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Consultation Analysis – a Mental Health and Wellbeing Strategy for Scotland

Final Report for The Scottish Government

Report V1.4 | 13 January 2023

Report prepared by: EKOS Ltd.

The opinions expressed in this report are those provided by respondents to the call for evidence.

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1 Introduction

1.1 Background

The Scottish Government is developing a new Mental Health and Wellbeing Strategy, building on the current strategy which was published in 2017[1] and Transition and Recovery Plan published in 2020[2].

The new Mental Health and Wellbeing Strategy will guide the work that the Government, and its partners, will do to improve mental health and wellbeing in Scotland. This will include an overall shared vision, a set of outcomes, and how these will be achieved to improve people's mental health and wellbeing.

The Scottish Government want to make sure that the Strategy does the right things to improve mental health and wellbeing for people in Scotland, and that it focusses on every part of what mental health and wellbeing means. This covers a range of things, including:

- Addressing the underlying reasons behind poor mental health.
- Helping to create the conditions for people to thrive.
- Challenging the stigma around mental health.
- Providing specialist help and support for mental illness.

The Strategy will set out a longer-term approach to improve the mental health and wellbeing of the population. The Scottish Government will also publish delivery plans to set out the work it will do with partners over the coming years. These will show how the Scottish Government will make progress towards its outcomes, and how progress will be measured.

The Scottish Government want the Strategy to be equality and human rights-based, and the views of people who have experienced mental health issues are especially important to Ministers.

[1] The Scottish Government, Mental Health Strategy 2017-2027, 30 March 2017.
[2] The Scottish Government, Coronavirus (COVID-19): mental health - transition and recovery plan, 8 October 2020.

1.2 Consultation Methods

The consultation on the Mental Health and Wellbeing Strategy included the following approaches:

- Workshops taken forward by the Scottish Government and its partners in early 2022 to inform the outcomes framework.
- The Scottish Government held five virtual engagement events between 3rd August and 1st September 2022.
- A public consultation was held on the Scottish Government Citizen Space website from 29th June to 9th September 2022[3].
- Several events were also taken forward by stakeholders.

Further details on the consultation methods are provided in **Chapter 2**.

The Scottish Government posed a series of questions, and the answers to these will help the Scottish Government write the final Strategy and Delivery Plan, which is due to be published in 2023.

1.3 Report Structure

Alongside sections on the consultation methodology and a summary from the stakeholder events, the remainder of the consultation analysis report has been structured in line with the different parts of the Consultation Document, **Table 1.1**, over.

The detailed tables for the closed-ended questions contained in the Consultation Document have been provided in a separate **Supplementary Report**. We have included some high-level tables in the main report where appropriate.

A separate **Executive Summary** has also been produced.

[3] The Scottish Government, Mental health and wellbeing strategy: consultation, 29 June 2022.

Table 1.1: Consultation document and consultation analysis report

Consultation Document		Chapter in Report
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2 Consultation Methodology

2.1 Introduction

This Chapter provides an overview of the consultation methodology.

2.2 Engagement Events

Five virtual engagement events were held between 3rd August 2022 to 1st September 2022 to provide an opportunity for anyone interested to engage with the Scottish Government on the work being progressed to develop the new Mental Health and Wellbeing Strategy and to share their views.

These events were publicly advertised on EventBrite with links included on the consultation page on Citizen Space. Links to the events were also disseminated through the Scottish Government's key stakeholder networks.

Each event lasted two hours and included virtual break-out rooms for smaller group discussions. The events were well-attended by representatives from 117 organisations (**Table 2.1**) and largely comprised representatives from the public sector and third sector, including the NHS, local government, mental health charities, and equality advocacy groups.

Table 2.1: Engagement events

Date of engagement event	Total number of people who attended
3rd August 2022	44
8th August 2022	35
16th August 2022	74
26th August 2022	69
1st September 2022	64

Source: Scottish Government, Mental Health and Wellbeing Strategy Stakeholder Engagement– Summary Report.

The Scottish Government prepared a Mental Health and Wellbeing Strategy Stakeholder Engagement – Summary Report which provides an overview of the main feedback gathered at each event.

Circa 45 organisations that attended the stakeholder events also submitted a response to the public consultation (either an organisation response or a joint submission with other organisations).

A summary of the main themes which emerged across the stakeholders events is provided in **Chapter 4**, and this chimes with the feedback received to the public consultation.

2.3 Public Consultation

A total of 497 responses were received to the public consultation. This included two individual respondents who each submitted two responses. The most recent response from each individual respondent was retained and any additional information from their first response was added. Two responses were then removed.

The following analysis has been based on 495 validated responses, **Table 2.2**. Over half of all responses to the consultation were received from individual respondents (54%), with the remainder from organisations (46%).

Table 2.2: Public consultation respondents

Type of respondent (N=495)	Number	Percentage
Individuals	269	54%
Organisations	226	46%

Organisation respondents can be grouped under the following broad categories, **Table 2.3**. It should be noted that organisations are placed under one category, although it is recognised that there may be some crossover (e.g. a third sector membership organisation). The most common type of organisation respondent is third sector, followed by public sector.

Table 2.3: Organisation respondents by type

Type of organisation (N=226)	Number	Percentage
Third sector	114	50%
Public sector	76	34%
Membership organisation	35	15%
Private sector	1	1%

Health improvement is the main area of focus/operation for almost one-third of all organisation respondents (31%), **Table 2.3**. This is followed by organisations who support specific target groups (24%) e.g. children and young people, women, older people, young carers, and by mental health organisations (23%).

Note: “other” organisations includes for example local authorities, other public/third sector organisations whose area of focus is not captured elsewhere in the organisation subgroups (e.g. criminal justice, fire and rescue, water safety, etc).

Table 2.4: Organisation respondents by area of operation

Organisation subgroup (N=226)	Number	Percentage
Health improvement	70	31%
Organisations who support specific target group(s)	55	24%
Mental health	51	23%
Other organisations	31	14%
Education, training, and skills	19	8%

The consultation attracted responses from a diverse range of organisations. This includes a mix of organisations who provide support and services (or their members do):

- **To all people in Scotland or those living within a specific geographic area - i.e. population level interventions (e.g. an NHS Board or local authority), or are available or open to large parts of the population (e.g. a college or university)**. By their very nature, these organisations will support people who share a protected characteristic(s) as defined in the Equality Act (2010)[4]. Equalities is, however, not the primary remit or purpose of these organisations, rather it may be one of a number of strategic priorities or things that they do.
- **To marginalised, socially excluded or disadvantaged groups**. As above, this may include engagement with people who share a protected characteristic(s). The focus of these organisations is not at a population level, rather they have a specific focus on one or more groups of people with, for example, a shared experience or issue or background. Some examples include organisations who support people with mental health issues, people experiencing homelessness, people from ethnic minority communities, people with substance misuse issues, care experienced young people, people with particular health or long-term conditions, veterans, and people experiencing poverty.
- **To people who share a protected characteristic(s) as defined in the Equality Act (2010)**. Protected characteristics include: age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation. These organisations will have a sole or primary focus on a people with a protected characteristic(s).

[4] The Equality Act (2010).

Table 2.5 provides more information regarding the last two bullets points on Page 6 – that is the 114 organisations or 50% of all organisation respondents who support marginalised, socially excluded or disadvantaged groups or people who share a protected characteristic(s).

Table 2.5: Organisations who support people with a protected characteristic(s) or marginalised, socially excluded or disadvantaged groups

Organisations that support the following groups of people (N=114)	Number	Percentage
Protected characteristic		
Age	50	61%
Disability	22	27%
Gender reassignment	-	-
Marriage or civil partnership (in employment only)	-	-
Pregnancy and maternity	1	1%
Race	3	4%
Religion or belief	1	1%
Sex	8	10%
Sexual orientation	1	1%
Sub-total (unique organisations)	**82**	**72%**
Marginalised, socially excluded, or disadvantaged groups	**32**	**28%**
Total	**114**	**100%**

Note: Some organisations who support people with a protected characteristic support more than one group. As such, the Sub-total adds up to more than the breakdown by protected characteristic.

Individual respondents were asked to provide details from an equality, diversity, and inclusion perspective. Key points to note from the tables presented in **Appendix A** include that:

- Females are over-represented in the profile of individual respondents (71%) compared to the population as a whole.
- Individuals aged 25 to 49 years or 50 to 64 years make up the vast majority of individual respondents (86%).
- Over half of individual respondents (54%) report that they have a physical or mental health condition or illness lasting or expected to last 12 months or more:
    - A mental health issue is the most common condition or illness reported by these individual respondents (72%). This is followed by mobility issues or stamina/ breathing/fatigue issues, but to a much lesser extent.
    - 80% of individuals respondents who report that they have a physical or mental health condition or illness lasting or expected to last 12 months or more feel that the condition or illness reduces their ability to carry-out day-to-day activities either a lot (37%) or a little (43%).

- 89% of individual respondents describe themselves as heterosexual/straight.
- 2% of individual respondents consider themselves to be trans or have a trans history.
- 86% of individual respondents are from a Scottish or other British ethnic group, predominantly Scottish.
- Almost two-thirds of individual respondents do not belong to any religion, religious denomination, or body (65%).

2.4 Analysis

The vast majority of consultation responses were submitted through the Citizen Space website (84%), with the remainder submitted to the Scottish Government directly (16%). All responses were moderated by the Scottish Government Mental Health Directorate.

EKOS exported consultation responses from Citizen Space into Microsoft Excel for data cleaning, review, and analysis. Where submissions were submitted in another format, these were passed by the Scottish Government to EKOS for manual input into Microsoft Excel.

The analysis seeks to identify the most common themes and issues. It does not report on every single point raised in the consultation responses. For open-ended questions we have adopted the following approach to help readers get a sense of the strength/frequency of themes and issues raised by consultation respondents:

- Most Chapters in the report contain numbered themes (e.g. Theme 1, Theme 2, Theme 3, etc). These have been set out in order of relative importance (i.e. noted by the greatest number of respondents).
- Points raised have also been quantified in some way. For example, we use the terms “all”, most”, “many”, “some”, and “few” to articulate the strength of opinion.
- We have indicated which subgroups of organisation respondents have raised which themes (e.g. health improvement, mental health, etc). Due to some of the absolute numbers it has not been possible to draw out in more detail particular themes for different population groups. As such, we have not provided any further breakdown of responses beyond individual respondents. Individual and organisation respondents identify many similar points throughout the consultation.

The standard process is that equal weighting is given to all consultation responses. This includes the spectrum of views, from large organisations with a national or UK remit or membership, to individual’s viewpoints.

This analysis report quotes and paraphrases some of the comments received[5]. This does not indicate that these comments will be acted upon or given greater weight than others. All responses, where the respondent has given permission for their comments to be published, will be made available on the Citizen Space website.

2.5 Points to Note

The following points should be noted:

- Respondents to any public consultation or engagement event are self-selecting, and the responses may not be representative of the population as a whole.
- The Consultation Document was structured to allow respondents to answer questions independently in recognition that respondents may want to respond on one or some of the questions without wishing to express views on the others.
- Not all submissions were presented in line with the consultation questions.
- There does not appear to have been a campaign response – albeit there are some consultation responses from individual respondents and health improvement organisations that use the same or similar wording in open-ended questions. In part this likely reflects membership bodies (and others) pushing the public consultation out to their members and/or wider networks. Further, some organisations worked with others to prepare a joint response in addition to submitting their own organisation response.
- Some themes were raised throughout the consultation questions leading to considerable repetition of points and views. These included:
    - A need for a stronger focus on prevention and early intervention.
    - The importance of tackling poverty and inequality.
    - Supporting person-centred and whole-family approaches.
    - Placing mental health and wellbeing on an equal footing with physical health.
    - A need for increased community-based support and services.
    - Increased and longer-term funding for mental health and wellbeing services, including for the third sector.
    - Growing the workforce and building capacity – developing a skilled and diverse mental health and wellbeing workforce, and addressing talent attraction, recruitment, and retention challenges.

[5] Quotes are used from respondents who submitted a Respondent Information Form (RIF).

3 Stakeholder Events

3.1 Introduction

This Chapter presents a summary of the main points raised at the five stakeholder events which supplemented the public consultation. The themes covered below have been taken from the Scottish Government, Mental Health and Wellbeing Strategy Stakeholder Engagement – Summary Report which was prepared following the conclusion of the events.

3.2 What Influences Mental Health and Wellbeing

Attendees identified a common set of factors which are considered to have a positive impact on mental health and wellbeing, **Table 3.1**.

Table 3.1: Attendee views on what has a positive impact on mental health and wellbeing

Having a healthy balanced life	Spending time outdoors and having access to green spaces
Having a sense of purpose	Living in a healthy environment
Having good physical health	Feeling like you belong/having a sense of community
Feeling safe	Having close and meaningful personal relationships
Being free from abuse	Secure employment and good working conditions
Being free from discrimination	Feeling safe to speak about mental health without fear of stigma
Feeling valued	Being able to express yourself freely
Having equality of opportunity	Secure and stable housing
Having a real choice in how your care is delivered	

Attendees also identified a range of factors which are considered to have a negative impact on mental health and wellbeing, **Table 3.2**.

Table 3.2: Attendee views on what has a negative impact on mental health and wellbeing

Poverty	Cost of living crisis
Discrimination	Addiction
Trauma	Substandard housing conditions and/or unsupportive social landlords
Only offering medication as a mechanism for improving mental health	Bullying
Loneliness and social isolation	Domestic abuse
Not knowing where to access help and support	Thresholds for accessing mental health services being too high
Having a poor work/life balance	Poor communication between health professionals and patients
Long waiting lists for mental health services	

3.3 Wellbeing, Prevention and Early Intervention

The main pointers from the stakeholder events in relation to wellbeing, prevention, and early intervention to help inform the development of the Mental Health and Wellbeing Strategy were commonly framed by attendees as follows:

- The Strategy should put communities at the heart of its approach to wellbeing, prevention, and early intervention. Low-threshold, local services should be available, such as peer support groups or walking groups. Access to this level of support can prevent people experiencing poor mental wellbeing. It can also act as an early intervention for people who may already be struggling.

- Early intervention is important. There are lots of people who are not unwell enough to need a referral to a mental health service but are too unwell for low-threshold support. Stakeholders said that people in this group end up becoming so unwell that they need clinical intervention. This could have been avoided if early-intervention had taken place.

- Our responses to mental health and wellbeing need to become more proactive, rather than reactive. We need to consider how we can achieve this at all stages of a person's life, from pre-birth to old age.

- The Strategy should support people with long-term mental illness to self-manage their conditions. We should empower people to have an awareness of their triggers and early indicators. This can prevent the need for acute mental health care and hospital admissions.

- The Strategy should take account of social determinants of mental health. Issues such as poverty and inequality have a significant impact on mental health and wellbeing. Other factors include, for example: education, unemployment, job insecurity, working conditions, housing, early childhood development, and social inclusion.

- There should be investment into local amenities such as pools, gyms, parks, exercise classes, and peer support groups.

- We need a strong approach to tackling stigma in mental health and wellbeing. People should not feel judged for talking about these issues, particularly by employers. There should be a focus on changing the culture in Scotland so that people know it is okay to prioritise their health and wellbeing. People often feel that they should put work first rather than ensure a healthy balance.

- Families should be equipped with knowledge on how to support the mental health and wellbeing of children and young people. Ensuring positive attachment and good mental health from a young age prevents a range of adverse outcomes later in life.

3.4 Provision of Support and Services

To help inform discussions on the provision of support and services, attendees at the stakeholder events raised the following points:

- In general, services are only able to respond to people who are very unwell due to lack of capacity and funding. We must manage waiting lists and ensure there are enough resources in place so people can access help when they need it.

- Many people are unaware of the support and services that are available to them, or how to access them. People should be able to find information on all levels of support ranging from local walking groups to crisis level intervention. We should also try to connect people directly to advice and support, rather than signposting.

- Services should centre around the whole person. Practitioners should consider all aspects of a person's life and how it affects their mental health. This should include social determinants, family circumstances, religion, physical health, etc. We should also empower people to make choices about their treatment. For example, medication versus talking-based therapies, or digital versus face-to-face engagement.

- When people need a clinical intervention, we should ensure practitioners are listening to and validating their feelings and experiences. We need support for the individual, not the diagnosis.

