events at the SMHAFF are good examples of where we have worked in Scotland to put positive messages into the public domain.

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[4] Corrigan P (2005) User/consumer involvement in mental health service delivery. *Epidemiologica Psichiatria Sociale* **14 (1) 10-14**

[5] Quinn N, Shulman A, Knifton L & Byrne P (2011) The Impact of a national mental health arts and film festival on stigma andrecovery. *Acta Psychiatrica Scandinavica* **123** (1) 71-81

[6] Byrne P (2000) Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric treatment* **6** 65-72.

- **Ensure full user involvement** as stigma is a 'rights' issue and work to address this has the potential to empower and allow people to regain control. We have seen evidence of this empowerment within many arts-based programmes including the SMHAFF and within training initiatives such as the Glasgow Anti Stigma Partnership workplace training.

  People who have experienced mental health problems should be meaningfully involved in programme leadership, planning, implementation and evaluation. People should be involved with different diagnosis, experiences, age groups, gender, sexual orientation and from ethnic and income backgrounds. Due to stigma many people do not seek help or use treatment services. Therefore although it is important to involve people who are 'service users' it is also vital to engage those that do not take on this identity. Particularly when stigma may affect people who make use of self-help and lower tier interventions, and who may never associate themselves with the 'service user' movement. The initial development of 'see me' was built around the views of service users and there is real scope to take this to the next level in terms of the future direction of our stigma reduction work by ensuring that meaningful service user involvement is the key operating principle.

- **Focus on equity** as mental health problems are unequally distributed within communities. Our approach to date has been in general most often directed at the whole population although there has been some useful targeting such as towards health professionals, workplaces and schools. However, more work is needed that has a focus on disadvantaged communities or we risk increasing inequalities in stigma and mental health (Petticrew et al, 2004)[7]. Our future focus should combine general anti-stigma activity with actions targeted towards those at highest risk or who encounter multiple layers of discrimination, including older people, people in low-income communities, people with long-term conditions and disabilities, BME communities and refugees and asylum seekers.

- **Use messages and methods that are accessible and meaningful** to people who use different languages, have a learning disability, low literacy, visual or hearing impairment. Using communication methods and resources that reach different groups e.g. community centres in low-income areas or media which are accessed by children and young people or BME communities.

- **Work closer with specific communities to consider the different cultural context of mental health problems**. Different sections of society may hold different beliefs about mental health problems and its causes. For example some people see depression as a social construct that relates to power in society. Others hold cultural explanations linked to faith or traditional beliefs. It is important that as

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[7] Petticrew M, Whitehead M, Macintyre SJ, Graham H & Egan M (2004) Evidence on public health policy on inequalities. *Journal of Epidemiology and Community Health* **58** 811-16

our demography changes in Scotland both in relation to age but also ethnic mix that we build programmes that have messages and use methods that are based on an understanding of meaning attached to mental health. The limited but useful work of the Mosaics programme in Glasgow is a good starting point but learning from this needs to be built into our national approach to stigma.

- **Develop collaborative partnerships that are wider than our mental health world**. Developing partnerships with non-mental health organisations will help to make mental health everyone's business. One example of how this can be approached would be developing a wider stigma advisory network comprised of representatives from workplaces, schools and universities, community and civil society groups as well as people with a lived experience of mental health problems. Developing collective action that has the potential to grow the social movement required to achieve sustainable change.

- **Aim for sustainability** as large media campaigns can be expensive. Stigma is a deep-seated issue that will take a long time to reduce and it is therefore very important to develop programmes and approaches that can be sustainable. For example it may be easier to deliver mental health awareness sessions in employment but building capacity for HR managers to take on this role will be more sustainable long term. In Scotland we have already taken this approach within schools where placing mental health on the curriculum is a more sustainable approach than providing mental health sessions directly. Equally the work of 'See me' in terms of the 'Pledge' is a good example of work to embed mental health literacy within workplaces. We need to build on this work further to grow capacity within universal settings for others to take on this responsibility for mental health. This will initially require leadership from mental health at the centre but has the capacity to be more affordable and sustainable over the longer term.

- **Evaluate independently the effect on behaviour as well as attitude**. Evaluation can be expensive but it is essential to understand which stigma and discrimination reduction activities affect sustained behaviour change. Our current focus on the social attitudes survey although providing a crude measure of changes in society does not provide information on behavioural change and can be subject to reporting bias. Service user centred research should be an integral part of the evaluation process not only because there is a strong ethical argument to support this but this will also serve to empower those who are subjected to discrimination. The Scottish Mental Health Service User Research Network would be one support mechanism that could be used to support evaluation (details can be found on VOX's website).

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?

The mental health workforce needs to fully understand their responsibilities in relation to discrimination, not only in terms of mental health law but also in relation to disability discrimination (although the law needs strengthened in relation to discrimination for people with mental health problems).

Staff should be provided with clear and accessible guidance materials, local policies and operating procedures and training that help them to translate some complex aspects of law and many difficult grey areas.

'see me' needs to provide strong, targeted messages to the mental health workforce that are clear that stigma and discrimination are human rights issues.

Training and supporting literature is important, however as previously described contact has one of the strongest evidence bases, therefore training should involve personal stories and have high levels of user involvement built into these.

Over the past two years MHF has developed several training and development programmes that support the workforce in developing capacity to engage both with recovery and public mental health.

We worked with Glasgow City Council, NHS Ayrshire and Arran and the three Ayrshire and Arran local authorities to provide in all policies support. The principle aim of this work was to support involvement in outcomes focused planning, where we work with staff to build development plans to draw out the areas of their responsibilities that can have an impact on mental health. This facilitative process is a useful one for working with staff and supporting them to consider their practice in relation to discrimination. This approach could be explored more widely to support change within staff teams.

A key point in all sessions has been the importance of staff wellbeing, and the need for public services to walk the talk in relation to the support provided to their staff, the quality of the management relationships, and the extent to which people furthest from the labour market are able to take up employment.

