

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.

Support in Mind Scotland has consulted with members and people who use our services (who are both individuals experiencing mental illness and carers), and we welcome the approach to the consultation as being inclusive and with a timescale that has given us time to carry out this consultation. We welcome also the 4 areas of focus, and the fact that the strategy focuses on the whole person, on recovery and the importance of engaging with family members and carers.

One gap is that there is less emphasis than there needs to be on the needs of carers themselves for care and treatment in their own right particularly in relation to those caring for someone with severe mental illness who can be under significant strain. A second, more significant gap, is in the omission of forensic mental health services – i.e. services for people who need care and treatment in a secure setting. Finally, there is a need to give consideration to older people who experience mental illness other than dementia.

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.

Translating national policy and intention to quality local services being delivered equally well across the whole country remains a challenge. Good practice exists but sharing the learning from that good practice is patchy and depends too much on individual Service Managers' own priorities, preferences and inclinations. A national lead in trying to design and implement more systematic ways of rolling out good practice would be

valuable.

National leadership in terms of some key areas was identified through consultation with our members and service users :

- Transition between services remains difficult, and in terms of older people, the move from adult services to older adult services can result in lost continuity of service, and even more noticeable stigmatising from staff
- The need to challenge stigma was overwhelmingly the view of people with mental illness, and leadership in advancing public education through social marketing and media, as well as through ensuring this issue was a key part of the school curriculum were highlighted.
- The Welfare Benefits system still discriminates against people with mental illness

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

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?

This is not a specialist area for Support in Mind Scotland; however, our first observation is that suicide and self harming behaviour ought to be separated and considered separately, as self harm does not always indicate suicidal thoughts or tendencies.

In addition, we believe that, as in questions 9 & 10 to follow, responding quickly and sensitively to people who know they are becoming unwell is an important step in improving the overall wellbeing of the population and helping to reduce suicide.

The actions through Choose Life have been very effective in helping to open up the difficult issue of suicide, but the lack of appropriately trained staff within the NHS and other agencies present barriers to people who feel suicidal and who approach agencies to talk about these feelings. Continuing to roll out ASIST, Suicide Talk and other training for staff is important, not just to equip staff to respond, but to further reduce the fear

around talking about suicide amongst the population.

Our members with long term mental illness have described experiences of being left too long alone between appointments and feeling abandoned, and this impacts on their feelings of suicide; there could be more done to develop crisis plans and action plans for people leaving hospital, and/or presenting themselves in crisis to other staff.

Appropriate and sensitive support and information services for carers are also needed to help carers of people who have mental illness to respond to the person they are caring for if they express suicidal thoughts or attempt suicide. Information is available and encouraging and enabling staff to talk to carers openly about this issue would make that material more accessible.

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

Support in Mind Scotland works with other agencies with more direct expertise in this area, although we know and stress that this is a fundamental area of concern for our members and for us as an Organisation.

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?

Support In Mind Scotland is on the Management group of See Me, and is a full Alliance member. We will be part of the current review of See Me's objectives and structures, and will work with partners to develop the campaign based on evidence through research and consultation with people experiencing discrimination.

Our contribution to building on the progress made will be to support this review by consulting with our members on the issues, and to continue to support the campaign on an on-going basis. Key areas of work for us as an organisation in the future will be:

- Ensuring that messages presented in See Me and other materials present a positive image of people with mental illness, as some of our younger adult members have expressed this as a concern
- Supporting older people experiencing mental ill-health and their carers
- Speaking up for people experiencing discrimination in finding and/or sustaining work or training opportunities
- Developing information, training and support for carers to enable them to cope better and challenge discriminatory practice impacting on them and/or the person they care for

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

As for questions 9 & 10 to follow, our work is with people with mental illness and although we support any work that keeps people well, it is our priority to

ensure that people who know themselves they are becoming unwell, or whom others identify as becoming unwell, seek and are given help quickly and compassionately, so help reduce the impact of the illness on the long term wellbeing of the individual, and to promote early recovery.

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?

This is not our area of work or expertise. We support the general principle of intervening as early as possible to prevent ill-health and reduce the impact of ill-health on individuals and families.

However, we are concerned that we address transition issues between CAMHS and adult mental health services as the age of transition from one to the other cuts across the most likely ages of onset of psychosis, thereby compromising the necessary levels of expertise to work with young people and adults.