- The Strategy should make sure mental health is only medicalised when it needs to be. Community-based support and talking therapies can be a robust approach to a person's mental health and wellbeing.

- GPs should not be the only gateway to mental health services, especially when it can be difficult to access appointments. There should be many routes for referrals, and a broad range of services should be aware of how to direct people to the right place.

- The Strategy should support organisations to work in collaboration. Processes should be in place to ensure open communication between: mental health services; social work; police; education; other public services; and the third sector. We should establish robust information sharing protocols.

- It is important to recognise the contribution of the third sector and ensure more stability in funding. Longer-term funding rounds would be welcome.

- All workplaces should have trained mental health first aiders similar to what exists for first aiders in relation to physical ailments.

3.5 Additional Comments

Attendees at the stakeholder events raised additional comments, including in relation to the design, delivery and monitoring of the Mental Health and Wellbeing Strategy. This included:

- The Strategy should be written and published in an accessible format.
- There should be a robust approach to equalities and human rights.
- The Scottish Government should consider how to measure the success of the Strategy over its lifespan. This should go beyond using waiting list figures as the only indicator of success.
- The Strategy should be able to respond to changing circumstances, and new and emerging data and evidence.

4 Definitions

4.1 Question 1.1 - Do you agree with this description of "mental health"?

The Consultation Document defines 'mental health' as follows.

Everyone has mental health. This is how we think and feel about ourselves and the world around us and can change at different stages of our lives. Our mental health is affected, both positively and negatively, by lots of factors, such as our own life circumstances, our environment, our relationships with others, and our past experiences, plus our genetic make-up. Being mentally healthy is about having good mental health, as well as addressing mental health problems. Having good mental health means we can realise our full potential, feel safe and secure, and thrive in everyday life as well as to cope with life's challenges.

Table 1 (**Supplementary Report**) provides the quantitative response to **Question 1.1**. Key points to note include that:

- **79% of all consultation respondents agree with the description of 'mental health'**. There are relatively equal levels of support among individual and organisation respondents. A majority of all organisation subgroups agree with the description of 'mental health', most notably education, training and skills, health improvement, and organisations who support specific target groups.

- **21% of all consultation respondents do not agree with the description of 'mental health'**. Relatively equal proportions of individual and organisation respondents do not agree with the description. Among organisation respondents who reported no, mental health organisations are the organisation subgroup most likely to disagree with the description of mental health, followed by other organisations[6].

[6] 65% of mental health organisations agree with the description of mental health and 35% disagree. Respective percentages for other organisations are 75% (agree) and 25% (do not agree).

4.2 Question 1.2 - If you answered no, what would you change about this description and why?

Feedback from consultation respondents who do not agree with the description of mental health is presented below. Note: some note in their consultation response that they "broadly agree" with the description.

Theme 1: Mental health has a negative connotation

Many individual respondents and some organisation respondents (e.g. mental health organisations, organisations who support specific target groups) who do not agree with the description of mental health presented in the Consultation Document feel that the term 'mental health' or the description in its current format may be unhelpful because:

- It has a negative connotation.
- People with poor mental health experience stigma and discrimination.
- The description of mental health as presented in the Consultation Document is associated with a medical model of health.

Some individual respondents' also express support for the term 'mental health' to be replaced with a more appropriate term. Suggestions include:

- Good health (both physical and mental).
- Health and wellbeing.
- Emotional health.
- Psychological health.
- State of mind and emotional wellbeing.

Some organisation respondents (e.g. mental health organisations, organisations who support specific target groups) also feel that "We need to move towards the narrative with more awareness on the correlation between our mental health and wellbeing and our physical health and the definition should reflect that" or that "Care needs to be taken not to artificially separate mental health from physical health" in the description of mental health – "the two are linked and this gives a more holistic view".

Points raised are reflected in the organisation respondent quote below.

“Poor physical health leads to a range of mental health effects, and poor mental health leads to a range of physical health issues that negatively impact on life expectancy. It is suggested that the ‘aim should be for good health (both physical and mental), with parity of funding and esteem for mental health and physical health services’”.

Forensic Mental Health Services Managed Care Network

A few organisation respondents (e.g. health improvement organisations, organisations who support specific target groups) note that the wording “’Everyone has mental health’ is not required. You wouldn’t say this about physical health”.

Feedback from some individual respondents and organisation respondents (e.g. mental health organisations, organisations who support specific target groups) suggests the description implies that people with poor mental health may be less likely to realise their full potential, feel safe and secure, and thrive in everyday life, etc because of their poor mental health. This is disputed by these respondents. They suggest that people with good mental health may also not realise their full potential or cope with life’s challenges due to socio-economic factors, systemic challenges, etc.

Theme 2: Additional factors that affect mental health

Many of the consultation respondents who disagree with the description of mental health (i.e. individual respondents and organisation respondents, including health improvement and mental health organisations, and organisations who support specific target groups) identify additional factors that can affect our mental health, both positively and negatively, over and above those outlined in the description provided in the Consultation Document. These respondents feel that wider influences could be more adequately captured within the description of mental health.

The most common factors mentioned by these consultation respondents is that the description of mental health could be enhanced by including reference to physical health - given that an individual’s mental health and physical health are interdependent, and social-economic factors:

- Physical health.
- Socio-economic factors and background.
- Poverty and deprivation.
- The environment in which people live.
- Unhealthy behaviours and lifestyle choices.
- Substance misuse.
- Structural factors.
- Societal, cultural, and political factors.

- Biological and chemical factors.

“Mental health is strongly influenced by the social, physical, and economic environments in which people are born, grow, live, work and age. The emphasis in the definition needs to highlight these wider influences at population level”.

Public Health, NHS Greater Glasgow & Clyde

Theme 4: Good mental health is not linear

Many individual respondents and some organisation respondents (e.g. other organisations) note in their consultation response that good mental health is not linear - rather it is a continuum, it can change frequently, and at different stages of our lives. The point made by these respondents is that a person with good mental health may not have good mental health all of the time.

Further, these respondents note that mental health problems and wellbeing are not opposite ends of the same spectrum, and that people can move between the different states of wellbeing. As such these respondents consider it important to recognise that an individual can have a diagnosed mental illness, but they can have good mental wellbeing, and that an individual can have poor wellbeing without being mentally ill.

“The dual continuum should not be lost from the Strategy and its inclusion would bring a consistency across Strategy and learning opportunities”.

COSLA

Theme 4: Differences between relevant concepts and constructs

Some individual respondents and organisation respondents who do not agree with the description of mental health (e.g. health improvement and other organisations) note that the description does not reference or recognise the differences between the concepts and constructs of ‘mental health’, ‘mental wellbeing’, and ‘mental illness’. Rather they feel that the afore-mentioned terms are often used interchangeably and have become conflated.

This point is reflected in the following organisation respondent quote.

"For the individual this risks 'medicalising' where there is a wellbeing issue. For the system, it risks placing an unnecessary burden on clinical services when those requiring wellbeing support seek support from clinical settings and vice versa. This confusion around mental health terminology also risks conflating the roles of the workforce who support mental health and/or wellbeing. Given this, …separate definitions of mental health, mental wellbeing and mental illness are welcome and carefully considered definitions should be used accurately and consistently throughout the strategy and associated work.

However, whilst the title of this section indicates it addresses definitions, what has been provided are descriptions which are unlikely to help rectify current confusion. If definitions are what is sought, and as noted above, this is felt to be useful, definitions would benefit from being sharper and more concise with descriptions addressed later. The complexity of this task is recognised. It may also be helpful to reorder the definitions in the strategy to build up a picture of the different elements of mental health as a construct: Mental wellbeing, Mental illness, and Mental health".

COSLA

An alternative viewpoint is that the various terms mean the same thing, are interchangeable, and that having different descriptions is "ambiguous, unnecessary and may cause confusion" (e.g. some health improvement and mental health organisations).

The point about different constructs and concepts is made across the "description" questions in Part 1 and has not been repeated elsewhere in this Chapter.

Theme 5: Alignment of description with existing definitions and tools

A few respondents (e.g. health improvement, mental health, and other organisations) highlight existing definitions of mental health and other tools and resources that could be considered by the Scottish Government when finalising the description of mental health. There is reference to:

- World Health Organization definition of mental health[7].
- Mental Health Continuum (Tudor, 1996).
- Mental Health Foundation (2018).
- Scotland's Mental Health First Aid.
- Policy paper: The best start for life: a vision for the 1,001 critical days.
- The CHIME Framework (Connectedness, Hope, Identity, Meaning and Empowerment).

[7] World Health Organization, Strengthening mental health promotion.

Theme 6: Additional points

Finally, some additional points are raised by consultation respondents including:

- Some respondents feel that the description could incorporate additional points. For example, there is reference in the consultation responses to: physical health (as outlined above); how we behave (act); resilience/being resilient in face of adversity; ability to form meaningful and supportive relationships; and/or the importance of peer support.
- Some respondents provide additional or alternative wording e.g. to ensure that the wording better reflects the reality of situations and experiences.
- A few respondents feel the description of mental health is lengthy and could be sharper/more concise. This point relates to all “description” questions.
- A few respondents raise concerns about linking mental health to genetics and consider there to be a lack of evidence to support its inclusion.
- A few respondents advocate for the use of consistent terms throughout the Strategy document. An example provided is the “use of the term ‘mental health problems’ in the description of ‘mental health’, but that there is not a description elsewhere for this term (plus it is perceived negatively). Rather the term ‘mental health conditions’ is used elsewhere in the Strategy”.

4.3 Question 1.3 - Do you agree with this description of “mental wellbeing”?

The Consultation Document defines ‘mental wellbeing’ as follows.

Mental wellbeing affects, and is affected by, mental health. It includes subjective wellbeing (such as life satisfaction) and psychological wellbeing (such as our sense of purpose in life, our sense of belonging, and our positive relationships with others). We can look after our mental wellbeing in the same way as we do our mental health – and having good mental wellbeing can stop our mental health getting worse. The Royal College of Psychiatrists defines wellbeing as: ‘A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment’.

Table 2 (**Supplementary Report**) provides the quantitative response to **Question 1.3**. Key points to note include that:

- **84% of all consultation respondents agree with the description of 'mental wellbeing'**. There are relatively equal levels of support among individual and organisation respondents. A majority of all organisation subgroups agree with the description of 'mental wellbeing'.

- **16% of all consultation respondents do not agree with the description of 'mental wellbeing'**. Relatively equal proportions of individual and organisation respondents do not agree with the description. Among organisation respondents who reported no, mental health organisations are most likely to disagree with the description of mental wellbeing[8].

4.4 Question 1.4 - If you answered no, what would you change about this description and why?

Feedback from consultation respondents who do not agree with the description of mental wellbeing is presented below.

Theme 1: A repeat of views raised earlier

Some consultation respondents who do not agree with the description of mental wellbeing reiterate similar points to those raised at **Question 1.2** and for brevity these have not been repeated again (e.g. terminology).

Theme 2: Suggested additions to the description of mental wellbeing

A prevalent view among consultation respondents who do not agree with the description of mental wellbeing (e.g. some individual respondents and organisation respondents, including mental health organisations) is that the description could be enhanced or strengthened in some way. A point raised is that a wider range of factors affect mental wellbeing or have a role to play, and this could be more clearly articulated or emphasised within the description.

[8] 78% of mental health organisations agree with the description of mental wellbeing and 23% disagree. Rounding of percentages means that totals do not always total 100%.

The main suggested addition is that the description of mental wellbeing could be enhanced by including reference to physical health – "We can look after our mental wellbeing in the same way as we do our physical health" or "We take more of a holistic approach to wellbeing which includes both mental and physical wellbeing as both are interdependent".

The consultation responses also highlight a wider range of factors that can affect mental wellbeing, for example:

- Emotional wellbeing.
- Life circumstances/experiences (e.g. poverty, homelessness).
- Sense of meaning and purpose in life.
- A feeling of autonomy and control over one's life.
- Physiological conditions and impairments.
- Feeling connected to the natural world.

A point made by some organisation respondents who disagree with the description of mental wellbeing (e.g. health improvement and mental health organisations) is that care needs to be taken in putting too much emphasis or focus on the individual. These respondents emphasis that a person does not have complete control over their own mental wellbeing, and that it is influenced by a wider range of factors that are not sufficiently captured in the description (e.g. environmental, societal, cultural, political).

A few respondents provide additional or alternative wording for the description.

Theme 3: Existing definitions of mental wellbeing

A few organisation respondents (e.g. health improvement, mental health, and other organisations) point to other definitions of mental wellbeing that the Scottish Government could review when finalising the description of mental wellbeing, for example:

- Faculty of Public Health's 'Better mental health for all[9]'.
- World Health Organization definition of mental wellbeing.
- National Performance Framework uses the Warwick-Edinburgh measure to report and measure mental wellbeing. A suggestion is for definitions and outcome measures for the Mental Health and Wellbeing Strategy to flow from this.

[9] Faculty of Public Health and Mental Health Foundation, Better mental health for all - A public health approach to mental health improvement, 2016.

- The CHIME Framework.

Where mentioned by consultation respondents who disagree with the description (limited), comments on The Royal College of Psychiatrists definition included in the description of mental wellbeing in the Consultation Document attracts mixed views:

- On the one hand, some of these respondents note that they agree with the definition or feel that The Royal College of Psychiatrists definition on its own would be sufficient.
- Others do not fully agree with The Royal College of Psychiatrists definition (e.g. some health improvement and mental health organisations, and organisations who support specific target groups). Points raised include that the definition is embedded in the medical model of health, or that it does not adequately capture other aspects of wellbeing, or they are unclear why this definition is chosen over others, or they express disagreement with some of the wording in The Royal College of Psychiatrists definition.

Theme 4: Additional points

Additional points raised by respondents on the description of mental health include:

- A few organisation respondents feel the description of mental wellbeing is lengthy and could be sharper/more concise to avoid confusion, or that it is hard to understand.
- A few organisation respondents suggest that the Scottish Government could reconsider the use of the phrase 'subjective wellbeing'. For example, comments include that it is not clear what is meant, or what purpose it serves.

"It is not clear why you have labelled the different aspects of wellbeing as subjective and psychological and what purpose this serves. You may want to reconsider the use of the phrase 'subjective wellbeing'. Too often people living with mental health problems feel that their experiences and feelings are not taken seriously and their ability to make judgements on their mental health and wellbeing is questioned".

Scottish Recovery Network

4.5 Question 1.5 - Do you agree with this description of "mental health conditions" and "mental illness"?

The Consultation Document defines 'mental health conditions' and 'mental illness' as follows.

Mental health conditions are where the criteria has been met for a clinical diagnosis of mental illness. This means that a diagnosis of a mental illness has been given by a professional. Mental health conditions can greatly impact day to day life and can be potentially enduring. These include depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD), as well as bipolar disorder, schizophrenia, and other psychosis, among many more. How mental illness affects someone can change from day to day. The professional treatment and support that each individual needs can change too. Someone may have an acute mental health problem or mental health condition that has not yet been diagnosed, but they can still be unwell. Their diagnosis may also change over time.

Table 3 (**Supplementary Report**) provides the quantitative response to **Question 1.5**. Key points to note include that:

- **Almost two-thirds (64%) of all consultation respondents agree with the descriptions of 'mental health conditions' and 'mental illness'**. There are relatively equal levels of support among individual and organisation respondents. Among organisation respondents, organisations who support specific target group(s) and education, training and skills organisations are more likely to agree with the descriptions.

- **Over one-third (36%) of all consultation respondents do not agree with the description of 'mental health conditions' and 'mental illness'**. Relatively equal proportions of individual and organisation respondents do not agree with the descriptions. Among organisation respondents, mental health organisations are most likely to disagree with the descriptions, followed to a lesser extent by health improvement organisations[10].

4.6 Question 1.6 - If you answered no, what would you change about this description and why?

Feedback from consultation respondents who do not agree with the descriptions of 'mental health conditions' and 'mental illness' are outlined below.

[10] 30% of mental health organisations agree with the descriptions of 'mental health conditions' and 'mental illness', and 70% disagree. Respective proportions for health improvement organisations are 64% and 36%.

Theme 1: Terminology

Many consultation respondents who disagree with the descriptions of 'mental health conditions' and 'mental illness' raise points regarding terminology. These respondents (e.g. individual respondents and organisation respondents, including health improvement and mental health organisations, and organisations who support specific target groups) consider the terms 'mental health conditions' and/or 'mental illness' to be problematic in some way.