We have also been delivering social determinants of mental health training to primary care staff involved in anticipatory care and long term conditions management.

In both sets of training, some participants have voiced discriminatory attitudes, and have been able to explore and place these into context.

It is also important to reflect that stretched staff struggle to deal with clients or patients with high levels of complexity in the often short time they have with them or in high intensity environments such as Emergency Departments.

Context should be borne in mind, and a focus on discrimination, and zero tolerance of active discrimination should be encouraged. Equally, there should be the ability to make additional time or quiet space available so that in crisis or on first presentation the interaction between individuals and health professionals can be positive.

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

Universal approaches to wellbeing can be unsustainable and we are very aware that this strategy cannot aim to be everything for everybody and neither should it be.

Universal approaches to wellbeing can be counterproductive, as whilst they may achieve health gain they will do little to address inequalities. Those with the most personal resources will often be amongst those most receptive and able to access public mental health messages and opportunities.

With this in mind, MHF hopes that this strategy will adopt an inequalities focus and proportionately target resources on those who are most at risk of poor mental health.

Therefore we would recommend focusing wellbeing actions on:

- people in low income communities, and those subject to multiple inequalities, including those with high levels of complexity;
- people in later life (we undertook a joint consultation event with NHS Health Scotland and separate response will be co-ordinated by them)
- people from BME communities (we are submitting a separate response on behalf of our Ethnicity in Mind partners)
- refugees and asylum seekers (we are submitting a separate response on behalf of our Sanctuary partners)
- people who experience mental health problems (VOX are submitting a full response which we fully endorse)
- children and young people (we will address this later in this submission)
- LGBT people
- disabled people and those people living with long term conditions.

People living with long-term conditions - Research, such as that found in the Living Better project (2008-2011, led by SDC/MHF and funded by the Scottish Government), indicates that people with long term conditions are more likely to experience poor mental health than the general population. Research also suggests that good mental wellbeing is central to the successful self management of long term conditions. People from marginalised groups, including those living in areas of high deprivation, LGBT and BME communities are at increased risk of developing both mental and physical health problems.

At a national strategic level there is still considerable opportunity to improve links between mental health and long term conditions to ensure that holistic responses which recognise the interrelatedness of physical and mental health are developed, to improve access for people with long term conditions to support their mental wellbeing.

To address these issues, more emphasis is required on strategies which promote good mental health in this population, such as the development of peer support services for people with long term conditions, self management support and signposting to community resources.

Based on our work to develop peer support in mental health services, the Mental Health Foundation have been developing research evidence and guidance to support peer support for long term conditions over the last few years. Funded by LTCAS, the Mental Health Foundation are currently at the early stages of supporting two NHS Boards to develop peer support services in their localities, in partnership with a range of voluntary sector agencies. A key challenge in this work is that access to peer support for people with long term conditions is patchy, solely voluntary sector based and the quality of support available is variable. Links between NHS services and the voluntary sector around peer support are also poorly developed.

Further investment and strategic leadership from a mental health strategy would go some way to improving links, learning and services in this area. Recognition of the added value and unique contribution peer support can make to mental wellbeing of people with long term conditions within the mental health strategy would go some way to support work in this area.

People living in low income communities

We are fully aware that there exists a social gradient in mental health. Not only do those at the bottom of the gradient do less well than those at the top but those at the median also do less well than those above them. We therefore need to adopt a proportionate approach with more resources invested on those who do least well. The concept of proportionate universalism outlined by the Marmot review[8] warrants consideration. We also know that people who have existing mental health problems are over represented within these communities as poverty can not only be a consequence of mental health problems through social drift but the social injuries associated with poverty can place people's mental health at higher risk. If we are to make a change within low income communities we need to begin by fully engaging those who have had least say on our approaches to date.

We need to work alongside local organisations and recognise the contribution that they can and do make in promoting mental health and enabling people to remain well in low income communities. Increasing access to social and cultural activities should remain a priority for mental health improvement and for people with existing mental health problems the focus on sections 25-31 of the Mental Health (care and treatment)(Scotland) Act 2003 requires greater prominence in this strategy to ensure that they

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[8]

have equitable access to education, training, and social and leisure services. We need to invest and support volunteering opportunities within communities aimed at promoting wellbeing for all including volunteering for older people. Within our Brighter Futures project we found that older volunteers attributed many improvements in their lives to the volunteering experience we offered including within their own mental health. There should be support for local organisations to evaluate local led initiatives as currently many are funded only for service delivery hours and are not able to undertake evaluations. Equally many close at the end of their funding as they do not have access to further resources and cannot evidence the impact of their services. Voluntary organisations such as the associations for mental health often work at a community level and have a great deal of expertise in promoting social inclusion and supporting wellbeing for people that experience mental health problems and this should be exploited further.

There can be a lot of confusion not only on where to target interventions in relation to mental wellbeing promotion but also on what methods work in terms of reach and impact and which activities warrant investment. In the current environment of scarcity it will be important to prioritise those activities where there is an evidence base. The London School of Economics have produced a review of the evidence base in relation to mental health promotion and key areas are outlined below:

* Health visiting to reduce post natal depression
* Parenting interventions and school based social and emotional learning programmes for the prevention of persistent conduct disorder in childhood
* School based interventions to reduce bullying
* Early detection and early intervention for psychosis
* Screening and brief intervention in primary care for alcohol misuse
* Workplace screening for depression and anxiety
* Promoting wellbeing in the workplace
* Debt and mental health
* Collaborative care for depression for individuals with Type II diabetes
* Tackling medically unexplained problems
* Befriending for older adults
* Population level suicide awareness training and intervention
* Bridge safety measures for suicide

Many of these areas are already viewed as priority actions in Scotland such as suicide awareness training and some other areas for action are planned for wider roll out an example being Triple P. However, these activities also need careful targeting to ensure that they reach those most at risk of poor wellbeing such as parenting programmes for families living in low income areas. Our key recommendation is that a range of evidence based activities should be prioritised (or continue to be prioritised) but these programmes should be underpinned by an inequalities and social justice approach. It should also be accepted that some interventions do not have a strong evidence base not because they are not effective interventions but because there has been no evaluations undertaken. This was apparent in our recent review for the Baring Foundation of the role of the arts in promoting wellbeing for older people and in our work on the Brighter Futures project to improve the mental health of older people through peer mentoring. In both these areas the low level of investment in services for older people seemed to also play out in the investment in research.