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

Comments

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

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

As with previous questions, our aim is to achieve adherence to the principle of early intervention. An important action is to raise awareness amongst primary care providers who may be the first point of contact with someone who is becoming unwell, or their carer, to recognise when intervention is necessary and to be able to take the appropriate action. The important principle of practice is that the person and/or their carer are taken seriously.

More specifically, we need to emphasise the importance of accessibility of services, particularly for people whose mental health has deteriorated after a period of being well and for people who face sudden emotional social or other difficulties that threaten their mental health and wellbeing.

A particular concern is the move to Self Directed Support that, although promising more person-centred services, choice and control, will require assessment and administrative management. We are concerned that a significant number of service users will either not comply with assessment procedures, or not have their needs addressed within an assessment and administrative time frame and that will pose them a greater risk. We must ensure that some services remain freely accessible without hindrance of professional assessment and bureaucratic control.

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

Encouraging people to seek help is complex, requiring good information and education about illness and what help is available in their area. However, this is too simplistic, as encouraging help-seeking is far more complex.

People need to trust that the person they approach for help will listen, respect their own assessment of their situation, take them seriously and know what action to take. For people who are already becoming unwell, seeking help also becomes more difficult the more ill they become. Therefore, our work in this respect fits in a context of society being more tolerant, service providers and professionals being more able to recognise when action needs to be taken and being more compassionate in their response to people who are unwell.

We also urge professionals to listen to family members, friends and carers when they are raising concerns and work with them to try to provide help, within the constraints of confidentiality and personal responsibility that underpin services.

Help seeking is an outcome of other aspects of this strategy being put in place.

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?

Support in Mind Scotland is delighted to see the inclusion of Early Intervention in the Strategy, as an evidence based approach to early intervention for psychosis has been demonstrated to be cost effective and to deliver better outcomes for people in a Scottish context. We have worked closely with the Universities of Glasgow and Edinburgh to explore this issue and highlight the needs, and we recognise the major contribution made by Dr Andrew Gumley to the response to this question.

There is consistent evidence that EI services have benefit for engagement rates, readmission rates, access to family interventions and other psychological interventions and rates of functional recovery in patients with first episode psychosis.

A meta-analysis of various studies provides additional evidence to support the content and approaches, which early interventions services should deliver. Early intervention services providing a combination of individual CBT and family intervention reduce hospital admission, relapse rates and symptom severity, and improve access to and engagement with treatment. For people with early psychosis, early intervention services have clinically

important benefits over standard care.

Bertelsen M, Jeppesen P, Petersen L, Thorup A, Ohlenschlaeger J, le OP, et al. Five-year follow-up of a randomized multicenter trial of intensive early intervention vs standard treatment for patients with a first episode of psychotic illness: the OPUS trial. *Archives of General Psychiatry* 2008;65(7):762-71.

Nordentoft M, Ohlenschlaeger J, Thorup A, Petersen L, Jeppesen P, Bertelsen M. Deinstitutionalization

revisited: a 5-year follow-up of a randomized clinical trial of hospital-based rehabilitation versus specialized assertive intervention (OPUS) versus standard treatment for patients with first-episode schizophrenia spectrum disorders. *Psychological Medicine*;11:1-8.

Thorup A, Petersen L, Jeppesen P, Nordentoft M. The quality of life among first-episode psychotic patients in the OPUS trial. *Schizophrenia Research*;116(1):27-34.

Gafoor R, Nitsch D, McCrone P, Craig TK, Garety PA, Power P, et al. Effect of early intervention on 5-year outcome in non-affective psychosis. *British Journal of Psychiatry*;196(5):372-6.

Jackson HJ, McGorry PD, Killackey E, Bendall S, Allott K, Dudgeon P, et al. Acute-phase and 1-year follow-up results of a randomized controlled trial of CBT versus Befriending for first-episode psychosis: the ACE project. *Psychological Medicine* 2008;38(5):725-35.

Killackey E, Jackson HJ, McGorry PD. Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. *The British journal of psychiatry : the journal of mental science* 2008;193(2):114-20.

Guo X, Zhai J, Liu Z, Fang M, Wang B, Wang C, et al. Effect of antipsychotic medication alone vs combined with psychosocial intervention on outcomes of early-stage schizophrenia: A randomized, 1-year study. *Archives of General Psychiatry* 2010;67(9):895-904.

McCrone P, Craig TK, Power P, Garety PA. Cost-effectiveness of an early intervention service for people with psychosis. *The British journal of psychiatry : the journal of mental science*;196(5):377-82.