A wide range of points are raised, including that:

- The terms are felt to be "catch all labels".
- People with mental health conditions and illnesses are subject to negative judgements and stigmatisation and these terms may be unhelpful.
- The terms have negative connotations with the biomedical model of health.
- The term "mental illness" is not commonly used in the third sector.
- A mental health condition does not have to be formally diagnosed for the person to exhibit symptoms and negatively impact the individual and their family.
- The terms imply the person is "sick" or "ill" and that is not necessarily the case.
- The terminology may put some people off from seeking professional support, etc.
- Diagnosis based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5)[11] and/or International Classification of Diseases 11th Revision (ICD-11)[12] "is an imperfect science and is widely open to interpretation by psychiatrists".

Some support is therefore expressed among these consultation respondents for alternative wording, as illustrated by the following organisation respondent quote.

"This could be defined more clearly without defining as mental health conditions and illnesses… without getting into whether it has been clinically diagnosed or not".

Public Health, NHS Greater Glasgow & Clyde

[11] Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).
[12] ICD-11, International Classification of Diseases 11th Revision, The global standard for diagnostic health information.

Alternative suggestions include for example “mental health issue”, “mental health condition”, “mental ill health”, “mental health problems”, or “severe emotional distress”. There is not broad agreement to the use of particular “labels” or “categorisations” which are considered to be embedded in medical or clinical models of mental health/psychiatry.

“Individuals may meet the criteria for a clinical diagnosis but face barriers to accessing services which obstruct identification and / or diagnosis. Therefore, many individuals with mental health conditions may not have a formal diagnosis or may experience symptoms for years before they are formally diagnosed. Their diagnosis may also change over time”.

Institute of Health Visiting

“This definition does not fit well with that of ‘Mental Health’ where it is acknowledged that a wide range of factors can positively and negatively affect our mental health experience. Talking of mental health conditions and illness reduces this to a biological concept and does not recognise this wide range of factors. This is why many people talk of mental health problems rather than use the terminology of conditions and illness”.

Scottish Recovery Network

Some respondents (e.g. individual respondents, mental health organisations and organisations who support specific target groups) feel that the description lacks reference to:

- “Recovery” from mental illness and that individuals with mental health conditions, with the right help and support, may have good mental health and wellbeing or are working towards it (i.e. there is no reference to the “continuum of mental health”), or
- Babies, children, and young people (i.e. the descriptions are felt to be phrased from an adult’s perspective).

Some respondents consider it important that the descriptions are amended, and some provide alternative wording/terms.

Theme 2: Listing mental health conditions in the description

Consultation responses highlight three viewpoints on listing mental health conditions in the description:

- Some respondents consider it helpful for the description to include conditions/disorders that are not mental illnesses, but which can have significant effects of mental health and mental wellbeing.

- Some respondents feel strongly that it is important that some conditions which impact on our mental health are not labelled as a disorder, and that it is too prescriptive. A related point made is that listing conditions/diagnosis may make people feel stigmatised or excluded if they do not see their condition listed.
- Some respondents (e.g. primarily individual respondents) consider the list of conditions/diagnosis too narrow and that it could be extended to be more inclusive.

Theme 3: Additional points

A few additional points are raised by respondents on the descriptions include:

- As noted previously, language and wording could be clearer and less confusing.
- A few respondents feel that the descriptions are contradictory in places (see respondent quote below).

“The current definition of mental health conditions/illness currently contradicts itself. In Paragraph one it states that to have a mental health condition ‘a diagnosis of a mental illness has to be given by a professional’, but in paragraph three it is articulated that ‘Someone may have an acute mental health problem or mental health condition that has not yet been diagnosed, but they can still be unwell’.

Support in Mind Scotland believes that a mental health condition does not have to be formally diagnosed for the person to exhibit symptoms and negatively impact the individual and their family, friends, and carers etc. For example, at Support in Mind Scotland’s carers support groups’ family members attend whose close relations have not received a formal diagnosis but the condition exists significantly impacting their relationship due to symptoms of mental illness. Therefore, we believe that the definition of a mental illness must be altered to reflect this”.

Support in Mind Scotland

5 Our Draft Vision and Outcomes

5.1 Question 2.1 - We have identified a draft vision for the Mental Health and Wellbeing Strategy: "Better mental health and wellbeing for all". Do you agree with the proposed vision?

Table 4 (**Supplementary Report**) provides the quantitative response to **Question 2.1**. Key points to note include that:

- **Three-quarters (75%) of all consultation respondents agree with the draft vision for the Mental Health and Wellbeing Strategy**. There are relatively equal levels of support among individual and organisation respondents. A majority of all organisation subgroups agree with the draft vision, albeit to varying degrees. Among organisation respondents, education, training and skills organisations, other organisations, and health improvement organisations are most likely to agree with the draft vision.

- **One-quarter (25%) of all consultation respondents do not agree with the draft vision for the Mental Health and Wellbeing Strategy**. Relatively equal proportions of individual and organisation respondents do not agree with the draft vision. Among organisation respondents, mental health organisations and organisations who support specific target groups are most likely to disagree with the draft vision[13].

5.2 Question 2.2 - If not, what do you think the vision should be

Feedback from consultation respondents who do not agree with the draft vision presented in the Consultation Document are outlined below.

[13] 59% of mental health organisations agree with the draft vision and 42% disagree. Respective proportions for organisations who support specific target groups are 67% and 33%. Rounding of percentages means that totals do not always total 100%.

Theme 1: Suggested rewording of the draft vision

Many consultation respondents who do not agree with the draft vision raise points relating to the wording or language that is presented in the Consultation Document. The main points raised by these consultation respondents (i.e. some individual respondents, health improvement and mental health organisations and organisations who support specific target groups) have been summarised below:

- Some respondents feel that the word “better” in the draft vision has a negative connotation and they would like to see a more positive vision statement. Various alternatives are suggested, for example, “good”, “improved”, “optimal”, “positive”, “consistent”, “flourishing”, “thriving”, “nurturing”, “best possible”, and “realising potential”.

- Some respondents note that the vision statement fails to recognise that not everyone with a mental health issue or condition may be able to achieve better mental health and wellbeing. Some responses note that “better” may differ quite markedly depending on the intersectionality and differential circumstances of individuals and groups in society.

- Other respondents note that the vision implies a need for “universal improvement” (i.e. some people may already have very good mental health and wellbeing).

- Some call for a more ambitious vision statement to ensure that everyone realises their full potential (e.g. “best possible mental health and wellbeing”).

- Some respondents feel that the draft vision could have a greater emphasis on certain things, for example: improving mental health services and support; the sustainability of mental health services at all levels; access to treatment or support; addressing mental health stigma and ensuring parity of esteem for mental and physical health; reducing inequalities; good mental health and wellbeing for all from pre-birth to old age; the manner of support people receive (e.g. including compassionate, trauma-informed care); the prevention of poor mental health and wellbeing; and/or addressing the root causes of poor mental health and wellbeing.

Related points made by these respondents (e.g. including individual respondents, and health improvement, mental health and other organisations) is that it would be important for the vision to: be aspirational but achievable; be clear, focused, and specific; be quantifiable, measurable, and time-bound; and take a whole-person approach, in order for it to be truly effective.

Some alternative vision statements are provided by consultation respondents, including but not limited to the following examples:

"'Better mental health and wellbeing for all" works if we have a clear understanding of what the start point is. A vision is aspirational and so perhaps instead of "better for mental health and wellbeing for all it should be "good mental health and wellbeing for all".

Penumbra

"As written, the vision implies a need for universal improvement. However not 'all' of the population require 'better' mental health. The vision should:

- Either, centre on realising 'better' for those that need / seek / ask
- Or, describing the end state which is best possible mental health for all.

The vision should also be more ambitious as per earlier reference to realising full potential, i.e. best possible as opposed to merely being better".

Mental Health Strategy Programme Board - NHSGGC and associated HSCPs

Theme 2: The draft vision is too broad

Some respondents (e.g. some individual respondents and health improvement and mental health organisations) who do not agree with the draft vision for the Mental Health and Wellbeing Strategy feel that it is either "too broad", "too generic", "too vague", "too aspirational", and/or "non-specific".

Some of these respondents highlight definitions of mental health used elsewhere, agreed public health priorities for Scotland, and/or other ambitions, approaches, and systems that could be considered by the Scottish Government when finalising the vision. There is reference, mainly within organisation respondent consultation responses to the following:

- World Health Organization definition of mental health[14].
- Bronfenbrenner's Ecological Systems Theory[15].
- Trieste mental health system[16].

[14] World Health Organization, Strengthening mental health promotion.
[15] Bronfenbrenner's Ecological Systems Theory.
[16] Trieste mental health system.

- The Programme for Government 2021/22 which defines one ambition as 'Prioritising mental health and wellbeing so everyone in Scotland can thrive as we recover [from the pandemic]'[17].
- Public health priorities for Scotland (e.g. Priority 3: A Scotland where we have good mental wellbeing)[18].
- Other Scottish Government programmes such as Unscheduled and Urgent Care, and the previous Redesign of Urgent Care (which included mental health care)[19].
- National Performance Framework[20].
- The Human Rights Framework in Scotland which is currently being developed.

Theme 3: Mental health and wellbeing is influenced by many different factors

Some respondents note in their consultation response that achievement of the draft vision "while admirable" may not be realistic.

Recurring points made by these respondents (e.g. some individual respondents, and health improvement, mental health and other organisations and organisations who support specific target groups) include that:

- Mental health and wellbeing is influenced by a wide range of environmental and socio-economic factors (i.e. there would remain factors that the Strategy alone would be unable to influence).
- The draft vision statement minimises the complexity of the factors that influence mental health and wellbeing.
- There is a requirement for a multi-agency and multi-disciplinary effort to ensure that everyone has the best possible mental health and wellbeing.

Theme 4: Mental health and wellbeing should guide all government policy

Some individual respondents and a few organisation health improvement respondents (e.g. The Royal College of Psychiatrists in Scotland, Faculty of Rehabilitation of the Royal College of Psychiatrists in Scotland) use the same or similar wording in all of their consultation responses and highlight various points on the draft vision.

[17] The Scottish Government, Programme for Government 2021/22, September 2021.
[18] The Scottish Government, Scotland's Public Health Priorities, June 2018.
[19] The Scottish Government, Healthcare Standards.
[20] The Scottish Government, National Performance Framework.

This includes:

- “The mental health and wellbeing of the population is a key responsibility of any government towards its citizens and one that should guide all government policy rather than being restricted to a mental health strategy.
- Better mental health and wellbeing is an ongoing process and a core principle that must underpin all governmental priorities and policy.
- The draft vision in its current form would be difficult to measure and evidence that it has been achieved”.

These respondents also propose an alternative vision statement – “Sustainable mental health services, supported communities and giving individuals the right opportunities for good mental health”.

5.3 Question 2.3 - If we achieve our vision, what do you think success would look like?

Around 80% of all consultation respondents provide a response to **Question 2.3** which asks for views on what success would like if the vision for the Mental Health and Wellbeing Strategy is achieved. The main themes to emerge from the consultation responses are outlined below.

Theme 1: Improved outcomes

Most consultation respondents (i.e. individual respondents and all organisation subgroups) articulate a wide range of outcomes that might flow from achievement of the vision identified for the Mental Health and Wellbeing Strategy. It should be noted that outcomes are often framed by respondents in slightly different ways and use different wording/phrasing.

We have grouped the outcomes that are most commonly mentioned by respondents as follows:

- Mental health and wellbeing outcomes.
- Mental health and wellbeing supports and services outcomes.
- NHS-related outcomes.
- Wider outcomes beyond health.

Please also see **Appendix D**. Note: this is not meant to be comprehensive list, rather it is presented to provide a flavour of the feedback received from consultation respondents.

Theme 2: Access to the right support at the right time in the right place

Another common theme from across all consultation responses is the importance of people in Scotland, regardless of personal circumstances or background, where they live, or the severity of their mental health condition, being able to easily access or receive:

- The right and appropriate care, treatment, and/or support when they need it.
- The right care in a timely way.
- The right care in the right place.

These respondents note that this is with a view to:

- Ensuring early diagnosis, treatment, and support. For example, people are able to access a wide range of support including: pharmacological and non-pharmacological treatment, psychological services, counselling, advice, psychotherapy, complementary and alternative treatments, support groups, peer support, coping strategies, tools for self-care, community and local support.
- Ensuring access to supports and services ranging from low-threshold to crisis level interventions.
- Avoiding the need for crisis intervention and reducing the number of people requiring hospitalisation.
- Taking a holistic approach - seeing mental health and wellbeing as part of overall health and wellbeing.

Further, many of these same respondents emphasise that access to support should be fair, equitable, holistic, joined-up, responsive, rights-based, inclusive, person-centred, and tailored/targeted to the needs of people who share protected characteristics (e.g. age, disability, race, sex, sexual orientation).

Theme 3: Early intervention and a preventative approach

A prevalent view among individual and organisation respondents (all organisation subgroups) is that an early intervention and preventative approach is critical to reducing the need for clinical intervention. It is reported that such an approach could:

- Result in improved outcomes for people.
- Reduce pressure and burden on NHS health services.
- Reduce the cost of poor mental health and wellbeing on the NHS.

Theme 4: A non-medicalised response

Some individual respondents consider it important that Scotland moves to a "non-medicalised response to mental health". Success is said to be where people can access "holistic mental wellbeing support when they need it".

Theme 5: Additional points

As outlined at **Question 2.2**, some respondents reiterate a point about the importance of the Scottish Government ensuring the Strategy's vision is quantifiable and measurable.

A related point made by some individual respondents is that "Achieving better mental health and wellbeing for all needs to be an ongoing commitment and a journey rather than a measurable endpoint".

Finally, albeit not raised to a great extent, is organisation respondent feedback that success for the Mental Health and Wellbeing Strategy could be aligned with existing ambitions and outcomes (e.g. Public Health Scotland's Mental Health Indicators[21]).

[21] Public Health Scotland, Mental Health Indicators.

6 Our Key Areas of Focus

6.1 Question 3.1 - In the 'Draft Outcomes' section, we have identified four key areas that we think we need to focus on. Do you agree with these four areas?

The Consultation Document identifies four key areas that the Scottish Government think the Mental Health and Wellbeing Strategy needs to focus on: promoting and supporting the conditions for good mental health and mental wellbeing at population level; providing accessible signposting to help, advice and support; providing a rapid and easily accessible response to those in distress; and ensuring safe, effective treatment and care of people living with mental illness.

Table 5 (**Supplementary Report**) provides the quantitative response to **Question 3.1**. Key points to note include:

- **Almost two-thirds (65%) of all consultation respondents agree with the four key areas of focus**. There are relatively equal levels of support among individual and organisation respondents. A majority of all organisation subgroups agree with the four key areas of focus (except for mental health organisations). Among organisation respondents, education, training and skills organisations and other organisations are most likely to agree with the four key areas.

- **Over one-third (35%) of all consultation respondents do not agree with the four key areas of focus**. Relatively equal proportions of individual and organisation respondents do not agree. Among organisation respondents, mental health organisations are most likely to disagree with the four key areas of focus[22]. This is followed to a lesser extent by health improvement organisations.

[22] 39% of mental health organisations agree with the four key areas of focus and 61% disagree. Respective proportions for health improvement organisations are 65% and 35% respectively.

6.2 Question 3.2 - If not, what else do you think we should concentrate on as a key area of focus?

Feedback from consultation respondents who do not agree with the four key areas of focus is presented below.

Theme 1: A repeat of views raised earlier

Many respondents who do not agree with the four key areas of focus provide qualitative feedback that relates to points raised to earlier consultation questions.

First, most respondents suggest that the areas of focus could be more strongly framed in the context of the following aspects (i.e. be more explicit in this regard or have additional areas of focus), **Table 3.1**.