Employment and meaningful activity is consistency rated in the evidence as being a key factor in promotion and protection of mental health. In difficult economic times for all employers, there is a case to be made for the productivity dividend of promoting mental health across the workforce. Whilst this is often perceived and badged as a health at work initiative, many of the actions that create mentally healthy workplaces come from good management practice, and can be incorporated into business without additional resource. Where mental ill health does affect employees, work should continue to reduce active and implicit discrimination, including broadening activity with SME employers and those not engaged with health at work initiatives.

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 recommend that a programme of work is required to address not only the care and treatment needs of children and young people but to promote wellbeing for those at risk of poor mental health and to prevent mental health problems developing.

Much of the work to develop thinking and set actions to achieve this has already been undertaken within the Framework for Children and Young People's Mental Health[9] and this strategy should make a specific commitment to take this forward by 2015. This will require that investment in the mental health of children and young people must go beyond Child and Adolescent Mental Health Services (CAMHS), incorporating mental health in early year's education, early intervention programmes for parents, such as Triple P, and early years health visitors trained in mental health where there is an emerging evidence base.

The provision of infant mental health services should be seen as the next frontier for early intervention in every locality where high levels of need are identified, to ensure good foundations are laid for future development. We would also recommend an inequality focus is required to intervene at the earliest point for those at highest risk. For example mental health issues are recognised as both a cause and potential consequence of being looked after. With 52% of children who are looked after experiencing mental health problems compared with 8% of children in general[10].

Teachers need support to deliver the new health and wellbeing outcomes in

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

[10] Meltzer, H., Lader, D., Corbin, T., Goodman, R. and Ford, T. (2004) The mental health of young people looked after by local authorities in Scotland. Edinburgh: The Stationery Office

the Curriculum for Excellence, which include mental health. The mental health strategy should act to include mental health within initial teacher training and continuing professional development, alongside wider consideration of social, emotional and behavioural needs.

The role of the GP cannot be ignored as this is often the first point of contact for many young people who present with physical health problems that may mask emotional distress. Therefore this strategy should outline more fully how we can work to enable GP's to identify young people in distress or at risk at the earliest point. There can be some of the greatest gains here. Freer (2011) provides recommendations within the Public Mental Health Handbook such as the need to provide effective, brief, pragmatic, case-based training as part of the GP continuous professional development and the importance of creating youth friendly GP surgeries and online contact opportunities.

Help-seeking amongst young people needs to be promoted to ensure that they access services at the earliest point. This must include providing services which meet the expectations of young people and young adults.

With young people and 'digital natives' now living lives which flow seamlessly between online and offline paradigms, services must be prepared to offer e-health opportunities for services, and at the very least the ability for people to make contact online. Similarly services for all ages must assess internet use as part of holistic assessment of needs and enable continued access to online social capital during admission and recovery.

Young people are willing and able to innovate in such a way as to develop services that match their needs. MHF has recently supported an Innovation Labs process with young people developing prototype mental health services that use technology to meet needs. Open Space large group processes and innovation competitions and events are good ways to encourage and involve young people.

'see me' need to develop specific approaches to ensure that they are using methods and developing messages that are relevant to young people, in keeping with the approaches taken as they developed their 'Just Like Me' campaign in the early years of the campaign. National organisations and initiatives like 'see me' and 'Choose Life' can be helpful in seeding youth led initiatives such as the forthcoming 'Re-capture' photography exhibition on eating disorder recovery.

The impact of bullying on children and young people, both during childhood and in later life, can be substantial.[11] Scotland is leading the way in anti-bullying work through the work of respect*me*, managed by SAMH and LGBT Youth Scotland, and this is laying strong foundations for the good mental health of children and young people. A strategy for Scotland's mental health should include a focus on anti-bullying work, particularly if mental health and resilience developing activities both in and out of school are to be accessible to those subject to inequalities.

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[11] BMJ 2001, Bond et al, Does bullying cause emotional problems? A prospective study of young teenagers, 2001

Because young people's mental health falls across the policy areas of health, education, communities and families the web of stakeholders is large, and both mental health and non-mental health specific organisations in civil society have a role to play. We welcome the continued Scottish Government funding of Young Scotland in Mind, and see the potential for similar small pan-policy collaborating groups in other areas of mental health.

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[12]. As the NHS is now responsible for healthcare within prisons, a strategy for Scotland's mental health should take the opportunity to improve mental healthcare in prisons and young offenders' institutions.

It is also important to recognise and support key transition ages within CAMHS and work towards forging of positive pathways towards supportive adult services. For many young people the shift from CAMHS to adult services can be traumatic and every attention should be paid to easing this transition. Link support should be available to help young people move out of services into community life but also to move out of CAMHS and into adult services, particularly for young people between 16-25 years.

Overall, we should be aiming for the establishment of a family-centred mental health service where parents are supported rather than blamed, and helped with their as well as their children's mental health needs with timeliness and sufficient resource.

Mental health literacy within the wider services that support children and young people is vital. It is important that teachers and youth workers are able to identify children at risk and enable them to access support. In training session we have run with local authority education, social work and youth work staff we have been told that an absence of lower tier interventions for young people have been a problem.

We would welcome a wider range of choice for referral or support for young people in accessing self-help or lower tier psychological interventions as a means of reducing CAMHS referrals.

This should be coupled with greater confidence building and capacity building for those working with young people, so that the value of general mental health improvement work and low level support for low mood and challenges can be seen. This may also reduce the feeling that only CAMHS can help.