Bird V, Premkumar P, Kendall T, Whittington C, Mitchell J, Kuipers E. Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: systematic review. *Br J Psychiatry*;197(5):350-6.

Why are specialist Early Intervention services needed?

Most untreated psychosis, leading to an extended duration of untreated psychosis (DUP), exists within existing mental health services i.e. mental health issues have usually been identified already and the person is already in contact with mental health services – but psychosis has not been identified. This is why there is a need for a specialist Early Intervention service. If an Early Intervention service is provided it can and must work with primary care and wider mental health services and it is a resource to these wider services (see point 5 below).

Some evidence is now available about the rate of transition to psychosis in 'high risk' groups receiving additional, specialist mental health input. In the recent MRC EDIE 2 study, individuals at ultra high risk of developing psychosis could be identified from primary care, secondary care and voluntary sector organizations. This group engaged with monitoring based interventions or Cognitive Therapy. In a systematic review Preti & Cella identified 7 reports were identified detailing results from five independent RCT studies. Results showed that receiving any of the focused treatment was associated with a lower risk of developing psychosis if compared with no treatment or treatment as usual.

Preti A & Cella M (2010) Randomized-controlled trials in people at ultra high risk of psychosis: A review of treatment effectiveness. *Schizophrenia Research*, 123, 30-36.

Our experience with families in Scotland shows that the main frustrations are:

- Families concerned for their young person are often met with the

advice that nothing can be done unless the young person themselves seeks help – even though we know that the more unwell someone is, the less likely they are to know this and/or to seek help

- Families and young people are often told that their behaviour is 'normal' adolescent behaviour, or a result of misusing substances
- Late intervention often leads to a crisis resulting in compulsion under mental health law or the criminal justice system which is traumatic
- Late intervention can lead to criminal behaviour or thoughts of suicide

What changes are needed to existing service design in Scotland?

A key change to service design would be the introduction of a similar developmental approach to all mental health services as currently exists in CAMHs and Early Intervention services; i.e. a process of formulation that would be focused on the individual, with his/her diagnosis playing an important part, but not the only part, in determining the interventions best suited to that person.

Early Intervention, and a developmental approach, also have at their heart the belief that people can grow and change – in this regard this is directly comparable to a Recovery approach and the 2 approaches are complementary. Yet too many of our adult mental health services do not take a developmental approach.

In addition one could legitimately ask whether the current allocation of individuals to age related services is always in their best interests. There are significant problems attached to transitions, whether these be from CAMHs to adult services or from adult to older people's services, and it might be more useful (and cost effective) to develop services take greater account of individual needs. If this were the case, then Early Intervention services for people experiencing their first episode of psychosis would not necessarily need to be restricted to people of only a certain age.

We recognise that there are both resource and cultural challenges in adopting the particular approaches outlined above but we believe that moving towards a new model of mental health care and treatment of this kind would yield positive results over time and be aligned with the NHS Quality Strategy for Scotland.

Rural and Urban Services

For Scotland, with its varied geography and pattern of settlement ranging from urban to rural/remote, one model of service design will not be suitable for every area. There are particular differences, for example, between the central belt and the Highlands and Islands. The important thing is that each area should have an Early Intervention resource that encompasses the components listed under Point 3. Early Intervention services can be a direct service OR a resource to existing services, as is currently the case in rural Ontario and Cornwall.

In cities and other heavily populated areas a dedicated Early Intervention service would be justified by population numbers. In rural areas, the service design may need to be more of a resource to existing services. For either, dedicated Early Intervention resource has to include an education/training

element for non-Early Intervention mental health practitioners. It is possible to have the Early Intervention model and approach and support its implementation within existing services in rural/remote areas (rather than providing directly itself). But staff development is an essential component of this. Skill sharing/skilling people up in these areas (while not assuming that all expertise lies with the Early Intervention team) in Early Intervention approaches would ensure that access to such expertise would not be reliant on living in a large population centre.

Hub and Spoke models of early intervention reaching out into remote and rural settings are being developed across Australia (EPPIC Statewide). These settings have rural areas more vast than the whole of Scotland. Training, IT and consultation methodologies ensure adherence to model. The Scottish Government Chief Scientist Office have funded Health Improvement research into the development and evaluation of an Integrated Care Pathway for early psychosis. This research will provide an evidence-based model of implementation of EI in the Scottish context and could be rolled out and disseminated with training and follow-up to local teams and services.