Table 3.1: The areas of focus could have greater reference to the following aspects

Early intervention and prevention (e.g. self-management, a focus on key communities and populations at high risk, ensuring that people are well-informed, etc)	Improved/expanded recovery focused support/services and treatment options/quality services and quality of care (e.g. funding, staffing, training, and workforce development)/inclusive services/provision of safe and appropriate spaces for services delivery
Parity of esteem between mental and physical health	Carers of people with poor mental health/whole family approach/support
Populations at higher risk of mental ill health and distress, such as protected characteristic groups (e.g. those who are disproportionately impacted by mental health and face barriers to accessing support)	Lived experience – inclusion of people with lived experience as co-designers and co-deliverers of a) Mental Health and Wellbeing Strategy and b) improved mental health services
Addressing stigma and discrimination	Whole system approach – supporting good connections and relationships between services
A systematic approach - tackling the root causes of poor mental health, and identifying and targeting specific actions to tackle key risk factors and to boost positive mental wellbeing	Intersectionality in mental health
Tackling inequalities in mental health	Learning and best practice is shared which encourages service innovation and improvement
Mental health pre-birth, in early years/childhood and throughout different life stages	Addressing underlying structural barriers and challenges
Different settings (e.g. community, education, health, workplace, outdoor environment/nature)	Human-rights related elements of our mental health systems are given parity of esteem to treatment.
Person-centred support	Promoting individual choice and control in mental health care and support (i.e. having a real choice in how care is delivered)

Second, there is some respondent feedback on terminology used for the areas of focus. This includes from respondents who do not agree with the use of the terms/wording ‘mental illness’, ‘treatment’, ‘distress’, etc. “Normalising mental health” is considered important in this regard.

Theme 2: Comments relating to the four areas of focus

Some individual and organisation respondents (all organisation subgroups) provide specific feedback on one or more of the key areas of focus identified by the Scottish Government.

Promoting and supporting the conditions for good mental health and mental wellbeing at population level

- There is support for a system-wide early intervention and preventative approach.
- It is considered important to develop the conditions for good mental health - prevention and awareness of mental health and the factors that contribute positively and negatively.
- See also Theme 4 – Additional Points.

Providing accessible signposting to help, advice and support

- While signposting is considered important, this needs to be supported by resources that ensures equitable access and makes it easier to connect people with poor mental health to supports and services.
- Signposting is often insufficient for people who experience poor mental health. Attention needs to be given to ensuring an environment is created that enables individuals to act on signposting or supports them to do so. Support to access services and self-management could be added to the second area of focus’.
- An integrated, joined-up and collaborative approach is needed across services (i.e., NHS, local authority and third sector) that is responsive to individuals in need of mental health and wellbeing support.
- This area of focus could include help, advice, and support in the widest sense (e.g. with income maximisation, housing, transport education, training and employment, substance misuse), recognising that other circumstances may affect mental health and wellbeing.
- The ability to signpost effectively requires information on public sector and third sector mental health services and support to be routinely updated and communicated.

Providing a rapid and easily accessible response to those in distress

- That rapid and easily accessible support, while critical for those in distress, is also important for other individuals with mental health conditions/illness (i.e. effective early intervention before the point of crisis).

- The recent publication of suicidal crisis recommendations from the National Suicide Prevention Leadership Group (NSPLG) focussed on an approach which ensures those in need experience Time, Space and Compassion[23]. This approach has crossover to mental health care and could be included in the third and fourth (below) areas of focus.
- Previous indicators for mental health services have tended to focus on areas such as waiting lists which, although important, can place pressure on the wrong part of the system risking the focus being on shorter lists rather than prevention or ensuring quality of care. Ensuring quality and connectivity of services could be incorporated into this area of focus.

Ensuring safe, effective treatment and care of people living with mental illness

- Distress is not the only sign or symptom of mental illness and safe, effective care is undermined if it takes too long to access. Given this, it is important to recognise that rapid, easy access to safe, effective support is essential for all those experiencing poor mental health and mental illness. Improved quality and timely provision of care and treatment for those with mental illness.
- This area of focus could be strengthened by including reference to person-centred support.
- Ensuring a highly trained and skilled mental health workforce.
- Ensuring a range of medical and therapeutic interventions at all levels.

Theme 3: Strengthening or additional areas of focus

Some individual respondents and organisation respondents (including health improvement and mental health organisations and organisations support specific target groups) provide suggestions to strengthen the areas of focus or identified additional areas of focus for the Strategy. These have been summarised below:

- The link between complex trauma and long-term mental ill health.
- There is considered to be lack of reference to the quality or the need for timely provision of care and treatment for those with mental health conditions and mental illnesses.
- There should be a continued commitment to meeting the needs of those most in need - this should remain a key area of focus and one that must be balanced with developments in population mental health approaches.

[23] National Suicide Prevention Leadership Group, Time, Space, Compassion Three simple words, one big difference: Recommendations for improvements in suicidal crisis response, October 2021.

Theme 4: Additional points

Some individual respondents and a few health improvement organisation respondents (e.g. The Royal College of Psychiatrists in Scotland, Faculty of Rehabilitation of the Royal College of Psychiatrists in Scotland) use the same or similar wording in their consultation responses to highlight various points on areas of focus, including:

- "Our specialist mental health services are underfunded, understaffed and under-resourced to meet the needs of the most vulnerable in the population.
- We are deeply concerned by the shift from population-level mental health – as was the focus of the last mental health strategy – to population-level mental wellbeing.
- Much as smoking cessation services will not negate the need for cancer services, it is important that the strategy recognise that some mental illness will continue to exist regardless of population-wide preventative efforts.
- We welcome the focus on providing a rapid and easily accessible response to those in distress. However, this needs to be supported by timely access to appropriate specialist mental health supports and services where required.
- World Health Organization's recent 'World Mental Health Report: Transforming Mental Health for All' references to safe, effective treatment and care of people living with mental illness need to recognise the need for an equal if not greater focus on the continued need for development of specialist mental health services and timely access to high quality, evidence-based effective treatment options.
- Ensuring people with mental health conditions have better access to physical health care and improved physical health outcomes, as well as ensuring those with physical health conditions have better mental health outcomes, needs to be a key area of focus".

Additional points raised include:

- A few health improvement organisations feel that there may be a risk that the four areas of focus as presented in the Consultation Documents suggests a "hierarchy", and that it may be better to present them "side-by-side" in the final Strategy document.
- Some organisation respondents (e.g. across all organisation subgroups) suggest there needs to be a clear link/integration between the Mental Health and Wellbeing Strategy and the wider mental health policy context (e.g. the development of Suicide Prevention and Self Harm Strategies) and the wider policy context that contributes to reducing poor mental health (e.g. child poverty, employability).

- A few organisations respondents (e.g. other organisations) consider it important that the new Mental Health and Wellbeing Strategy is set within the context of the achievements of the previous strategy, including lessons learned and what worked well.

7 Outcomes

7.1 Question 4.1 - Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcome to address underlying social factors?

The Consultation Document asks respondents whether they agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcome “Through actions across policy areas, we will have influenced the social factors that affect mental health and wellbeing, to improve people's lives and reduce inequalities”.

Table 6 (**Supplementary Report**) provides the quantitative response to **Question 4.1**. Key points to note include that:

- **84% of all consultation respondents agree (i.e. either agree or strongly agree) that the Strategy should aim to achieve the specified outcome to address underlying social factors**. Organisation respondents are more likely to agree than individual respondents, and there is little variation between organisation subgroups.

- **9% of all consultation respondents disagree (i.e. either disagree or strongly disagree) that the Strategy should aim to achieve the specified outcome to address underlying social factors**. The same proportion of individual and organisation respondents disagree.

The percentages reported above for respondents who agree or disagree with the outcome do not total 100% - this is because the remainder of respondents have a “Neutral” response. This presentation of percentages is used throughout the rest of the main document for similar types of closed questions.

7.2 Question 4.2 - Do you agree that the Mental Health and Wellbeing strategy should aim to achieve the following outcomes for people?

The consultation asks respondents whether they agree that the Mental Health and Wellbeing Strategy should aim to achieve a number of outcomes for people (17 outcomes in total).

Table 7 to Table 23 (**Supplementary Report**) provides the quantitative response to **Question 4.2**.

Table 7.1 on the next page provides a high-level overview of the findings, and key points to note include that:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each outcome. On average 90% of all consultation respondents agree with each outcome.
- While most individual and organisation respondents agree with each outcome, organisation respondents tend to be more positive. On average 95% of organisation respondents agree with each outcome. This compares to 87% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each outcome. This is highest among organisations who support specific target groups and lowest among education, training, and skills organisations.
- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the outcomes. This ranges from a low of 4% of all consultation respondents to a high of 6%.

Table 7.1: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for people?

Outcome	Agree	Neutral	Disagree
People have a shared language and understanding of mental health and wellbeing and mental health conditions. (N=406)	87%	7%	6%
People understand the things that can affect their own and others mental health and wellbeing, including the importance of tolerance and compassion. (N=409)	90%	5%	5%
People recognise that it is natural for everyday setbacks and challenging life events to affect how they feel. (N=407)	91%	5%	4%
People know what they can do to look after their own and other's mental health and wellbeing, how to access help and what to expect. (N=407)	91%	3%	5%
People have the material, social and emotional resources to enable them to cope during times of stress, or challenging life circumstances. (N=406)	90%	3%	6%
People feel safe, secure, settled, and supported. (N=410)	91%	2%	6%
People feel a sense of hope, purpose and meaning. (N=408)	88%	5%	6%
People feel valued, respected, included, and accepted. (N=409)	91%	2%	6%
People feel a sense of belonging and connectedness with their communities and recognise them as a source of support. (N=409)	87%	7%	6%
People know that it is okay to ask for help and that they have someone to talk to and listen to them. (N=407)	91%	3%	5%
People have the foundations that enable them to develop and maintain healthy, nurturing, supportive relationships throughout their lives. (N=410)	89%	5%	6%
People are supported and feel able to engage with and participate in their communities. (N=410)	88%	6%	6%
People with mental health conditions are supported and able to achieve what they want to achieve in their daily lives. (N=410)	91%	3%	6%
People with mental health conditions, including those with other health conditions or harmful drug and alcohol use, are supported to have as good physical health as possible. (N=410)	90%	4%	6%
People living with physical health conditions have as good mental health and wellbeing as possible. (N=409)	92%	3%	5%
People experiencing long term mental health conditions are supported to self-manage their care (where appropriate and helpful) to help them maintain their recovery and prevent relapse. (N=407)	88%	6%	6%
People feel and are empowered to be involved as much as is possible in the decisions that affect their health, treatment and lives. Even where there may be limits on the decisions they can make (due to the setting, incapacity or illness), people feel that they are supported to make choices, and their views and rights will be respected. (N=405)	92%	2%	5%

7.3 Question 4.2.1 - Do you have any comments you would like to add on the above outcomes?

Question 4.2.1 asks respondents for any additional comments on the 17 outcomes specified at **Question 4.2**.

Given the large and diverse range of outcomes presented above, there are an equally diverse range of comments. Around three-fifths of all consultation respondents provide a response, and we have tried to reflect on the most common themes below.

Theme 1: Outcomes need to be specific and measurable

A prevalent view (e.g. among health improvement and mental health organisations, and some individual respondents) is that the outcomes could be more specific and need to be measurable. These respondents note that the outcomes are "vague", "lack specificity" or may be "difficult to measure". Many respondents feel that outcomes should be SMART (Specific, Measurable, Achievable, Relevant, Time-Bound).

"Unclear as to how they would ever be measured successfully as outcomes, for example supporting people to self-manage could easily look the same (from a measurement perspective) as leaving people to get on with it alone when no real change to services or access to services has been achieved."

NHS Education for Scotland

A related point is that some of these respondents feel that there may be too many outcomes, and that there are may also be significant areas of overlap.

Theme 2: Constrained resources to deliver against the outcomes

While most consultation respondents agree with the outcomes and consider the Scottish Government ambition "laudable", a concern raised (primarily by individual respondents) is that achievement of all of the outcomes may be challenging and would require significant additional investment for mental health services and support.

A related point is that some respondents consider there to be a lack of detail around the steps that would need to be taken to achieve the outcomes.

Theme 3: An over-emphasis on self-management

A small number of respondents (mostly individual respondents and some organisations who support specific target groups) are concerned about the focus of outcomes on self-management (i.e. there is a perceived over-reliance). Points raised by these respondents include that:

- Self-management is not a replacement for dedicated mental health support/services.
- Self-management tools and techniques may be more difficult for people with a severe or acute mental health issue.

Theme 4: Stigma

Where mentioned by consultation respondents (e.g. a small number of individual respondents and health improvement and mental health organisations), the focus of outcomes on addressing the stigma and discrimination of people with mental health issues is welcomed. Various points are raised by these respondents, including the importance of action to:

- Reduce the hesitancy of asking for help.
- Address stigma around mental health in the workplace.
- Reduce stigma among healthcare providers in order to improve mental health services.

Theme 5: Additional points

Some consultation respondents raise additional points which are outlined below in order of frequency:

- Additional support is required for carers. Carers of individuals who have mental health issues are vulnerable to poor mental health themselves due to caring responsibilities.
- There needs to be a cultural change in attitude towards mental health among health professionals who often view physical health and mental health separately rather than holistically.
- The availability of, and access to, community support is an important part of the mix and could be expanded.
- There is a fundamental need to reduce inequality and poverty in order to achieve the outcomes (i.e. the root causes of poor mental health and wellbeing).

7.4 Question 4.3 - Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for communities? This includes geographic communities, communities of interest and communities of shared characteristics.

The consultation asks respondents whether they agree that the Mental Health and Wellbeing Strategy should aim to achieve four outcomes for communities.

Table 24 to Table 27 (**Supplementary Report**) presents the quantitative response to **Question 4.3**. **Table 7.2** provides a high-level overview of responses.

Table 7.2: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for communities? (all consultation respondents)

Outcome	Agree	Neutral	Disagree
Communities are engaged with, involved in, and able to influence decisions that affect their lives and support mental wellbeing. (N=395)	90%	6%	4%
Communities value and respect diversity, so that people, including people with mental health conditions, are able to live free from stigma and discrimination. (N=395)	91%	4%	6%
Communities are a source of support that help people cope with challenging life events and everyday knocks to wellbeing. (N=395)	87%	9%	4%
Communities have equitable access to a range of activities and opportunities for enjoyment, learning, participating, and connecting with others. (N=394)	92%	3%	6%

Key points to note from **Table 7.2** include that:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each of the outcomes for communities. On average 90% of all consultation respondents agree with each outcome.
- While most individual and organisation respondents agree with each of the community outcomes, organisation respondents tend to be more positive. On average 94% of organisation respondents agree with each outcome for communities. This compares to 87% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each outcome. This is highest among health improvement organisations and lowest among education, training, and skills organisations.

- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the four outcomes for communities. This ranges from a low of 4% of all consultation respondents to a high of 6%.

7.5 Question 4.3.1 - Do you have any comments you would like to add on the above outcomes?

Question 4.3.1 asks respondents for any additional comments on the outcomes for communities specified at **Question 4.3**. Around half of all consultation respondents answer this question, and the most common themes are outlined below.

Theme 1: A repeat of views raised earlier

A prevalent view (e.g. among health improvement and mental health organisations, and some individual respondents) is that the outcomes for communities could be more specific and need to be measurable. Similarly, some respondents consider that a lack of investment in mental health services, including sustainable funding for the third sector, may make it difficult for these outcomes to be achieved.

Theme 2: The role of community-based support and services

Some respondents (e.g. some individual respondents, health improvement and mental health organisations, and organisations who support specific target groups) who note the value and contribution of community-based mental health services and support also raise points of concern.

The points raised by these consultation respondents include:

- It is important not to have an over-reliance on communities to support those with mental health issues (i.e. the role/involvement of communities should not displace support from mental health professionals).
- Community-based mental health support, on its own, may not be appropriate for individuals with a severe or acute mental health illness.
- There are disparities in levels of community capacity in different parts of the country, and in particular within deprived areas. This could exacerbate existing geographic inequalities in access to community-based mental health support. Additional community development support may therefore be required.
- Specific attention could also be given to remote/rural communities as they are different from urban areas and will require different solutions (i.e. a one-size-fits-all approach is not considered appropriate).

7.6 Question 4.4 - Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for populations?

The consultation asks respondents whether they agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for populations.

Table 28 to Table 31 (**Supplementary Report**) presents the quantitative response to **Question 4.4**.

Table 7.3 provides a high-level overview and key points to note include that:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each of the outcomes for populations. On average 89% of all consultation respondents agree with each outcome.
- While most individual and organisation respondents agree with each of the outcomes for populations, organisation respondents tend to be more positive. On average 93% of organisation respondents agree with each outcome. This compares to 87% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each outcome for populations. This is highest among health improvement organisations and lowest among other organisations.
- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the four outcomes for populations. This ranges from a low of 6% of all consultation respondents to a high of 8%.