We would like to see steps taken to enable peer support between young people, both in relation to lower tier support for those experiencing low mood or mental ill health, but also in wider vigilance and early intervention.

We see no reason why interventions similar to, but distinct from mental

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

health first aid and ASIST could not be developed for young people to help recognise and enable help seeking amongst friends and peers.

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

The provision of CAMHS across Scotland is patchy and inconsistent and the target that by March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMH services is too long for vulnerable young people to wait.

NHS Boards need to be provided with a strong message that those children and young people who are most vulnerable should be assessed in a much shorter timescale.

Guidance should be provided to practitioners to support them to identify children and young people at most risk, whilst being fully aware of the risks of intervening too early.

There is already a risk adverse culture within child protection and this should not be transferred to NHS services, however being aware of risk factors can help practitioners to prioritise those in greatest need of support.

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?

Self-management approaches and resources have an important role to play in supporting people to management their own mental health. We would recommend that these approaches and resources are targeted proportionately at those most at risk.

This will require that existing approaches and resources such as WRAP, online CBT and Living Life to the Full are pilot tested with different vulnerable groups such as older people, young people and BME and low-income communities.

Modified versions of these could then be made available via methods identified as most suitable by these communities (online CBT will be less suitable for the older old in our population).

Other approaches identified as being helpful by people themselves should be considered such as Mindfulness and art-based approaches. There is a limited but albeit positive evidence base on the value placed on the arts as a vehicle to promote recovery by people with mental health problems. They have expressed the importance of the positive new identities that they have adopted as artists after many years of feeling the weight of the negative identities attached to being diagnosed with a mental health problem.

There is a general need to support self-referral and reduce unnecessary gate keeping and early intervention routes such as Glasgow's STEPs service should be endorsed. This is particularly important around the threshold for people in later life, where they are often preventing from accessing services once they reach 65. Where possible early support should be located within primary care preventing people from engaging with specialists mental health services unless necessary. We would recommend that the strategy has a focus on early intervention services to support people in (social) crisis where short term focused support can be provided preventing problems from escalating and exacerbating existing mental health problems.

Models such as the user led crisis service in Lothian are positive examples of voluntary sector flexible responses that can reduce pressure on NHS crisis services.

The role of service user peer support and recovery workers within acute hospital settings should be developed. For example NHS Lanarkshire in partnership with Lanarkshire Links employ staff with service user experience to work within hospital wards to provide support on developing Wellness Recovery Action Plans. These plans are aimed at improving self-management and preventing future hospital admissions. These positive developments in peer support have not extended to people in later life however, and there is real scope in doing so as our evidence from Brighter Futures highlights[13]

In line with the requirements under Sections 25-31 the strategy should reflect the importance of local authority provision of community based positive approaches, particularly within non-health or social service settings. This should include access to leisure programmes, arts activities and open space programmes in partnership with local leisure services, park ranger services, forestry commission etc. The mental health in all policies support we have been providing to our Scottish local authorities has facilitated discussion of novel ways for public services to support recovery, and further capacity building for 'non-traditional mental health' departments to contribute as part of their existing outcomes frameworks would be beneficial. Throughout our work with older people we have been told repeatedly that often they do not feel that community services are for them. Joint work is required to support local authorities to work with older people to ensure that services that promote wellbeing are accessible and meaningful to them. One key recommendation would be to fully implement the TAMFS later life action plan.

The personalisation agenda provides opportunities for people with mental health problems to access the types of support that help keep them well and this change if properly implemented and supported could increase choice. When consulting with service users across the country we found that many experienced significant barriers to accessing self-directed support with a key feature being structural stigma, whereby services often felt that the service user would struggle to manage the process. It would be hoped that in the coming years the personalisation agenda will be implemented in a more equitable way.

The consultation strategy recognises the role of the Living Better project which worked to address the mental health of people with long term conditions. With the project finishing in March 2011, we call for the recommendations from the Living Better project to be adopted within this strategy to ensure that the focus on supporting the mental health needs of people with long term conditions is maintained.

Key suggestions from the final project report pertinent to this question include:

- Increased access to peer support services for people with long term conditions
- Improved signposting to community services by primary health professionals
- Increased access to mental health awareness training for those with long term conditions and those supporting them
- Recognition of times within patient journeys when mental health support may be specifically required, such as following diagnosis and around annual reviews.

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[13] Goldie I (2011) Brighter Futures [online]. Available at: http://www.mentalhealth.org.uk/publications/

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

The stigma of mental health and low levels of mental health awareness still persists across many health services. These factors act as a deterrent not only to help seeking by individuals, but also to the provision of appropriate support and signposting / referrals. A key factor within this is widespread misunderstanding of the meaning of the term “mental health”.

To address this, the strategy needs:

- To look at ways of developing a common language about mental health which encourages help seeking, e.g. adopting terms such as emotional wellbeing
- To provide mental health awareness training to frontline non mental health professionals
- To provide access to mental health awareness training to people at particular risk of developing mental health problems, such as people with long term conditions

A key area to consider in promoting help-seeking is in relation to stigma within communities and self-stigma. Within our work on the Brighter Futures project we found that many older people did not seek help, partly due to services often wrongly attributing their mental health problems as a natural consequence of ageing but also due to self-stigma and a sense that low mood was ‘to be expected’ when you got older. Our stigma reduction work in Scotland over the coming years should focus on all the types of stigma including stigma within communities and self-stigma and be aware that some groups experience higher levels of stigma and discrimination (people in later life and people from BME communities).

In general, services need to be meaningful to people who are most at risk and where possible be provided in non-stigmatising ways. The role of the voluntary sector is important in this respect as local organisations such as Health in Mind, LAMH and RAMH (as well as national NGO’s such as Penumbra and SAMH) are often able to work very closely with communities and provide flexible services in non-stigmatising ways (using local community centres). This expertise needs to be exploited and good practice shared with NHS colleagues. Equally the impact of the spending cuts on these services needs to be considered (this point has been more fully explored in the VOX spending cuts review paper – available on request).