What does an Early Intervention service for psychosis look like?

Early intervention (EI) services offer comprehensive multimodal and multidisciplinary care in the early phase of psychosis. Their aim is to provide quick access assertive outreach, to reduce duration of untreated psychosis by providing a range of therapeutic approaches to minimise symptoms and maximise functioning, specifically targeting this population.

Therapeutic approaches include low dose medications, family interventions, psychosocial interventions such as groups, CBT and vocational rehabilitation. Early intervention services focus on engagement, emotional recovery and tolerance of diagnostic uncertainty, usually including service users within the spectrum of psychosis.

The majority of EI services do not exclude those who use substances/alcohol but no specific evidence was identified looking at outcomes for this group.

To be defined as an Early Intervention service in the accepted sense, the following key components MUST be present:

- Multidisciplinary
- Open about and comfortable with diagnostic uncertainty;
- Services that can work with people in an age and culturally appropriate way (e.g. can relate to young people and others in a way that they can engage with)
This requires a developmental approach – taking into account the individual plus the development of their life context – this is a significantly different philosophical approach from most adult services
- Assessment done on outreach basis
- Multidisciplinary case formulation
- Psychologically informed care
- Developmentally sensitive
- Family engagement
- Family interventions (systemic and behavioural)
- Psychological therapies (CBT)
- Vocational interventions
- Minimal dosage of medication
- Assessment and follow up during critical period – up to 3 years.

- **Multi-disciplinary formulation**
History + current factors connected to the individual –how they interact over time → when best to intervene → possible barriers to intervention.
People are assessed by ESTEEM for 12 weeks before a provisional formulation is made. An extended assessment takes place if there is uncertainty after this period of time.

Without the above components, it is not an early intervention service.

There is a need for flexibility about how long someone may require to use the Early Intervention service, for example for those at most risk of arrested recovery. Approximately 60% of ESTEEM patients don't go on to CMHTs for this reason, but continue to receive treatment via ESTEEM. This maximizes clinical outcomes, quality of care and cost effectiveness.

There is also a need for flexibility in terms of family/carer engagement. For example, if families and carers have a different view of the situation that the service user, separate workers from the same service can work with each. This is the approach followed by ESTEEM.

It is relevant to note here that if someone refuses to engage with the Early Intervention service in spite of best efforts (including the use of age/culturally appropriate outreach), then the first intervention may still be via use of mental health legislation but the person can subsequently be referred to the Early Intervention service.

Action

- Continue to promote and encourage a recovery approach in treatment, through the implementation of the the Rights, Relationships Recovery work and standards
- Develop and adequately fund Early Intervention services across Scotland, particularly in the rural areas, and to see these services linked to wider initiatives for young people and adults – such as education, housing and other services – and not just linked to statutory health services
- Provide ready access to a source of informed advice for NHS staff not necessarily working in mental health – prioritising GPs as they will not necessarily encounter serious mental illness for the first time and so may not be expert in recognising the signs
- Resolve the problems caused by the division of mental health services into CAMHS and adult services, recognising the average of onset for mental illness
- Ensure staff are trained to have the skills to adopt a developmental approach to working with individuals – i.e. able to take into account an individual's wider developmental needs
- Promote services where psychological and social interventions are as effective as medical interventions

A final, and absolutely vital need is that we develop practice that truly engages family and friends as allies and partners. Addressing issues of confidentiality is mentioned in responding to other questions, and ensuring

that families are given the support they need in their own right to:

- Understand the social, legal and other issues they face
- Know where they can go for help and support
- Be as informed as they can be to be able to support their relative and be an effective part of the care and support required taking into account their own needs and capacity to provide that support

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?

Support in Mind Scotland welcomes the development of psychological therapies as a very useful adjunct to medication, which in itself is not a cure. For people experiencing psychosis, they often report also feelings of severe anxiety, depression, despair and other feelings that are associated with worse outcomes and even leading to suicide, and psychological therapies have been shown to have beneficial effects in addressing these emotional issues.

Working with the whole person, more comprehensive assessments and assessments focused on recovery (considering more than treating the immediate illness) are fundamental principles.

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

NHS Boards need more guidance and instruction on how to put ICPs into practice. Models which see designated individuals having responsibility for the implementation of ICP have sometimes resulted in ICP being seen as a specialist activity and not part of a core approach. Elsewhere, where responsibility for ICP has been added on to the workload of existing staff it has been an area of work that has not received the priority it requires.