Table 7.3: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for communities?

Outcome	Agree	Neutral	Disagree
We live in a fair and compassionate society that is free from discrimination and stigma. (N=393)	88%	5%	8%
We have reduced inequalities in mental health and wellbeing and mental health conditions. (N=392)	90%	4%	6%
We have created the social conditions for people to grow up, learn, live, work and play, which support and enable people and communities to flourish and achieve the highest attainable mental health and wellbeing across the life-course. (N=392)	89%	4%	8%
People living with mental health conditions experience improved quality and length of life. (N=393)	91%	4%	6%

7.7 Question 4.4.1. Do you have any comments you would like to add on the above outcomes?

Question 4.4.1 asks respondents for any additional comments on the outcomes for populations specified at **Question 4.4**. Less than half of respondents provide a response, and the most common themes are described below.

Theme 1: A repeat of views raised earlier

Many consultation respondents restate points they made to earlier questions - **Question 4.2.1** and **Question 4.3.1**. In summary:

- Outcomes could be more specific and need to be measurable.
- Achievement of the outcomes for populations requires increased funding for mental health support and services.
- A focus on addressing stigma is welcomed

Theme 2: Outcomes for populations are overly ambitious

There is some feedback from consultation respondents (e.g. individual respondents and health improvement and mental health organisations), that the outcomes for populations are complex and overly ambitious. A point made by these respondents is that it may be difficult for the Mental Health and Wellbeing Strategy to tackle these issues on its own.

Theme 3: Mental health and wellbeing should guide all government policy

Some respondents (e.g. individual respondents and health improvement and mental health organisations) feel that outcomes for populations may fit better within an overarching government strategy or that all government strategies should be “mental health proofed” with reference to outcomes for populations. Mental health and wellbeing should guide all government policy rather than being restricted to the Mental Health and Wellbeing Strategy.

Theme 4: A focus on reducing inequality

A few respondents (e.g. individual respondents and organisations who support specific target groups) highlight the importance of reducing income and health inequalities in order to achieve the outcomes for populations. A point made by these respondents is that the Strategy and its outcomes should take account of social determinants of mental health – as issues such as poverty, deprivation, and inequality (amongst others) have a significant impact on mental health and wellbeing.

Theme 5: Geographic variations

Further, some individual respondents note that while poor mental health and wellbeing can be experienced wherever you live, there are differences in needs and access to services when urban and rural/remote areas are considered. A point made by these respondents is that a “one size fits all” approach would not be appropriate.

7.8 Question 4.5 - Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for services and support?

The consultation asks respondents whether they agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for services and support.

Table 32 to Table 38 (**Supplementary Report**) presents the quantitative response to **Question 4.5**.

Table 7.4 provides a high-level overview and key points to note include that:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each of the outcomes for services and support. On average 91% of all consultation respondents agree with each outcome.
- While most individual and organisation respondents agree with each of the outcomes for services and support, organisation respondents tend to be more positive. On average 94% of organisation respondents agree with each outcome. This compares to 89% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each outcome. This is highest among education, training, and skills organisations and lowest among organisations who support specific target groups.
- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the four outcomes for services and support. This ranges from a low of 4% of consultation respondents to a high of 8%.

Table 7.4: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcomes for services and support?

Outcome	Agree	Neutral	Disagree
A strengthened community-focussed approach, which includes the third sector and community-based services and support for mental health and wellbeing, is supported by commissioning processes and adequate, sustainable funding. (N=396)	86%	7%	6%
Lived experience is genuinely valued and integrated in all parts of our mental health care, treatment and support services, and co-production is the way of working from service design through to delivery. (N=394)	88%	9%	4%
When people seek help for their mental health and wellbeing they experience a response that is person-centred and flexible, supporting them to achieve their personal outcomes and recovery. (N=395)	93%	3%	5%
We have a service and support system that ensures there is no wrong door, with points of access and clear referral pathways that people and the workforce understand and can use. (N=396)	90%	5%	5%
Everyone has equitable access to support and services in the right place, at the right time wherever they are in Scotland, delivered in a way that best suits the person and their needs. (N=396)	93%	2%	4%
People are able to easily access and move between appropriate, effective, compassionate, high-quality services and support (clinical and non-clinical). (N=394)	93%	2%	5%
Services and support focus on early intervention and prevention, as well as treatment, to avoid worsening of individual's mental health and wellbeing. (N=395)	92%	4%	5%

7.9 Question 4.5.1. Do you have any comments you would like to add on the above outcomes?

Question 4.5.1 asks respondents for any additional comments on the outcomes for services and support specified at **Question 4.5**. Around three-fifths of consultation respondents answer this question, and the most common themes are summarised below.

Theme 1: A repeat of views raised earlier

Many respondents provide a repeat of views made to earlier questions - **Question 4.2.1, Question 4.3.1, and Question 4.4.1**. In summary:

- Outcomes could be more specific and measurable.
- Achievement of the outcomes for services and support requires increased funding for mental health services and support.
- That there are variations in access to support and services when different geographies are considered.
- There is a need to tackle poverty and inequality in order to support good mental health and wellbeing.

Theme 2: A stronger focus on early intervention and prevention

There is agreement among consultations respondents (e.g. individual respondents, organisations who support specific target groups and health improvement and mental health organisations), that a stronger focus on early intervention and prevention for mental health services and support is crucial. Points raised by these respondents include that:

- Support is expressed for a more proactive approach to mental health and wellbeing at all stages of a person's life.
- An early intervention and prevention approach could reduce waiting lists for mental health support and prevent the need for acute mental health care and hospital admissions.

Theme 3: Lived experience

Consultation respondents (e.g. individual respondents, mental health organisations and organisations who support specific target groups) agree that it is important to ensure that people with lived experience of mental health issues are meaningfully engaged and consulted to help inform the design, delivery, and improvement of mental health services and support. This is reported to be with a view to ensuring that mental health services and support better meet the needs of service users.

Some of these respondents raise points that would need to be considered carefully, including:

- It is important not to over-burden people with lived experience of mental health issues (or organisations who advocate on their behalf) in the process.
- Sensitivity and expertise is required when engaging people with lived experience of mental health issues.
- Lived experience is one of a number of sources of information that can be used to build or further develop the evidence base for improving mental health and wellbeing services and support.

Theme 4: Third sector providers

Some respondents (e.g. primarily individual respondents) raise the following concerns in relation to the provision of mental health and wellbeing services and support:

- There is considered to be an existing over-reliance on the third sector to help deliver mental health and wellbeing services and support in Scotland.

- A perception that some third sector organisations who provide mental health and wellbeing services and support are not as professional as others/public sector, and that this is further reflected in the level of workforce development and in their ability to provide a consistent level of service/support.

On the other hand, other respondents (e.g. some individual respondents and organisations who support specific target groups) express support for an expanded role for third sector organisations in the delivery of mental health and wellbeing services and support.

Theme 5: Individualised Care

Individualised and person-centred care and support is highlighted as important by some respondents (e.g. individual respondents, and health improvement and mental health organisations). A prevalent view among these respondents is that people with poor mental health are not a homogeneous group, and that generic mental health and wellbeing support and services or a one-size-fits-all approach would not be appropriate or lead to improved outcomes.

7.10 Question 4.6 - Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcome for information, data, and evidence?

The consultation asks respondents to what extent they agree that the Mental Health and Wellbeing Strategy should aim to achieve the following outcome for information, data, and evidence:

‘People who make decisions about support, services and funding use high quality evidence, research, and data to improve mental health and wellbeing and to reduce inequalities. They have access to infrastructure and analysis that support this’.

Table 39 (**Supplementary Report**) presents the quantitative response to **Question 4.6**. Key points to note include:

- **88% of all consultation respondents agree (i.e. either agree or strongly agree) with the outcome for information, data, and evidence**. Organisation respondents are more likely to agree than individual respondents. Among organisation subgroups, health improvement organisations are more likely to agree with the outcome.

- **5% of all consultation respondents do not agree (i.e. either agree or strongly agree) with the outcome for information, data, and evidence**. Individual respondents are slightly more likely to disagree than organisation respondents. Among organisation subgroups, education, training and skills organisations are more likely to disagree with the outcome.

7.11 Question 4.6.1 - Do you have any comments you would like to add on the above outcome?

Question 4.6.1 asks respondents for any additional comments on the outcome for information, data, and evidence specified at **Question 4.6**. Almost half of all consultation respondents provide a response, and the most common themes are summarised below.

Theme 1: Lived experience is of critical importance

There is consensus across consultation responses (i.e. individual and organisation respondents) of the importance of taking lived experience into account from an information, data, and evidence perspective. Further, it is considered important that a balance is struck between the use of quantitative and qualitative, lived experience sources.

Theme 2: Data sharing

An issue raised primarily by health improvement and mental health organisations is that there is a lack of robust information/data sharing protocols between mental health and wellbeing service providers (e.g. within the public sector, between the public and third sectors). These respondents note that this can result in silo working and that improvements in data sharing could improve the effectiveness of service delivery and improvement.

A related point centres on the ease with which information/data can be routinely shared between mental health and wellbeing service providers. For example, there is some organisation respondent feedback that suggests NHS digital infrastructure requires additional investment as many records are still kept in paper/hard copy.

Theme 3: Intersectionality of Data

A few respondents (e.g. individual respondents and organisations who support specific target groups) emphasise the importance of gathering and using intersectional data. This is with a view to developing a better understanding of the multi-dimensional issues faced by those with more than one protected characteristic.

Theme 4: Resource implications

There is some feedback from individual respondents and all organisation subgroups that raises a concern that information, data, and evidence requirements may result in an increased administrative burden, workload, and/or bureaucracy for frontline organisations. Aligned to this point, is a call for additional financial resources to support implementation.

Theme 5: More research required

A few consultation respondents (e.g. individuals and mental health organisations) whilst agreeing with the outcome believe that there needs to be increased investment in research to provide up-to-date evidence for mental health and wellbeing service providers (i.e. to ensure an evidence-led approach).

7.12 Question 4.7 - Are there any other outcomes we should be working towards? Please specify:

Question 4.7 asks respondents whether there are any other outcomes the Strategy should be working towards. Just over half of all consultation respondents provide a response, and the most common themes are summarised below.

Theme 1: Easy, rapid, and equitable access to mental health and services

The most common theme identified (e.g. among individual respondents) is the need for easy and rapid access to mental health and wellbeing services for all. These respondents feel that access to mental health and wellbeing services is not equitable, that access can often be difficult and slow, and that there are geographic variations in access. Taken together, addressing these issues could have a significant positive impact on Scotland's mental health and wellbeing.

Theme 2: Early intervention for infants and children

Many consultation respondents (e.g. individual respondents and a mix of organisation subgroups) note that an early intervention and preventative approach for infants and children should be a key desired outcome for the Strategy. These respondents describe the wide range of benefits that such an approach could have for babies and young children (and their families) – now and throughout their lives. For example, developing the skills they need to live happy and healthy lives – supporting good mental health and wellbeing, and preventing and addressing childhood trauma, etc. Additional points raised by some of these respondents is the importance of increasing awareness at a young age of coping strategies and self-care to help manage and minimise any symptoms that individuals may be experiencing.

Theme 3: A repeat of views raised earlier

Many consultation respondents took the opportunity to provide similar points as mentioned elsewhere in the consultation, most notably about the relationship between physical and mental health (i.e. the need for a holistic approach). Other points raised include:

- The importance of reducing stigma in mental health.
- Achievement of the outcomes requires increased funding for mental health services and support.
- The lived experience of service users is important as is the knowledge and expertise of service providers.

Theme 3: Reduce waiting times

Some consultation respondents (e.g. individual respondents) highlight the need for an outcome to reduce waiting times. Quick and easy access to mental health and wellbeing services is viewed as critical, especially for those whose mental state is getting worse or who are in crisis or distress.

Theme 4: A greater focus on those with serious and complex mental health conditions

A small number of respondents (e.g. individual respondents, health improvement organisations) feel that the outcomes do not have a sufficient focus on the needs of, and long-term support and care for, individuals with serious and complex mental health conditions. For example, these consultation responses refer to complex trauma, complex post-traumatic stress disorder (PTSD), psychosis, etc.

8 Creating the Conditions for Good Mental Health and Wellbeing

8.1 Question 5.1 - What are the main things in day-to-day life that currently have the biggest positive impact on the mental health and wellbeing of you, or of people you know?

Almost three-quarters of all consultation respondents provide a response to **Question 5.1**, and responses have been categorised in **Table 8.1**. Consultation respondents (i.e. individual and organisation respondents) identify a common set of factors in day-to-day life that have the biggest positive impact on their own mental health and wellbeing or of people they know/support. The factors identified are similar to those identified at the Stakeholder Events (**Chapter 3**).

Table 8.1: Respondent views on what has a positive impact on mental health and wellbeing

Secure employment, fair pay, good working conditions, and opportunities for career progression	Financial stability and security
Having good physical health	Structure, routines, roles, relationships, and responsibilities
Being active (e.g. play, sport and physical activity, recreation and leisure activity, social activity, arts and culture), having a range of interests and hobbies, and having the opportunity to try new things/ experiences.	Knowing how to find/access informal and formal support when it is needed (e.g. including within different settings such as education, workplace, community, etc). Quick and easy access to specialist and practical information, advice, and inclusive support as well as knowledgeable staff
Access to nature, green and open space	Having freedom and choice
Feeling safe	A healthy and balanced diet and the means to access this
Feeling safe to speak about mental health without fear of stigma or discrimination	Strong connections with other people, a personal support network (e.g. family/friends/neighbours) and community involvement
Being able to have fun and feel good about yourself	A safe, secure, stable, and supportive home environment
Having close, healthy, honest, positive, meaningful, supported, and trusting personal relationships	Having a sense of purpose, contribution and belonging
Support to cope with life transitions	Pet ownership or being around animals
Being able to make healthy decisions	Access to education/sustaining education

Feel listened to, heard, and supported	Person-centred care/having a real choice in how your care is delivered/self-determination
Access to peer support	Work or education-life balance
Sense of autonomy or control over circumstances. Having choice and control over what is happening, and the resilience and ability to cope with changing circumstances.	The ability to engage in meaningful and productive activity

8.2 Question 5.2 - Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Around one-quarter of all consultation respondents provide a response to **Question 5.2** (i.e. additional qualitative feedback to supplement their response to **Question 5.1)**, and the main themes are presented below.

Note: In addition, a large proportion of consultation respondents either simply confirm whether their response to **Question 5.1** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable". These responses are not captured in the percentage above or the themes described below.

Theme 1: A repeat of views raised earlier

Some respondents took the opportunity to provide a repeat of views made throughout the consultation, among other things this includes:

- Social and environmental determinants of health are important considerations when developing the Mental Health and Wellbeing Strategy.
- Additional financial resources for the public sector and longer-term funding for the third sector is required to make a real difference and to have a positive impact on mental health and wellbeing at a population level.
- Factors that have a positive impact on mental health and wellbeing can be subjective, personal, and changeable.
- Different settings all have a role to play in promoting and supporting good mental health and wellbeing (e.g. community, education, workplace).
- Lived experience and co-production to inform and shape mental health care, treatment and support services is key.
- The relationship between mental health and physical health/better integration of physical and mental health support.

- The importance of early years.
- The need for additional support for carers.

Other respondents either restate similar points to those raised at **Question 5.2** or expand on these points in some way (e.g. feeling connected, regular exercise, etc).

Theme 2: Additional factors identified

Some consultation respondents (e.g. individual respondents) highlight additional factors in day-to-day life that have the biggest positive impact on their own mental health and wellbeing or of people they know/support. Most are already captured in **Table 8.1**. Those not previously captured include for example:

- Alleviating the impact of the current cost-of-living crisis.
- Compassion and understanding.
- Being able to attend church.
- Sleeping well/having a good sleep pattern.
- Volunteering.
- Flexible and hybrid working arrangements.
- Having time for yourself.
- Neighbourhood attractiveness.
- Sense of pride in your local environment/surroundings.
- Places and spaces in local communities for people to come together and to interact.
- Community empowerment.
- Dignity and respect in the delivery of services.

Theme 3: The health and social care sector

Some respondents (e.g. individual respondents, health improvement organisations) consider it important that more is done at a national level to increase the attractiveness of the Health and Social Care sector as a career option.