As previously discussed, greater understanding of the ways in which people use new technology to reach out for help, and the extent to which they would like these avenues to be open for linking with services may create safe, and potentially low cost avenues for seeking support. We know that people with internet access do use the internet to reach out in crises, and it may be that traditional building based services with face to face appointments and waiting times may not suit some people, who might abandon help seeking and potentially present more acutely later.

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?

It is vital that first contact services properly identify the main issues that are creating the crisis for the individual. There also needs to be a lower tier of crisis support available within the community.

There are inconsistent admission practices with many people being admitted to acute hospital wards because of social situations that they face such as problems at work, with housing, family stresses or harassment in the community.

Introducing a mental health triage service that can properly assess the issues and identify local support opportunities is likely to reduce the need for admissions or shorten the length of hospital stay. However importantly it will improve outcomes for service users.

The Glasgow out of hours service offers this support and the learning from this work should be disseminated across other NHS Boards. Equally the voluntary sector crisis service in Lothian is a good example of a lower tier service that can be accessed in a flexible way at an early stage.

Peer led approaches have real potential to support people at these points and could be further developed with good practice examples emerging from the US.

In order to identify mental health needs of people with long term conditions, primary care services in general, and practice nurses in particular are key. However, the Living Better project found that primary care nurses require training and confidence building to integrate mental health screening and signposting into their role in managing long term conditions.

Consequently the Living Better project recommends that mental health awareness training be made available to all primary care staff to support more effective mental health assessments and referrals and signposting, specifically for those with long term conditions. To ensure the involvement and support of general practitioners it was also recommended that GPs are also involved in this training, and that at least one practice protected learning time session per annum is devoted to mental health.

Health checks for older adults and those subject to inequality are key aspects of preventative spend in screening and addressing long term conditions in areas of deprivation, via Keep Well they also provide a context for gentle discussion of mental wellbeing.

MHF has been delivering a new training course for practitioners to increase confidence in exploring mental health in the health check, bridging mental health, seen as a specialist or complex issue to the daily work of a range of public service roles. We see this as pivotal to enabling the public service workforce to realise and mobilise the mental health component of their role within existing capacity.

The training has been seen as a way of improving the effectiveness of the whole health check, and not solely as a means of addressing the small formal mental ill health section. The training session has been delivered fourteen times in eight health boards in Scotland, and has reached workforce groups as broad as practice nurses, physiotherapists, healthcare assistants and pharmacists. We have seen many examples of public service workers thinking laterally about their role in relation to mental health and wellbeing. We have seen some novel widening of access to the health check for other groups subject to inequality, such as in prisons and in employability services. This was widely seen as beneficial by both providers of the check, and by colleagues in these services. There have been some pressures on Keep Well practitioners as we observed in the sessions we facilitated, particularly in relation to the time they are actually given to complete the checks and the time they feel they need to make the checks maximally beneficial.

Primary care services also to be fully aware of the community referral options that are available locally to support good mental health.. The work undertaken by the ALISS project is in a position to support this and should be integrated within primary care settings.

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?

A learning culture needs to be developed to provide opportunities for practitioners to connect with research on what treatments and support approaches are effective. Often practitioners have few opportunities to explore different approaches and this is particularly the case for nursing staff, where it can be difficult to leave their posts to attend training and development sessions. The mental health voluntary sector also have few development opportunities due to contraction in funding as training budgets are often the first to go. This is equally the case with evaluation as although voluntary sector services are often highly monitored they have little or no funding to spend time on evaluating the effectiveness of their practice in more meaningful ways.

We need to take an evidence based approach whilst being aware that the absence of evidence does not always reflect how effective an approach can be. Therefore the workforce need the opportunities to reflect on guidance such as NICE and SIGN but also to have an eye to innovation where there is strong value placed on services by service users. The central issue in ensuring that time is not spent on non-value adding activities is to engage and listen to service users about what activities help them achieve the outcomes that they desire.

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

Within our BME response we have outlined the need for equality impact assessment and a programme of work around ICP's for BME communities and refugees and asylum seekers. Impact assessment in relation to other equality groups is also important including older people and LGB & T people.

One key issue in relation to ICP's is that the successful operationalizing of these requires services to work closely together and for this to happen the key intermediary role of the voluntary sector in supporting people to move between care and treatment and community life needs to be fully recognised. ICP's still feel like an NHS process when for many people support workers from within voluntary organisations often play the key supporting and linking role.

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?

The continued investment in the work of VOX is to be commended and has been recognised in the UK and internationally as a strong commitment to meaningful service user involvement in Scotland. However at a local level this commitment and investment is often more variable with some health boards strongly investing in local involvement structures and others either less so or not at all. User empowerment is an area where strong national leadership, coupled with consistent local investment could yield genuine added value.

The structure of local involvement mechanisms is a less of an issue, but it is vital that NHS Boards are monitored in terms of levels and quality of user involvement in planning, implementation and evaluation of services and in providing support for the development of service user leadership.

In Scotland we have no standards for user involvement, however the standards for community engagement could usefully be adapted and used as a tool for monitoring levels of local involvement. Locally there is much to be done to move from tokenism to full participation. We need to move to a system of monitoring NHS Boards in terms of user involvement in service design and delivery where service users themselves are asked to rate the NHS board performance and progress.

We also need to ensure that NHS Boards are involving all people who use their services not only those who connect with the service user movement (where structures exist). Many people who experience anxiety and depression would not view themselves as service users or engage with a service user network. In addition, there are many groups that are less represented in existing structures such as older people, young people and people from BME communities. NHS Boards need to be challenged to find ways to connect with these groups.

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

The key resource for working in partnership with service users and their families will be to train and support staff to work in a family centred way and to understand the different role of family within various cultures. This point has been addressed more fully in 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?

NHS NES have a pivotal role to play in staff training and development and have already made positive strides through the 10 Essential Shared

Capabilities work. This training needs to be widely available to the mental health workforce and should inform professional training programmes including clinicians.