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

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

We very much welcome and support the inclusion of focusing on recovery as a principle of the strategy. We are partners with the Scottish Recovery Network and Support in Mind Scotland was on the Working Group that developed the 10 Essential Shared Capabilities for Mental Health Practice. We support continuing this work.

Our concerns are that locally, financial constraints will lead to service losses and reductions locally, thus making it more difficult for service users and

carers to be involved in service design and delivery, and, importantly, have no say in the difficult financial decisions that are being made about services.

This makes the availability of advocacy for service users and carers vital, and we would hope that there will be no reduction in funding for advocacy, but that these services are protected.

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

Support in Mind Scotland would talk less about tools and more about approach: we support the drive towards co-production as a model of working that enables the individual to own and be part of resolving and addressing the issues that affect them, so developing partnerships at the individual service level.

However, for carers, Support in Mind Scotland is developing range of publications and training materials that will enable carers to be better informed and more able to work with professionals:

- Wills and Trusts Booklet – information on the legal and financial aspects of caring for someone with a mental illness
- Carers' Information pack – factual information on illnesses, treatments and sources of support
- Prospect Personal Development Training – a modular based training programme for carers to increase their confidence, their coping skills and their capacity to develop through the experience of caring for someone. One module in this programme is called "Common Ground", aimed at bringing professionals and carers together to share perspectives and experiences and reach more effective ways of working together.

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?

Comments

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

Comments

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

Comments

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

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

Support in Mind Scotland welcomes the inclusion of this principle in the Strategy, but feel we still have a way to go, in spite of the very positive developments that there have been and that are outlined in the document.

Carers can now more easily find information and sources of support than a decade ago, as we found in our survey in 2010: "It's their job; it's my life". However, supporting carers goes further than supporting their role in the care and treatment of their family member. Carers need support in their own right to fulfil their caring role; and, particularly for carers caring for someone with severe mental illness, their own health and wellbeing can be affected by the stress and difficulty of providing support. Ensuring that assessments lead to appropriate support for carers themselves is very important.

In general terms it is not helpful to talk about carers always in purely generic terms. Carers who use our services have said that much more regular contact with psychiatrists is required for those with severe mental illness and for their carers. It would be helpful for this to be instigated by psychiatrists and CPNs rather than waiting for the carer to contact them.

Caring for someone with a mental illness does create additional/different anxieties and needs and one large gap in the Strategy is consideration of forensic services – services for those who require care and treatment in secure settings. In these very difficult and stressful circumstances, carers may themselves develop mental health problems.

Support In Mind Scotland hosted a conference on this issue in 2010, and several key recommendations emerged in relation to supporting carers:

- One specific issue for carers in this situation is the need for professionals to have clearer guidelines about what can and cannot be shared, as the issue around confidentiality makes supporting the person who is ill even more stressful.
- There is a need also for better support of carers through the criminal justice system, including advocacy, better information and clearer protocols.
- The concept of recovery for carers has to be considered and understood by professionals
- Earlier intervention – including earlier support from local police following initial contact from the carer about their concerns

Finally, further work could be done between carer advocacy organisations and the mental health tribunal service in ensuring carers are offered and informed about carer advocacy when they are identified as the Named Person.

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?

As with the response above, staff need clearer guidelines and protocols about what can and cannot be shared with the carer within the context of maintaining confidentiality. Carers need information to be able to be not just involved in their relative's care, but in fact to be the main carer for that person. Carers would benefit from having a clear named person who would keep the carer informed, as this can become lost when many professionals from many different agencies are involved.

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

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

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?

This issue gives rise to concern. Although we welcome the move to identify the minority and at risk groups who currently do not or cannot access services, and thereby work to improve access, the use of information on who uses services has to be carefully regulated. Providers, including organisations like ours in the voluntary sector, gather information and are happy share anonymised, statistical information to enhance the capacity of the Government and the NHS to understand where the gaps are.

To address this issue, realistically, an organisation like Support in Mind Scotland cannot target unrepresented groups independently but must work with specialist minority organisations who will be able to reach those who need support and develop partnerships with those of us who can provide it. Ensuring we gather and submit accurately aggregated information (avoiding double counting etc) is a responsibility of such organisations.

However, we are very uncomfortable with being asked to supply information about service users that is not anonymised, or is being used for other purposes – such as costing services as has happened in Glasgow because of the move to introduce self-directed support as the primary mechanism for funding and delivering services.