Points raised centre on: talent attraction, recruitment, and retention; workforce development; fair pay; good working conditions; and ability to engage with specific target groups. Investing in, valuing, and recognising the contribution of those who work in the Health and Social Care sector in Scotland, is viewed by these respondents as a key component to achieving the strategic ambitions set out for the Mental Health and Wellbeing Strategy. Facilitating increased collaboration and connectivity between services is also considered important.

Theme 4: Existing evidence base

A few respondents (e.g. health improvement organisations) note that there is a well-established evidence base that identifies the factors which most affect mental health, either positively or negatively. A point made is that this wider evidence base could be reviewed by the Scottish Government to ensure that they are fully understood and reflected in the final Strategy document.

8.3 Question 5.3 - What are the main things in day-to-day life that currently have the biggest negative impact on the mental health and wellbeing of you, or people you know?

Around 80% of all consultation respondents provide a response to **Question 5.3**, and these have been categorised in **Table 8.2**. Consultation respondents (i.e. individual and organisation respondents) identify a common set of factors in day-to-day life that have the biggest negative impact on their own mental health and wellbeing or of people they know/support. The factors identified are similar to those identified at the Stakeholder Events (**Chapter 3**).

Table 8.2: Respondent views on what has a negative impact on mental health and wellbeing

Poverty	Cost-of-living crisis
Financial insecurity/money worries	Long-term impact of the COVID-19 pandemic
Loneliness and social isolation	Lack of social connections and interaction
Stigma/discrimination/feeling judged	Life changes (e.g. bereavement)
Personal relationship problems/difficulties/ breakdown/rejection	Substance use/addiction
Housing (e.g. affordability, availability, conditions, security)	Job security/in-work poverty
Mental health and wellbeing services (e.g. lack of investment, long waiting lists, difficult to access, limited flexibility in delivery, not knowing where to access help and support, lack of community resources, lack of person-centred support, insufficient workforce development)	Unemployment/long-term unemployment
Trauma/abuse	Having a poor work-life balance/work-related pressure and stress
Domestic violence/abuse	Poor physical health/other health conditions
Caring and family responsibilities	Lack of access to transport/poor public transport links
Lack of community/community spirit/community groups and services	Not feeling listened too/a lack of empathy and compassion
The benefits system	Poor diet/not eating well

Poor communication between health professionals and patients (e.g. prior history, sharing information, lack of joined up services, referral pathways)	Difficulties getting an appointment for GP/waiting lists for other health services (e.g. scans)
Lack of opportunities and choice	Lack of access to affordable childcare
Only offering medication as a mechanism for improving mental health	Lack of access to, and affordability of, sport and physical activity
A lack of self-worth, self-confidence, or self-esteem	Climate emergency
Media coverage (e.g. negative news stories), and social media	Politics/government
Lack of structure and routine	Lack of access to green and open spaces
Lack of safe spaces/not feeling safe/feeling unsafe in local environment	Bullying

8.4 Question 5.4 - Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Around one-fifth of all consultation respondents provide a response to **Question 5.4** (i.e. additional qualitative feedback to supplement their response to **Question 5.3**), and the main themes are presented below.

Note: In addition a large proportion of consultation respondents either simply confirm whether their response to **Question 5.3** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable". These responses are not captured in the percentage above or the themes described below.

Theme 1: A repeat of views raised earlier

Some respondents took the opportunity to provide a repeat of previous points, including but not limited to those presented at **Question 5.2** (and Theme 1):

- Social and environmental determinants of health are important considerations when developing the Mental Health and Wellbeing Strategy (e.g. tackling poverty and inequality).
- There could be an increased focus on early years.
- That factors will interplay and will be significantly impacted by other external factors and how an individual experiences them.

- The protective factors are linked to those that are important in suicide prevention, and it would be important for there to be a clear link/integration between the Mental Health and Wellbeing Strategy and the wider mental health policy context.
- The existing evidence base on what has a negative (and positive) impact on mental health and wellbeing could be reviewed by the Scottish Government to ensure that they are fully understood and reflected in the final Strategy document
- There is considered to be a lack of longer-term funding for the third sector.
- Ensuring that mental health is only medicalised when it needs to be.

Theme 2: Additional factors identified

Some respondents (e.g. individual respondents) who answered **Question 5.4** highlight additional factors in day-to-day life that have the biggest negative impact on their own mental health and wellbeing or of people they know/support. Most factors are already captured in **Table 8.2**. Those factors not previously captured include the following, **Table 8.3**.

Table 8.3: Additional factors that have a negative impact of on mental health and wellbeing

Fear of rejection	Delayed discharge from hospital for individuals with a severe and enduring mental illness due to a lack of investment in community housing and wrap around support packages
Feeling undervalued	A lack of understanding and awareness of mental illness in society and in different settings (e.g. education, workplace)
Not feeling like you belong or are accepted	Thresholds for accessing mental health services being too high
Criminal justice system	A lack of places and opportunities for play
A lack of wrap-around service provision	A lack of recognition, value and professional esteem afforded to the social care workforce by other health and social care professionals, as well as wider Scottish society
Feeling disconnected from other people	Poorly designed spaces and places

8.5 Question 5.5 - There are things we can all do day-to-day to support our own, or others', mental health and wellbeing and stop mental health issues arising or recurring. In what ways do you actively look after your own mental health and wellbeing?

Table 40 (**Supplementary Report**) provides the quantitative response to **Question 5.5**.

Table 8.4 provides a high-level summary, and key points to note include that:

- Among all consultation respondents the top five ways selected for how they actively look after their own mental health and wellbeing are: time with family and friends, sleep, time in nature, exercise, and hobbies/practical work.
- When responses from individual respondents and organisation respondents are examined, it can be seen that a higher proportion of individual respondents select each of the pre-defined options than organisation respondents.
- Question design means that the results may be skewed. For example, not all organisation respondents answered the question as some may assume it was aimed at individual respondents.

Table 8.4: In what ways do you actively look after your own mental health and wellbeing

Ways to look after your mental health (N=296)	Individuals	Organisation	All consultation respondents
Time with family and friends	84%	78%	83%
Sleep	81%	71%	78%
Time in nature	77%	80%	78%
Exercise	74%	78%	75%
Hobbies/practical work	74%	78%	75%
Cultural activities	44%	62%	49%
Mindfulness/meditation practice	42%	54%	46%
Community groups	37%	65%	44%
Other	32%	59%	40%
None of the above	3%	8%	4%

Multiple response question where respondents could select more than one option and all that applied. Percentages may total more than 100% as a result.

8.6 Question 5.6 - If you answered ‘other’, can you describe the ways in which you look after your own mental health and wellbeing, or the mental health and wellbeing of others?

Table 8.4 shows that 40% of all consultation respondents selected “other” and identify additional ways that they look after their own mental health and wellbeing. Responses include the following, **Table 8.5**.

Table 8.5: 'Other' ways to look after your own mental health and wellbeing

Cooking and/or eating well/healthily	Mindfulness/meditation
Reading, watching television/films, and/or creating/listening to music	Going on holiday
Creative activities	Planning, structure, and routine
Pet ownership or being around animals	Taking time for yourself
Religion/faith/spirituality	Sleeping well
Sport and physical activity	Having fun and being playful
Peer support groups and peer-led activities	Gardening
Volunteering	Inter-generational activities
Self-improvement activities and learning/doing new things	Collegiality and teamwork
Self-care/self-management	

8.7 Question 5.7 - Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Most consultation respondents did not answer **Question 5.7**, or respond "no" or "not applicable, etc, or indicate that they responded as an individual or organisation. Among the circa one-fifth of consultation respondents who did answer **Question 5.7**, the main points are summarised below.

Theme 1: Barriers faced in looking after your own mental health and wellbeing

Many consultation respondents (e.g. primarily individual respondents but also some health improvement organisations and organisations that support specific target groups) highlight a wide range of barriers to people embracing activities which support their mental health and wellbeing, **Table 8.6**.

Table 8.6: Barriers to looking after your own mental health and wellbeing

A lack of financial resources exacerbated by the cost-of-living crisis	Poor physical health
The location, availability, and accessibility of different activities	Barriers faced by particular target groups (e.g. age, sex, disability, ethnicity)
When you are experiencing poor mental health	A lack of knowledge of things to do locally
Previous experience of stigma and discrimination	Not having people to do things with
A lack of free time available (e.g. childcare, other caring responsibilities, work/study, other commitments)	Poor weather conditions for outdoor activities
A lack of confidence or motivation	Understaffing in NHS services
Access to private and/or public transport, cost of transport	

"…people often tell us that embracing these activities can be very difficult when you are experiencing mental health problems. For many signposting or patient information approaches just do not work. What does work is peer-led approaches where people are supported by someone who understands and can work with them to find activities that benefit their wellbeing and help with access".

Scottish Recovery Network

Some of these respondents (e.g. health improvement organisations, organisations who support specific target groups) go on to note that it is important that investment is made, and further action taken to reduce such barriers in order to ensure equal access to services/activities to support good mental health and wellbeing for all.

Theme 2: Additional ways to look after mental health and wellbeing identified

Some consultation respondents (e.g. primarily individual respondents) identify additional ways that individuals may be supported to look after their own mental health and wellbeing:

- Feeling able to talk openly about mental health and wellbeing.
- Expanding provision of peer support groups and peer-led activities in communities of place, interest, and shared experience.
- An increase in social prescribing.
- That for some people, medication is the answer.
- Increased provision of respite care/support to help carers.
- Teaching children and young people traditional skills (e.g. making and creating things).

Theme 3: A repeat of views raised earlier

A few respondents simply restate or expand on points they raised about ways in which they look after their own mental health and wellbeing. These are captured above and are not repeated here.

Theme 4: Additional points

Additional points raised (e.g. primarily individual respondents), albeit not to any great extent, include:

- That it is difficult to fully understand the individual needs and circumstances of others. Some people might not find suggestions of ways that they could look after their own mental health and wellbeing helpful, and that it may exacerbate issues.
- More could be done to increase awareness and understanding of coping strategies and self-care to help manage and minimise any symptoms that individuals may be experiencing.
- That it is important for people to know where to go to access information and advice about what is happening in their community and be supported to become involved.
- There is a perceived need for increased investment in communities, community groups, community-run mental health and wellbeing services, counselling services, and/or the provision of spaces and places for communities to come together.

8.8 Question 5.8 - Referring to your last answers, what stops you doing more of these activities? This might include not having enough time, financial barriers, location, etc.

Almost two-thirds of consultation respondents answer **Question 5.8** which asks for views on what stops you doing more of these activities.

Theme 1: Similar points to those raised to Question 5.7

Almost all consultation respondents who provide a response identify similar factors to those that are raised at **Question 5.7, Theme 1**. For example, this includes factors such as: a lack of financial resources exacerbated by the cost-of-living crisis; the location, availability, and accessibility of different activities; a lack of free time; and when you are experiencing poor mental health and wellbeing.

Theme 2: Additional factors identified

Some respondents (e.g. primarily individual respondents) identify additional factors that prevents them (or people they know or support) from doing more of these activities. This includes the following factors, **Table 8.7**.

Table 8.7: Additional factors that prevents people from doing more of these activities

Energy or mood levels	A lack of access to childcare
A lack of supportive personal relationships	Poor maintenance of local paths and pavements
A lack of (or loss of) community infrastructure and opportunities	Cost of appropriate clothing and/or equipment (e.g. for sport and physical activity)
Impact of COVID-19 (e.g. long-COVID, heightened anxiety, etc)	Do not know where to start
The effects of medication	Little or no access to in-person peer support
Waiting times to access mental health and wellbeing services	A lack of access to local greenspace

"The Strategy should explicitly reflect that there are structural factors having a major impact on ability for individuals and communities to benefit from the range of protective elements that support good mental wellbeing - such as affordability, access (e.g. to greenspace), low pay issues impacting on wellbeing (e.g. holding multiple jobs creating pressures on family life, sleep, etc).

Public Health, NHS Greater Glasgow & Clyde

8.9 Question 5.9 Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Around 15% of consultation respondents answer **Question 5.9**. There are no new or additional themes to report that have not been described elsewhere in the consultation analysis report.

Note: In addition a vast majority of consultation respondents either simply confirm whether their response to **Question 5.9** is as an individual or organisation respondent, do not provide a response, or answer "no", "no further comment", or "not applicable". These responses are not captured in the percentage above.

8.10 Question 5.10 - We know that money worries and debt can have an impact on mental health and that this is being made worse by the recent rise in the cost of living. In what way do concerns about money impact on your mental health?

Around 60% of consultation respondents provide a response to **Question 5.10** and describe ways in which concerns about money impact on their mental health. The feedback has been summarised below.

Theme 1: A wide range of money-related concerns

Most respondents who answer **Question 5.10** note that concerns about money has a huge impact on mental health and wellbeing. There is reference across consultation responses (i.e. individual respondents and all organisation subgroups) to the current cost-of-living crisis and that concerns about money are at the forefront of peoples' minds.

These respondents typically refer to the following money-related concerns (i.e. for them personally and/or for people they know or support), **Table 8.8**.

Table 8.8: Money-related concerns

Paying household bills	Job insecurity and/or concerns about being made redundant
Affording the basics (e.g. clothing, food, heat)	Not being able to work due to factors such as caring responsibilities, poor physical health, poor mental health
Cost of petrol (e.g. to travel to and from work, to access services)	The benefits system.
Less financial stability and disposable income	Delays in receiving benefit payments
Managing debt or problem debt	The perceived stigma attached to being reliant on support systems e.g. benefits, food banks, borrowing money from family or friends
No savings/not being able to save to cover any unexpected costs	The ability of some individuals with mental illness to manage money

Theme 2: Impact on mental health and wellbeing

Consultation respondents (i.e. individual and organisation respondents) report that the afore-mentioned money concerns lead to the following, **Table 8.9**.

Table 8.9: Impact of money-related concerns

Worry	Insomnia/disturbed sleep
Stress	Overwhelmed about the future/future uncertainty/fearful of what the future holds
Anxiety	Limited choices and opportunities
Low mood	Unhealthy coping mechanism
Feeling isolated	Suicidal thoughts and behaviours
Feeling hopeless or worthless (e.g. guilt and shame)	Poor concentration
Pressure on personal relationships and the home environment	Weight loss
Relationship breakdown	

In addition, some respondents highlight the impact of increased costs on the availability, accessibility, and affordability of community-based services and activities.

"Parent-carers raising disabled or seriously ill children and young people are more likely to experience poorer wellbeing than the parent-carers of non-disabled children and young people. This poor wellbeing is due to the extra financial, emotional and physical demands of raising a disabled child. Research has found that families with disabled children face an average of £581 in extra costs per month. (Disability Price Tag, SCOPE, 2019)".

Family Fund

"People who are in poverty, or live in deprived areas can face a duel stigma and discrimination, both for their mental health, and their deprivation. The fear of being judged and dismissed for multiple reasons can stop people from asking for help and support, which in turn can lead to worsening mental health…There is also data to suggest greater attention is needed to support financial inclusion, employability and income security and stability for people living with complex mental illness. Many are at greater risk of poverty, are less able to navigate their way around complex benefits systems and are unlikely (in part due to stigma) to ask for early support".

See Me

Theme 3: Poverty and inequality

Many respondents (e.g. individual respondents and organisation respondents) emphasis that the impacts of money concerns and cost-of-living crisis are not felt equally across society. There is reference across these consultation responses to the following points:

- The relationship between poverty/deprivation and mental health and wellbeing.

- Specific population groups are disproportionally affected (e.g. disabled people, people with long-term conditions, lone parents, people with complex mental illness), and this has a direct impact on mental health and wellbeing.

Theme 3: No impact personally but money concerns are a reality for many

Some respondents (e.g. individual respondents and organisation respondents) note in their consultation response that they personally do not have money concerns or that it is not currently a significant issue for them. In many cases, these respondents add that they do, however, worry for family members and/or others in society who are in a less fortunate position and who are struggling to make ends meet or are barely coping.

8.11 Question 5.11 What type of support do you think would address these money-related worries?

Over half (circa 56%) of consultation respondents provide a response to **Question 5.11** and describe the type of support that could address these money-related worries. The feedback has been summarised below.