Reflective learning environments should be developed including opportunities to explore issues online, individually through supervision and collectively within group settings. This does pose challenges in backfilling posts to allow staff time to learn. However, supporting workforce development will create more effective and efficient services in the longer terms where staff morale and wellbeing is supported. It needs to be openly acknowledged that the mental health workforce make complex decisions on a daily basis and can often be working with people at their most vulnerable point. We therefore need to walk the talk and support staff with decision making and provide opportunities for reflection. This is not only important for the mental health of the workforce but will create greater opportunities to share learning and will improve decision making. Mental health services need to move towards a learning culture. Student nurse training does not provide the same level of exposure to services as previous modular training and although this does provide a higher degree of formal learning opportunities for students it reduces the contact that services have with questioning students. Services no longer have the same level of focus on teaching, which needs to be recaptured to drive up standards of care.

Equally changes in the design of services mean that more nurses are community based and often services that deal with the most vulnerable people are not seen to have the same status as community services. In the past acute and forensic services were viewed as specialities and although we are moving back towards this we need to do more to provide staff working in those sectors with more specialist skills (including crisis services).

Ethnic monitoring and equality impact assessment need to become embedded into daily practice to ensure that people's cultural and specific needs are met.

The mental welfare Commission also have a key role to play in promoting awareness of the underpinning principles of the Mental Health (Care and Treatment)(Scotland) Act 2003.

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

Building on our experience within our mental health in all policies training, staff should be supported to explore what actions they can identify that they are already taking that support the implementation of the SRI. Often there is a range of activity taking place already that can provide a starting point and catalyst for change. The mental health workforce need to be supported to work together to identify for themselves improvements that need to be made and actions that will support this. Although this process will require facilitation and support.

Promoting ownership of the change process will not only help to ensure buy in from staff but enable staff to reflect on their own practice. These change processes should be led by groups or networks that are interdisciplinary and bring together staff and service users and carers. Existing recovery networks could potentially provide a mechanism for taking this work forward dependent on membership. Staff not only need to understand why they are being asked to change practice but it also has to make sense to them in the context of their own practice. To be successful in implementing the SRI it will be important to acknowledge the barriers and challenges that staff encounter and to recognise their efforts in making progress.

Service user have a strong role to play in promoting this work and again exposure to the stories of service users can be both compelling and challenging, motivating staff to reflect on practice.

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

The Scottish Recovery Network has made good progress in developing resources to support a cultural shift in services. In other parts of the UK Recovery as a concept can be treated with some suspicion amongst service users who often feel that it is a thinly veiled attempt to cut services. However the network in Scotland has to be commended for its work in ensuring that Recovery is fully and firmly on the agenda of services. We have only positive comments to make surrounding the recovery networks operating across the country such as within NHS Lothian and NHS Lanarkshire with whom we have worked closely around the development of SMHAFF. The role that SRN has played in supporting the development of Peer support again has to be commended.

The service user movement has gone through a period of development over the past 5 years and moving forward towards 2015 SRN should be supported to work closely with VOX and local involvement structures to ensure that service users are leading the cultural change within services. One of the key barriers in relation to embedding recovery approaches in services is stigma and building on the evidence of what works to address stigma then service users should be employed to train and support staff in recovery approaches and in monitoring change/progress (applying contact theory). The SRN currently supports the Scottish Mental Health Service User Research Network which can be used as a mechanism for developing service user evaluators who could recovery impact assess services.

One area for development is in relation to equalities and we would recommend that SRN prioritise this work in the coming years. Please see the Ethnicity in Mind response for fuller recommendations.

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?

Services need to move towards a family centred approach, where there is full recognition of the context in which people live their lives and the impact that family dynamics can have both in offering support but also in potentially being part of the underlying problem. This is particularly important for vulnerable service users such as older people and children and young people, where they often do not have the power to change elements of family life.

Adopting a family centred approach brings with it a number of implications for workforce development and service redesign. All new builds should consider accommodations that will support family engagement (e.g. comfortable, child friendly and private visiting space within ward settings).

The support needs of young carers have been a low priority with generic carers organisations often being the main form of support. However, the needs of young people who have a parent with a mental health problem can be complex and quite different from someone caring for a parent with a physical disability.

Glasgow Association for Mental Health's young carers project found that effective and consistent parenting was a major part of the issue for young people (e.g. the lack of a parent who instils hope about the future and helps their child to make transitions). More work is needed in this area to ensure that young people who have a parent with a mental health problem get the support they need and where possible are preventing from developing a mental health problem later in life themselves.

There are currently no formal involvement structures for supporting carers nationally although there are some examples of positive local work such as Lanarkshire Links, GAMH and MECOPP. We would recommend that this strategy commits to consulting with families and carers on the best way to involve them in local and national policy and service design. It cannot be assumed that a VOX structure would work for carers and previous attempts to develop such a structure failed. More innovative approaches may be required such as online contact, however there has been little exploration of the views of carers since 2005 therefore work needs to be undertaken to revisit this with a wide range of families.

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?

Professional training and ongoing professional development training and support should aim to build competency within the mental health workforce to operate in family centred ways.

These training resources and activities should reflect the complexity of family life both in terms of the potential for support but also in terms of dysfunctional family relationships being a determinant of mental health problems. Staff should be supported to assess family dynamics and to negotiate change within families. They also need to be equipped to provide practical support such as signposting family members to carers services (where they exist) and connecting young carers with services that offer support for young people.

It is important when working with vulnerable people such as children and young people or people with dementia to learn from the current review of child protection that risk aversion can interfere in family dynamics and dismantle systems of support. Staff need to be supported to explore how best to balance working to achieve the best outcomes for the individual within the complexity of a family unit. When people need to move onto continuing care such as within care homes there needs to be commitment to retain family support and engagement (respecting the role that they have in their family members life).

Sharing information with carers when a person presents in crisis is a complex area and never more so than when involving a particularly vulnerable person such as a young person who may be disclosing self-harm or someone with dementia. The mental health workforce often has to deal with these complexities in isolation. It should be acknowledged that to deal effectively with these issues staff need to have a high level of emotional literacy and strong interpersonal skills.