Therefore we would ask the Government to put in place strict guidelines for Councils on the kinds of information that can be gathered and the purpose of gathering it.

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

Comments

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

As in a previous response, services for older people are not just about dementia, and we would like to see age barriers removed so that we can develop a continuity of care for older people, recognising that mental illness spans age groups and age specific services. Enabling people to continue using services that benefit them as they age would be beneficial, as would having recognition that not all mental health problems in later life are age related.

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?

Work should continue to ensure that the learning materials contained in the '10 Essential Shared Capabilities' is made widely available and promoted to as wide a range of professionals working in mental health services as possible. This 'rights-based, recovery-focused' approach is central to developing person-centred services that support individuals to take responsibility for their own recovery, with the help and support of their families and friends who provide the relationships that are crucial to recovery.

Service user and carer groups and voluntary organisations have a key role to play in ensuring that mental health workers are exposed to and understand the service user perspective, and in these times of financial constraints, there must be a national lead in terms of ensuring that advocacy services, and service user and carer services are protected as part of the partnership in providing care and support. Support in Mind Scotland has had to close some carers' services for carers of people with mental illness due to changes in local authority funding, and this is undermining the capacity to develop and delivery person-centred care, by denying the principle that carers are key partners in the provision of care.

The Carers Strategy is clear that carers are partners, and as such enabling them to continue to provide support is of equal importance in terms of funding as other mental health services.

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?

Comments

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?

This Framework lays out the principles and the elements of good practice but lacks an interactive dimension that would enable staff to explore and understand the application of these principles in the work setting. Linked training materials that involved service user and carer input to deliver could be a productive avenue to explore.

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

Comments

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

Comments

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

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?

In response to question 30 – Support in Mind Scotland would like to see support to develop psychological therapy services to increase access and reduce waiting times for accessing such help. Further work to address the different levels and intensity of psychological interventions, and work to explore how a wider range of agencies could be involved in delivering lower level (of intensity) psychological interventions, could extend the access to support at the right time for individuals. Further exploration of differences between a psychological approach and delivering psychological therapies could help to assess the need for formal therapeutic interventions and in what circumstances this might be avoided.

Question 31 – there has been a great deal of emphasis on gathering services user and carer views, but there is still frustration that action is often not taken in support of those views:

- The needs of mental health carers was well documented in our recent survey, "It's their job, it's my life" (2010) and yet Support in Mind Scotland failed to persuade the local authority in Highland that supporting mental health carers was an important discrete service requirement and our specialist service has been lost in this area.

There is a need not just to map and benchmark experiences and outcomes in terms of ensuring quality and equity of the experience for services users and carers, but also to take a lead at national level to monitor the financial support for delivering on the priorities that emerge across different local authority areas. Mapping where key services are being lost and the impact on the individuals and their families of losing those services is an important part of this process.

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

As a national organisation with many services spanning the whole of the country and therefore operating in different local authority areas, a consistency of approach in reporting on service outcomes linked to funding agreements and contracts would be helpful. Embedding clinical outcomes would also require clear guidance on what was being asked and why; and finally, there would need to be clear statements covering issues such as confidentiality of service users and carers who may be required to divulge different kinds of information to that which we gather currently.

Being part of a national drive to have more accurate information about outcomes to aid planning and service development is important, but achieving consistency across our services in Scotland would require national guidance and support.

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

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

As in our response to question 11, Early Intervention services for people with mental illness can bring significant cost savings over a period of time, as well as the much better outcomes for individuals. We would urge the development of these services, with the training and information for health professionals and for other relevant services included.

As a general point, we are distressed to see that more cost effective voluntary sector services are often lost through short term funding decisions, where more creative and economic solutions might be found through more flexible negotiation with local voluntary sector service providers.

Shifting the culture and the relationship between local providers and community planning is important, not just to look for direct cost savings, and

to avoid losing good local services through lack of funding, but to explore and encourage genuine partnerships between agencies that produce 'win-win' solutions.

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

Comments

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

A major concern for Support in Mind Scotland is how we support people to make their voice heard in circumstances where they may be subject to specific orders. Although the Mental Health Act takes this rights based approach, under other legal frameworks, people affected by mental illness need support and assistance to ensure that their rights and voices are maintained – for example, where they are victims of crime or witnesses of crime and where their illness means they are regarded as unreliable witnesses.