Theme 1: Money advice and support

A prevalent view among individual respondents and organisation respondents (all organisation subgroups) is the need for the provision of money/debt management and budgeting advice and support for those who need it. As well as making it easier for people to feel they can talk about money concerns and access this type of support. A related point is that there is considered to be a need for financial education from a young age, and for the provision of money advice to be more integrated with other service provision.

While money advice is raised across the board, many respondents also identify the need for a wider range of advice and practical support on, for example: income maximisation; welfare rights; mental health and wellbeing; healthy eating/nutrition; cooking on a budget; energy efficiency measures; and housing.

“In our recent engagement conversations people highlighted that many are finding it difficult to access money advice and debt advice services as they are experiencing high demand and often have very limited resources. It was suggested that mental health services and supports in all areas could be more proactive in developing good working relationships with local benefits, money, and debt advice agencies. This could enable mental health services to develop more understanding as well as enabling better access to the support required”. Scottish Recovery Network

We support “anti-poverty actions to reduce the underlying causes of deprivation and inequality, to increase the basic minimum wage and to improve access to welfare benefits, through an approach that retains an individual’s dignity and promotes fairness and opportunity”.

Social Work Scotland

Theme 2: Government intervention and support

Many respondents (primarily individual respondents) consider that government could and should do more to help people with money-related worries. These consultation responses frequently identify the need for greater intervention and support at this level, **Table 8.10**.

Table 8.9: Respondents views on government support needed

Access to free and impartial money advice	Reducing child poverty
Increasing the minimum wage	Tackling fuel poverty
Taxation and fiscal changes	Increasing the state pension
Reducing taxes and national insurance contributions	Improving public transport and active transport infrastructure
Increased tax for the highest earners	Ensuring that public transport and childcare is available, accessible, and affordable
Stopping energy price cap increases	Support for energy bills
Fighting inflation	Housing (e.g. bad landlords, secure tenancies, social rent cap, more affordable social housing)
Reducing fuel duty	

In addition, some individual respondents and organisation respondents highlight the importance of government investment for interventions that help promote and support good mental health and wellbeing, and for such provision to be accessible, affordable, flexible, etc. For example:

- Health and wellbeing advice and support.
- Sport and leisure.
- Community and social activities.
- Peer support.
- Outreach support.
- Increased and longer-term funding for the third sector to support subsidised provision and/or services that are free of charge.

Theme 3: Benefits system

Many individual respondents feel that there is a need to improve/change the benefits system – reducing bureaucracy and complexity of systems and processes, making it work better, and making it easier to use.

Theme 4: Employability and employer support

Some respondents (e.g. some individual respondents, organisations who support specific target groups) feel that employability support alongside support for employers/businesses is needed to:

- Help people find and sustain secure employment.
- Support employers to create quality jobs.
- Support employers to embed fair work and pay practices.
- Tackle in-work poverty.
- Ensure wage increases that are in line with inflation.

Theme 5: Universal basic income/minimum income guarantee

Some respondents (i.e. some individual respondents and some organisation respondents across all organisation subgroups) call for the introduction of a Universal Basic Income (UBI) or Minimum Income Guarantee (MIG) as a way to reduce poverty, improve income security, and boost wellbeing.

9 Access to Advice and Support for Mental Wellbeing

9.1 Question 6.1 - If you wanted to improve your mental health and wellbeing, where would you go first for advice and support?

Table 41 (**Supplementary Report**) provides the quantitative response to **Question 6.1**.

Table 9.1 provides a high-level summary.

Table 9.1: If you wanted to improve your mental health and wellbeing, where would you go first for advice and support

Where go first for advice and support (N=284)	Individuals	Organisation	All consultation respondents
Friends or family or carer	34%	18%	30%
GP	29%	22%	27%
Other	13%	29%	17%
Online support	10%	6%	9%
Third Sector (charity) support	3%	19%	7%
Helplines	4%	0%	3%
Workplace	3%	0%	2%
Local community group	1%	3%	2%
College or University (e.g., a counsellor or a student welfare officer)	1%	1%	1%
Health and Social Care Partnership	1%	0%	1%
NHS24	0%	0%	0%
Community Link Workers	0%	1%	0%
School (e.g., a guidance teacher or a school counsellor)	0%	0%	0%
Midwife	0%	0%	0%
Health visitor	0%	0%	0%
An employability provider (e.g., Jobcentre Plus)	0%	0%	0%

Note: “Other” responses include the following: some respondents highlight option(s) provided in the pre-defined list (e.g. GP); some respondents note that the first port of call would depend on the circumstances/situation; some report that they would approach more than one source for advice and other; and organisation respondents identifying gaps in the pre-defined list (e.g. Social Work Scotland, community nursing teams, community pharmacies). Where specific examples of “other” sources of support are provided, this includes for example: church/religious groups; private sector counsellors or psychiatrists; people with lived experience/who have the same condition; peer support groups; and forums (e.g. National Rural Mental Health Forum).

Key points to note include that:

- Among all consultation respondents, friends/family/carer/ is the first port of call for advice and support to improve their mental health and wellbeing. This followed, but to a lesser degree by, GP, other, online support, or third sector (charity) support.
- When responses from individual respondents and organisation respondents are examined, it can be seen that a higher proportion of individual respondents select each of the pre-defined options than organisation respondents. The exception is third sector (charity) support, and this likely reflects organisations' increased awareness and knowledge of the support provider landscape in Scotland.
- Question design means that the results may be skewed. For example, not all organisation respondents answer the question as some assume it was aimed at individual respondents.

9.2 Question 6.2 - If you answered 'online' could you specify which online support?

9% of all consultation respondents report that they would use online support as the first place they would go to for advice and support to improve their mental health and wellbeing. These consultation responses identify the following points:

- Some respondents simply note that they would undertake an internet search to identify potential sources of support and/or online materials and resources as a starting point (e.g. tips and tools for self-care, published research articles, blogs, social media, podcasts).
- Some respondents identify specific source(s) of online information and support. This includes: NHS; The Online Clinic; Moodjuice; Facebook groups; Living Life to the Full for Adults (LLTTF); Functional Neurological Disorder (FND) Hope; Sleepio; Meditation apps; Mind; Action for Happiness; Able Futures; peer support forums; No More Panic chat room, Feeling Good app, Wellbeing Lothian; Samaritans; The Royal College of Psychiatrists.

9.3 Question 6.3 - Is there anywhere else you would go to for advice and support with your mental health and wellbeing?

Table 42 (**Supplementary Report**) provides the quantitative response to **Question 6.3**.

Table 9.2 provides a high-level summary and key points to note include that:

- Consultation respondents report that they would access advice and support with their mental health and wellbeing from a wider range of sources.
- The most common responses include: GP, friends or family or carer, online support, third sector support, and helplines.
- A higher proportion of organisation respondents identify each source compared with individual respondents.

Table 9.2: Is there anywhere else you would go to for advice and support with your mental health and wellbeing

Where else go to for advice and support (N=252)	Individuals	Organisation	All consultation respondents
GP	43%	51%	45%
Friends or family or carer	36%	57%	41%
Online support	27%	43%	31%
Third Sector (charity) support	23%	49%	29%
Helplines	18%	36%	23%
Workplace	19%	28%	21%
Local community group	10%	39%	17%
Other	12%	26%	15%
NHS24	10%	23%	13%
Health and Social Care Partnership	6%	23%	10%
College or University (e.g., a counsellor or a student welfare officer)	4%	20%	8%
School (e.g., a guidance teacher or a school counsellor)	3%	21%	7%
An employability provider (e.g., Jobcentre Plus)	2%	11%	4%
Health visitor	0%	15%	4%
Midwife	1%	11%	3%
Community Link Workers	0%	0%	0%

Multiple response question where respondents could select more than one option and all that applied. Percentages may total more than 100% as a result.

9.4 Question 6.4 - If you answered 'online support' could you specify which online support?

Almost one-third (31%) of all consultation respondents report that they would also access online support for their mental health and wellbeing, **Table 9.2**. A higher proportion of organisation respondents select 'online support' than individual respondents.

The sources identified by these consultation respondents are similar to those presented above at **Question 6.2**. Additional sources identified include, for example:

- Mental health helplines e.g. Breathing Space.
- Mental health charity websites.
- Online mental health services (e.g. Togetherall, Silver Cloud).
- NHS websites/NHS inform.
- Various apps e.g. STOPP, DECIDER SKILLS, Feeling Good, CALMS.
- Specialist websites covering specific issues/health conditions.
- Self-care information sites.
- Self-help books and guides.
- Private sector online counsellor or therapist (e.g. BetterHelp).
- CBT Online Course (e.g. Beating the Blues).
- Peer support groups.
- Faith groups.

A few organisation respondents also refer to the support they make available to their employees and/or volunteers (e.g. Employee Assistance Programmes).

9.5 Question 6.5 - If you answered 'local community group', could you specify which type of group/ activity/organisation?

Less than one-fifth (17%) of all consultation respondents report that they would go to a local community group to get advice and support with their mental health and wellbeing, **Table 9.2**. A higher proportion of organisation respondents select 'local community group' than individual respondents.

These consultation respondents identify a range of community groups including:

- Leisure, recreation and social groups and activities (e.g. arts, crafts, culture, befriending, music, sport and exercise).
- Outdoor activity groups (e.g. walking groups, outdoor swimming).
- Mental health groups and activities (e.g. Andy's Man Club, Men's Sheds, COPE, Penumbra, Saheliya, Wellbeing Hubs, mindfulness spaces).
- Health groups, projects, and activities.
- Addictions support groups.
- Church and faith groups.
- Peer support groups.
- Carers groups.
- Postnatal support groups.
- Link clubs.
- Community-based and community-led groups and charities.

9.6 Question 6.6 - Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Around one-fifth (21%) of all consultation respondents provide a response to **Question 6.6** (i.e. additional qualitative feedback to supplement their response to earlier questions in **Section 9**), and the main themes are presented below.

Note: In addition, a majority of consultation respondents either simply confirm whether their response to **Question 6.6** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable". These responses are not captured in the percentage above or the themes described below.

Theme 1: Personal experiences of accessing mental health and wellbeing support

Many individual respondents provide details of their personal experience of accessing mental health and wellbeing support (or of someone they know).

There is reference across these consultation responses to it being difficult for many people to take the first step and ask for help, and many individual respondents describe having a poor experience of public sector mental health and wellbeing services, for example:

- Support that is not tailored or sensitive to specific groups (e.g. ethnic minorities).
- Support that is not inclusive (e.g. people who do not have digital skills).
- Support that is not person-centred.
- Not feeling that they have been treated appropriately (e.g. respect, care, and dignity).
- Concerns about confidentiality.
- Stigma and discrimination in mental health services.
- Waiting times or difficulties accessing referrals or appointments.
- The location, availability, and accessibility of different support services.
- Having to access private sector support (e.g. counselling), where personal finances allow, as an alternative to navigating the NHS system.

Theme 2: A repeat of views raised earlier

Many consultation respondents (individual respondents and all organisation subgroups) identify similar points to those raised at earlier consultation questions. This includes, for example, the importance of:

- Effective early intervention and prevention.
- Making it easy for people to access help when they need it, and making it easy to access the support that is right for them, etc.
- Trusted relationships, clear signposting, and connecting people to mental health and wellbeing support.
- Having a range of support and services available, and that people know how to access them.
- Increasing awareness of community-based support services as well as providing longer-term funding and capacity building support for the third sector.
- Services working together in partnership to address factors that support mental wellbeing and reduce mental distress.

“We recognise that there needs to be a variety of ways that we can access support for mental health and wellbeing and this needs to be a shared care and support model, i.e. from medical areas (not just GPs, but utilising psychological therapies, nursing, link practitioners, OTs), community resources and individuals with lived experience. A variety of support is needed; each has its place”.

Aberdeen City Health and Social Care Partnership

“An issue in accessing services and support is the lack of systems or services working together. We need to acknowledge the challenges that people face and the inequalities in ability to negotiate seeking support or services: online access, understanding how health systems work, language barriers, not fitting criteria to access, being passed from one part of the system to another, completing forms, connections between statutory services and third sector etc.

Roles such as community link workers and third sector organisations who can support people through the maze of support needs to be strengthened with long term funding commitment. Also investment in befriending support – likely through Third Sector organisations – needs to be increased and long term. If we want to fulfil the ambition of mentally healthy and supportive communities, these are key areas of investment”.

Public Health, NHS Greater Glasgow & Clyde

“A ‘trusted person’ is key when considering the first point of response. This will likely vary depending on the age and circumstance of an individual, where strong relationships exist within their life already. If they are not already in contact with supports and services, these may not be the first port of call. Key is that sufficient information is available that the first point of contact can help direct towards appropriate support and that services within the mental health system can effectively support and individual to move between them.

COSLA

Theme 3: GPs – a focus on medication

Some respondents (e.g. individual respondents and some mental health organisations) feel that GPs may not always be best placed to support people with their mental health and wellbeing and/or feel that GPs can only prescribe medication (i.e. less of a focus on what community-based support an individual can access or self-care). In this regard, these respondents feel that GPs should not be the only gateway to mental health services, especially when it can be difficult to access appointments. There should be many routes for referrals, and a broad range of services should be aware of how to direct people to the right place.

“Most of those involved in engagement highlight the importance of family and friends and local community groups but also of GPs. Some have expressed concerns that there continues to be a focus on telling people to go to their GP for help with mental health and wellbeing problems when the reality is that GPs do not feel that they have much to offer, other than medication. The idea of wellbeing hubs offering non-clinical and community-based support to people in addition to or as an alternative to medication is very much welcomed”.

Scottish Recovery Network

“For mental illness there needs to be a much greater focus on the governance of effective, reliable and safe interventions/treatments. Harm can be caused in situations where governance is lacking e.g. mindfulness for people with psychosis delivered by people without a high level of training and supervision, prescribing of anti-depressants to people who are experiencing mild symptoms. Both these interventions can be very effective when used in the correct situations but need careful governance to be applied safely”.

NHS Lothian

Theme 3: How and when advice and support is delivered

In addition to the points noted above about person-centred support and that everyone should be treated with respect and dignity, etc, additional points raised by some individual respondents and organisation respondents (e.g. other organisations, organisations that support specific target groups) to help maximise the chances of a positive experience of accessing mental health and wellbeing services are outlined below. This includes:

- All primary care staff should have a level of mental health training.
- How (and indeed whether) someone chooses to access advice and support about their mental health will vary from person to person and depend on the relationships they have with those around them.
- Individuals may have different preferences and needs (e.g. digital versus face-to-face engagement). Further, while online support may be a popular option, it would not be appropriate for everyone (e.g. someone in suicidal distress).
- Mental health and wellbeing support needs to be available 24/7.

“Mental illness does not only happen Monday to Friday 9-5, and current service models do not take account of people’s working patterns therefore making it difficult for them to access help when they might need it”.

COSLA

9.7 Question 6.7 - We want to hear about your experiences of accessing mental health and wellbeing support so we can learn from good experiences and better understand where issues lie. Please use this space to tell us the positive experiences you have had in accessing advice and support for your mental health or wellbeing.

Less than half (44%) of all consultation respondents provide a response to **Question 6.7** and either provide details of their personal experience of accessing support for their mental health and wellbeing, or of someone else's experience of accessing support (e.g. family member) or from an organisation perspective. The main themes are presented below.

Note: In addition a large proportion of consultation respondents did not provide a response, or answer "no other comments", or "not applicable". These responses are not captured in the percentage above or the themes described below.

Theme 1: Positive experiences

Some individual respondents have a positive experience to share about accessing advice and support for their own or a family member's mental health or wellbeing. A positive experience is in the main centred on factors such as:

- People receiving support quickly and when they need it.
- Feeling listened too and not judged.
- Being supported by staff who show empathy, compassion, and kindness.
- Trusted relationships.
- Nature of the support (e.g. counselling, talking therapies, being connected to community-based activities and local amenities, coping mechanisms and strategies, skills to build resilience, face-to-face engagement, online support and apps, knowledgeable and supportive GP, employer assistance programmes, CBT).
- Being supported by frontline workers (e.g. community mental health nurses, link workers, specialist charities, peer support) who have knowledge and understanding of mental illness and/or of specific conditions.
- Safe spaces (e.g. do not feel medical or clinical).
- Feeling involved in the decisions that affect their mental health and wellbeing (e.g. being supported to make informed choices).