This raises issues around: recruitment of staff; focus of professional training; access to good quality support and supervision, professional development resources and opportunities for reflection. Much of this agenda was explored within Rights, Relationships and Recovery (the review of the nursing workforce) and it would now be timely for the Mental Health Strategy to commit to reviewing progress and supporting NHS Boards to further implement. Similar work needs to be undertaken with other mental health fields including the often forgotten voluntary sector workforce.

Voluntary sector services are monitored by the Care Commission and a review of workforce competency and training needs could be usefully undertaken in partnership.

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 therapeutic nature of inpatient psychiatric wards has been called into question over recent years both by service users themselves and within reports such as the Centre for Social Justice Report (2011)[14] which recently called for the need to 'complete the revolution'. This report stated that the move to 'community care' and the cultural shift that was required never fully happened following the hospital closure programme. It also stated that many hospitals are untherapeutic and services are risk averse, driving much detention and levels of medication. They recommend that acute inpatient psychiatric wards should become Psychiatric Intensive Care Units and have higher status, better defined models of care and work more intensively with the patient, so their care can be 'stepped down' to a community setting at the earliest, most therapeutically appropriate point. This is a recommendation that we would endorse. We would also recommend higher levels of support to make the transition back into community life and support to remain connected with as much of daily life as possible when in an acute inpatient setting. The focus of acute services should be on supporting the service user to remain as connected as possible and retain as much control in their lives as they can. The National Standards for Crisis Services provide recommendations around therapeutic risk taking that should equally apply to all mental health services.

Over recent years we have had an increase in the development of crisis services which have in part aimed to reduce hospital admissions, however although large scale investment in these services has created greater specialities they appear to be difficult to sustain and not achievable in many parts of remote and rural Scotland. Many service users have told us that what they need in crisis is someone that they know to talk to and out of hours access to support. We would recommend that crisis services continue to develop but that these should focus on the hours that day time services are unavailable and we should be equipping day time service staff with skills to support someone in crisis (CPN's and voluntary sector staff).

We would also recommend that all nurse training start with generic skills and knowledge about mental illness. It should reflect the prevalence of mental health problems, the co-existence of mental and physical ill-health and the need to avoid stigma and promote good mental health behaviours in whichever specialism they practice. This has the potential to make a real difference as many people with mental health problems experience stigma and discrimination in general hospital settings including people that are particularly vulnerable such as older people and people with dementia.

Primary care also has a vital role to play in supporting people with common mental health problems and reducing people's need for specialist mental health services (that often have more stigma attached to them including self-stigma). Where possible primary care staff should be supported to develop competencies that support them to identify need, deliver effective brief interventions and to signpost and refer to appropriate services where needed.

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[14]

The role of the voluntary sector is pivotal and much of the ongoing support for people experiencing longer term mental health problems is provided within this sector. Service users currently have real concerns about the future of the voluntary sector (more on this point is available within VOX's review of the spending cuts). Certainly the common perspection is that services are at risk. The personalisation agenda brings many opportunities but also risk. Services such as Clubhouses will struggle to operate and we feel that the impact of personalisation on mental health services needs to be carefully monitored to be sure that service users do indeed experience greater levels of control and choice and don't find themselves losing vital community support services.

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?

We should have equality indicators on all HEAT targets so that NHS Boards have to demonstrate progress in relation to BME communities. Data recording and monitoring needs to be mandatory e.g. in relation to the HEAT target linked to SIMDR. If we are to improve accessibility to services we will need to fill the gaps in data collection for BME communities that currently exist.

Much further work needs to be undertaken to fully understand the significance of 'double stigma' and for some groups, such as Gypsy/Travellers, the impact of racism and/or 'feeling you have to hide your identity/ethnicity' on your mental health. We are aware from our work with these groups that this stigma can have a significant impact on people's lives, but more information is required to enable us to understand how we can best provide accessible and appropriate support.

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

There needs to be a forum to share knowledge and expertise in relation to working with people from BME communities, where the voluntary and statutory sectors come together to support, promote and share knowledge in this area. The loss of the regional networks that were developed by NRCEMH and the NHS Health Scotland race equality programme means there is currently no shared learning environment beyond Ethnicity in Mind (where the main focus is on research). However the Ethnicity in Mind network provides a transferrable model.

There needs to be more cross-departmental working and knowledge transfer to make services more accessible to people from BME communities. NES has a key role to play in disseminating learning to inform clinical and workforce training. NES should connect with the work of Ethnicity in Mind to benefit from evidence from research in this field and to engage with a wide range of perspectives. Mandatory staff training on ethnicity recording linked to the KSF process is required. It is important to provide mental health awareness training to interpreters to ensure that they are provide sensitive and appropriate services.

It is also important that we raise awareness mental health and expectations within BME communities themselves and work through current service user involvement structures to support them to reach out to service users, such as PFPI and local user forums. However it is important to be mindful that these structures may not be the most appropriate way of engaging with people from BME organisations and we need to learn from the work of VOX in establishing innovative ways to engage.

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

Comments

Again we would emphasise the importance of addressing the mental health of people with long term conditions. Evidence from the Living Better project not only highlights greater mental health need within this population, but also indicates that individuals with long term conditions feel there is a current lack of mental health support available to them, either from health services or community services.

Gaps exist in relation to children and young people from BME communities, refugees and asylum seekers, Gypsy/Travellers, women, people subject to human trafficking, and BME community members who are LGB or T. We need to recognise and equip the mental health workforce to address intersectional issues, for example the needs of female asylum seekers. There are a number of service gaps that exist for BME people including access to advocacy services and to psychological therapies as well as counselling services. Overall, to promote help-seeking and reduce stigma it is important to develop work that engages the wider BME communities to build their capacity to identify people who may be at risk and to provide local support and where appropriate signposting to more specialist services.

We anticipate that the forthcoming strategy will address the gaps in services for older people (including those with long term conditions) through the implementation of the TAMFS later life action plan and responses to the later life consultation on this strategy. We also welcome the further implementation of the dementia strategy but hope that this will not be viewed as the only later life action/commitment. Both this plans need to be enacted equally.

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

Comments

There needs to be a greater recognition within the mental health strategy of other governmental departments, divisions and units can make to mental health improvement. This would specifically include other health divisions where there are known to be higher risk of mental health problems occurring, such as the long term conditions unit.

Strategic partnership working is necessary at a governmental level between these two areas of government, if it is to effectively trickle down to Health Board and Community Health Partnership levels.

Work needs to be undertaken to bring together the disability and equality agendas to ensure that we take a human rights approach to mental health and acknowledge complex identities that people have and co-morbidity. The mental health workforce need to be provided with support to translate disability, incapacity and equality legislation and alongside mental health law and to understand what this means for their practice.

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?

Again we would point to the need for more holistic working across government which recognises the interrelatedness of mental health and physical health and identifies whole person approaches which can be adopted and delivered within local communities.

Work around equalities in essential to meet the gaps in services for members of BME communities and refugees and asylum seekers.

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?

Workforce development resources including individual support and supervision processes need to focus on values, culture and behaviour as well as skills and knowledge and line managers need training in creating reflective learning environments for staff working within their teams. For example debriefing sessions following critical incidents have long been considered to be best practice in supporting reflection, practice improvement and wellbeing of staff but in practice these are not consistently provided. Developing a more reflective environment is vital if practitioners are to be supported to explore complex issues such as identity, culture and human rights.

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

We would recommend a survey that explores cultural competency would be an important development as the workforce currently seem to lack confidence in this area as lack of effective ethnic monitoring would suggest. Such a survey would provide a clear direction for workforce development and training. Equally service user involvement practices are variable across the country and tokenism is still a key issue, again a survey to explore competency and training needs would help to move this agenda on

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

During the capacity building sessions with primary care, anticipatory care and local authority staff MHF has run over the last two years, a key point raised has been the value of reflection time.

The sessions have been valued as opportunities to look at job roles in the context of a wide range of policy outcomes and areas of interest.

Understanding role in context was seen as being important for motivation to collect data and engage in outcomes focused planning.

The primary care and anticipatory care training sessions discusses complexity in primary care, and the potential offered by the Minnesota Edinburgh Complexity Assessment Tool currently being developed by the Universities of Edinburgh and Stirling. The idea of complexity has been well received by practitioners, who have broadly welcomed the idea that a method of assessing and prioritising chaotic and difficult circumstances might improve patient outcomes as well as assist with workforce stress, and stigma.

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

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.

See Ethnicity in Mind response for information on this point in relation to the need to undertake benchmarking around service responses to the needs of BME communities, however this is also relevant for other equality target groups. We already have the tools to equality impact assess and these should be applied to national benchmarking resources.

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

Comments

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

MHF believes that understanding the role of mental health and wellbeing in delivery should be part of the competences of most public service professionals.

All nurse training should start with generic skills and knowledge, including about mental illness. It should reflect the prevalence of mental health problems, the co-existence of mental and physical ill-health and the need to avoid stigma and promote good mental health behaviours in whichever specialism they practice.

Mental health, and the social determinants of mental health should form a greater part of undergraduate medical training, and in postgraduate training for GPs and the Royal College of GPs should review their curriculum accordingly.

Outwith the obvious route of clinical training, a wide range of workforce groups have been identified in a piece of scoping work undertaken by SDC for NHS Health Scotland as having a role in mental health improvement.

Capacity building and development support for these groups to recognise, leverage, and promote their role in mental health improvement would increase the capacity of non-clinical staff to improve mental health.

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

This improvement work needs to focus equally across NHS services and the voluntary sector. Both these sectors play pivotal roles in supporting people at different points and are of equal importance. To date the role of the voluntary sector has frequently been ignored has lacked investment and as a result services have not had the same opportunity to reflect and learn. However despite this much innovation takes place within the voluntary sector and there is much to be gained in enhancing partnerships between both sectors (and beyond).

All improvement work needs to centre around the views and experiences of service users, we need to continue to develop creative ways to meaningfully engage people with mental health problems in service improvement work. We need to continue to find ways to engage people who often have least voice such as people with dementia, older people, children and young people and people who have complex needs.

With regards to dementia, the work of the Scottish Dementia Working Group, is highly commended and offers a blueprint for how people with a diagnosis of dementia can collaborate to influence policy and practice at a national level. It is important that their work continues to be supported. There is also potential for positive links to be made between SDWG and VOX for example, to explore and advocate for the mental health needs of people with dementia.

On a UK level, the Dementia Engagement and Empowerment Project (DEEP), led by MHF, has gathered together evidence on the nature and extent of the participation of people with dementia in the design and delivery of services and their role in campaigning for change. The findings from this project, which are due later in 2012 will offer useful information to bolster user participation by people with dementia in voluntary and statutory agencies.

We need to continue to take a public mental health perspective and bring together colleagues from the health improvement world, public health and mental health services to ensure that we work to promote mental health, address inequalities, prevent mental health problems and support recovery.

Equally we need to continue to find cost effective ways to make mental health everyone's business and to build champions and mainstream mental health improvement work across a range of universal settings. To achieve this effectively we need to build mental health leaders who feel confident and able to facilitate these developments in others. We would recommend that a mental health leadership programme be re-established with a key focus on promoting equality, addressing inequalities and challenging stigma and discrimination as these are the really difficult issues that we need to tackle and we need strong and well supported leaders to take these forward.

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?

Practitioners often focus on aspects of mental health law where they have specific responsibility and the underpinning principles and Sections 25 -31 are given less priority. Currently there is no requirement to report on activity towards addressing these sections and no statutory organisation has a role in monitoring these activities.

The mental health workforce need to be provided with support to translate disability, incapacity and equality legislation and alongside mental health law and to understand what this means for their practice.