Theme 2: Negative experiences

Some individual respondents provide details of a negative experience of accessing advice and support for their mental health and wellbeing (or someone they know). Low levels of satisfaction are expressed in terms of the following factors:

- Availability and accessibility of mental health services (e.g. location, opening hours).
- Long waiting lists to access public sector mental health services. Not everyone has the resources to access private sector counselling (i.e. feel alone and unsupported, escalating mental health issues, knock-on impact on family/carer).
- Variable experience with GP contact (e.g. difficulty making appointments, lack time, lack knowledge and understanding of mental illness/specific conditions, default position is to prescribe medication which may not be the most appropriate type of support).
- Being worried about confidentiality and the potential for information to be shared without their consent.
- A lack of mental health and wellbeing support in schools.
- Thresholds for accessing mental health services being too high.
- Online support may not be suitable in all cases/situations.

Theme 3: Organisation perspectives

Where feedback is provided by organisation respondents, this highlights the following:

Individuals who need support are more likely to have a positive experience if:

- Services are easily accessible and are available when they need them.
- They feel able to ask help, free from stigma and discrimination.
- They are listened to by someone who has interest in them as a person not just on presenting symptoms (i.e. taking the time to understand the root causes). Consistency and continuity of support worker/support.
- They feel that the person has empathy (e.g. how you feel and validate your experiences and feelings), has compassion, and helps to identify what supports they need and to get them in place.
- Time and space to speak (e.g. treated with dignity and respect, feeling validated, not feeling rushed, being supported for as long as is needed, non-judgmental support, etc).
- Do not have to retell the history/background/story to different people.
- Someone to help set realistic goals and to support them to reach these goals and celebrate when they do.
- Supportive relationships/wider support networks.

- Supportive employers/supported employment.

To provide a positive experience for individuals accessing mental health and wellbeing advice and support, services providers need to:

- Improve access to mental health and wellbeing support.
- Provide person-centred and whole-person support.
- Provide whole-family support.
- Provide services that are flexible and responsive to individual needs.
- Provide safe, welcoming, and inclusive environments and spaces.
- Be connected with other service providers.
- Improve communication and information/data sharing arrangements.
- Build trusted relationship between staff and client.
- Provide choice in all elements of care.
- Be able to provide clear signposting and connect people into community support (e.g. befriending, peer support). Linking ongoing care with a third sector organisation.
- Provide primary care practitioners with training on mental health and wellbeing and the impact of stigma and discrimination.
- Address recruitment challenges and create a more diverse workforce.
- Reduce waiting lists (e.g. increased burden placed on other service providers due to long waiting lists for NHS appointments).

“It’s also really important that people are listened to, are taken seriously, validated, collaborated with. Often the best, least stigmatising support, comes when people with lived experienced are involved in the decisions about their care and support. Being given enough time to speak and to share experiences without feeling rushed makes a huge difference when asking for help. Seeing the whole person, not a diagnosis, means that people will feel listened to and validated when asking for help, wherever it may be”.

See Me

9.8 Question 6.8 - Is there anything else you would like to tell us about this, whether you’re answering as an individual or on behalf of any organisation?

Around 10% of all consultation respondents provide a response to **Question 6.8**. The points raised are largely reflected elsewhere in the report, and no additional themes are identified.

Note: the vast majority of consultation respondents either simply confirm whether their response to **Question 6.8** is as an individual or organisation respondent, do not provide a response, or answer “no”, “no other comments”, or “not applicable”.

9.9 Question 6.9 - We also want to hear about any negative experiences of accessing mental health and wellbeing advice and support so we can address these. If you have experienced barriers to accessing support, what have they been?

Table 43 (**Supplementary Report**) provides the quantitative response to **Question 6.9**.

Table 9.3 provides a high-level summary.

Table 9.3: If you have experienced barriers to accessing support, what have they been

Barriers (N=242)	Individuals	Organisation	All consultation respondents
Long waits for assessment or treatment	63%	71%	65%
Lack of understanding of issues	51%	54%	52%
Having to retell my story to different people	49%	56%	50%
Not the right kind of support	45%	56%	48%
Time to access support	45%	56%	48%
Lack of awareness of support available	35%	67%	43%
Stigma	28%	67%	38%
Not a good relationship with the person offering support	32%	43%	35%
Support not available near me	26%	59%	35%
Discrimination	23%	52%	31%
Other	22%	41%	27%
Travel costs	17%	48%	25%

Multiple response question where respondents could select more than one option and all that applied. Percentages may total more than 100% as a result.

Key points to note include that:

- Consultation respondents report that the main barrier to accessing support is a long wait for assessment or treatment. This is followed by a lack of understanding of issues and having to retell my story to different people.

- There are some notable differences when responses by individual respondent and organisations respondent are examined. For example, organisation respondents are more likely to report each barrier, and are more likely to report a lack of awareness of support available and stigma as specific barriers to accessing support.

9.10 Question 6.10 - If you selected 'other', could you tell us what those barriers were?

Around one-quarter (27%) of all consultation respondents report 'other' barrier(s).

The most common responses are points that could fit within one of the pre-defined barriers listed in **Table 9.3**, and/or further elaboration on a specific point (e.g. details of the length of time the person has been waiting for support).

Other barriers reported include (absolute numbers a low in all cases):

- When a person has a mental illness, they may not have insight and/or be able to ask for help.
- Not being taken seriously or feeling listened too.
- Lack of anonymity especially in small communities.
- Worries about confidentiality/difficulty building trust.
- Access to mental health support can be difficult if you work in that field (e.g. especially if you live and work in a small town).
- Families/carers feel that they are not able to speak with healthcare professionals about a family member's serious mental health issues.
- The cost of accessing privately funded support.
- Geographic variation in the availability of mental health services (e.g. urban versus remote/rural).
- Underfunded services, recruitment challenges, and staff shortages.
- Not all primary care practitioners have knowledge and understanding of mental health problems, trauma, etc.
- Poor communication and a lack of collaboration and coordination between services.

9.11 Question 6.11 - Is there anything else you would like to tell us about this, whether you're answering as an individual or on behalf of any organisation?

Around one-fifth of all consultation respondents provide a response to **Question 6.11**. Many individual respondents provide narrative that is captured elsewhere in **Section 9** or in other parts of the report.

Note: a majority of consultation respondents either simply confirm whether their response to **Question 6.11** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable".

10 Improving Services

10.1 Question 7. 1 - We have asked about the factors that influence your mental health and wellbeing, about your own experiences of this and what has helped or hindered you in accessing support. Reflecting on your answers, do you have any specific suggestions of how to improve the types and availability of mental health and wellbeing support in future?

In particular, do you have any thoughts on how the new National Care Service can create opportunities to improve mental health services?

Around two-thirds of all consultation respondents answer **Question 7.1** and provide thoughts on how to improve the types and availability of mental health and wellbeing support in future. Individual respondents are more likely than organisation respondents to answer this question.

Theme 1: A repeat of views raised earlier

Most individual respondents and organisation respondents (all organisation subgroups) provide a repeat of views raised to earlier consultation questions. Examples of this includes the following:

Consultation respondent views about the person/individual

- Removing barriers to seeking help.
- A person-centred or whole-person approach.
- Addressing stigma and discrimination related to mental health.
- Better and more meaningful involvement of people with lived experience to improve the design and delivery of mental health services and support.

Consultation respondent views about mental health and wellbeing services

- An increased focus on early intervention and prevention support.
- Ensuring equitable, consistent, and timeous access to mental health and wellbeing support. Reducing waiting list times.

- A wide range of services is required (e.g. medical and non-medical services, recovery-focused services, talking therapies, community-based support, peer support, self-management tools and approaches, advocacy support, targeted, specialist and crisis interventions, trauma-informed care, social prescribing, support for carers).
- There needs to be a range of methods of service delivery (e.g. in-person, phone, online, groups, drop-ins) – and the importance of choice.
- More services that are located within community settings.
- More services available outwith traditional working hours (i.e. out-of-hours support).
- Effective signposting and referral ("no wrong door").
- Welcoming, safe, and inclusive environments and spaces.
- The important role of link workers in supporting individuals transition between services/ providers, including connecting people with other support in their community.

Consultation respondent views about the sector

- There requires a shift to value all mental health services and supports equally, including recognising and investing in the role of community-based, third sector and peer-led services/supports.
- Addressing sector recruitment challenges.
- Workforce development, including training for primary healthcare staff to improve integrated pathways into mental health and wellbeing support, treatment and care.
- Improved communication and a joined-up approach between clinicians and other professionals – a holistic approach.
- Increased funding for mental health and wellbeing services, including longer-term funding for the third sector.
- Promoting and supporting mental health and wellbeing in community, education, and workplace settings.

"As a whole, the mental health and wellbeing sector must better recognise that there is no one way to support the mental health and wellbeing of a diverse and multicultural population and that an adequate person-centred approach requires offering a wide range of services, points of access, and methods of service delivery".

Coalition for Racial Equality and Rights (CRER)

Theme 2: New national care service

The only other theme relates to the new National Care Service. This includes qualitative feedback from a few respondents (e.g. a few individual respondents and all organisation subgroups).

Some of these individual respondents and organisation respondents (education, training, and skills organisation, mental health organisation, other organisations) raise concerns with proposals for the new National Care Service. The range of views provided is as follows.

Support is expressed by these respondents for a more decentralised approach and/or a community model of support. Concerns include:

- The extent to which design and delivery of the National Care Service would be capable of being responsive to local needs and circumstances (i.e. not a one-size-fits-all approach, the importance of services being designed and delivered locally, recognising the different needs of those living in remote and rural communities).
- That aligning mental health services and supports to the new National Care Service continues to perpetuate a medical model of mental health.
- The National Care service Bill does not explicitly state which sectors and organisations health and social care information can be shared between. It is suggested that this should include the third sector to help equalise the relationship between statutory and third-sector services and provide easier access to information across the whole care system.
- The NCS Financial Memorandum does not account for additional funding for the third sector.

“Recently, significant work has been underway to improve mental health services including ongoing collaborative work to develop standards of care and substantial local investment in early intervention and support. Local authorities support children through school counselling and community-based services. These community services are designed based on the principles of collaboration with children, young people, and families. The centralisation of delivery risks destabilising work being undertaken, removing the opportunity to work closely and innovatively with our communities. The mental health system is also underpinned but local knowledge and connections across local authority provisions that would be put at risk by some of the provisions in the Bill”.

COSLA

Other individual respondents and some organisations respondents (e.g. health improvement organisations, mental health organisations) emphasise the importance of:

- Integration between the National Care Service and other services.
- Improved information/data sharing arrangements between the NHS and National Care Service.
- A stable and well-trained workforce.
- Improved engagement with people with lived experience.
- Ensuring joined up, responsive, and high-quality care and community services which may require multidisciplinary input.

“Would like to see provision of social care and support based on individual need rather than eligibility, reflecting the provision of health care. Ensuring that community placements are available quickly, to prevent lengthy delayed discharges from specialist mental health and learning disability settings, should be a key outcome measure for the National Care Service”.

Royal College of Psychiatrists in Scotland

“It will be helpful for the National Care Service to have a full understanding of the scale and scope of the whole of the mental health service landscape to ensure good services for people”.

Penumbra

“It must be noted that Support in Mind Scotland is concerned that the National Care Service Financial Memorandum does not account for additional funding for the third sector. If the third sector is to be considered an active partner in the National Care Service then this must equally be demonstrated through funding… Without this additional funding there will not be equity or consistency throughout mental health services across Scotland”.

Support in Mind Scotland

11 The Role of Difficult or Traumatic Life Experiences

11.1 Question 8.1 - For some people, mental health issues can arise following traumatic or very difficult life experiences in childhood and/or adulthood. What kind of support is most helpful to support recovery from previous traumatic experiences?

Two-thirds of all consultation respondents answer **Question 8.1** on the kind of support that is considered to be most helpful to support recovery from previous traumatic experiences. Feedback is presented below.

Theme 1: Trauma-informed practice

A prevalent view among individual respondents and organisation respondents (all organisation subgroups) is that a trauma-informed approach to supporting survivors of abuse, or any traumatic event in childhood and/or adulthood is key to managing wellbeing, supporting recovery, and preventing re-traumatisation.

"The most important thing for me is for professionals to have knowledge and understanding of trauma and adverse childhood experiences (ACEs) and adopt a person-centred, holistic trauma informed approach when dealing with traumatised individuals. Empathetic awareness of trauma and the effect it has on people will go a long way to provide the support traumatised individuals need aside from any particular targeted therapy".

NHS Forth Valley

"Users of domestic abuse services highlighted that good support was centred around individualised treatment, where they are seen as a real person – not just a case number. They felt properly supported when they were listened to and given the space they needed to heal and deal with the trauma they had experienced…Some individuals spoke of fear and worry when reporting domestic violence to authorities in case their children were removed. This lack of trust must be rebuilt in order to prevent further suffering and improved mental health for both women and children in dangerous situations".

Scottish Women's Convention

Theme 2: Key principles of a trauma-informed approach

Aligned to Theme 1, many individual respondents and organisation respondents (all organisation subgroups) outline the key principles of a trauma-informed approach, including:

- Non-judgemental.
- Feeling safe.
- Trusted relationships.
- Collaboration
- Empowerment.
- Choice.

Related points raised by these consultation respondents include the following:

Individual

- Feeling listened to.
- Being supported by professionals who are compassionate, empathetic, and kind.
- Being able to access support for as long as is needed.
- Being able to "dip-in dip-out" of trauma-informed support as and when required.
- Not having to retell their story to different people.
- Whole-family approach.

Services

- Accessible, flexible, and responsive continuum of support.
- A trauma informed workforce in the widest sense.
- Improved trauma awareness, training, and capacity building within different settings (e.g. education, health and social care, workplace) - to the appropriate level according to roles and responsibilities as described in the NHS Education for Scotland (NES) trauma framework.
- Integrated service provision (e.g. addictions, emergency services, social work, mental health services, etc).
- Out-of-hours support.

Theme 3: Types of support required by those that have had difficult or traumatic life experiences

Individual respondents and organisation respondents (all organisation subgroups) note that trauma affects people in many different ways and that it is important for people to be able to have access to a wide range of supports and treatments in order to support recovery from previous traumatic experiences, **Table 11.1**.

Table 11.1: Respondents views on support needs to aid recovery from previous traumatic experiences

One-to-one, group and family trauma therapy (e.g. trauma aware and trained counsellors and/or psychologists)	Therapeutic activities
Talking therapies e.g. cognitive-behavioural therapy (CBT) and dialectical behaviour therapy (DBT)	Art therapy, garden therapy, equine therapy, outdoor therapy, sport, etc (i.e. the importance of accessing wider support in non-clinical environments)
Counselling, including from expert third sector organisations	Advocacy support
Evidence based treatments e.g. Eye Movement Desensitization and Reprocessing (EMDR)	Crisis helpline
Peer support	Befriending
Signposting and connecting people to access services and support in community settings.	Mentoring
Coping skills/strategies and resilience plans	Medication and medication reviews
Safety and stabilisation strategies	Social prescribing
Mindfulness and meditation	Self-help guidance

11.2 Question 8.2 - What things can get in the way of recovery from such experiences?

Almost two-thirds (circa 63%) of all consultation respondents answer **Question 8.2** on things that can get in the way of recovery from traumatic or very difficult life experiences in childhood and/or adulthood. Common themes are presented below.

Theme 1: Service-related factors

Most consultation respondents (i.e. individual respondents and organisation respondents, including all organisation subgroups) identify various service-related factors which can get in the way of recovery from traumatic or very difficult life experiences, including:

- Mental health and wellbeing services that are not trauma-aware and trauma-informed/ not guided by the key principles of trauma-informed approaches.

- A lack of a trauma-informed workforce.
- Waiting list times to access referrals and support.
- Reduced availability of services.
- Access to support that is short-term (e.g. a set number of counselling sessions)/access to support that is not consistent.
- Resources being too focussed on medical approaches.
- Failure to diagnose/mis-diagnosis.
- Not receiving timely and/or the right type of help and support(s).
- Services that do not adequately cater to the needs of people with protected characteristics.
- Rigid and formulaic models of support rather than flexible and responsive services.
- A lack of support from GPs.

“Many people with a learning disability have experienced abuse and trauma, often from a young age. When we tell people about this we are often not listened to or believed. It is assumed that we experience trauma differently, so we are not offered therapy. Again, we are treated as ‘different’ and our experiences are dismissed. Sometimes we may communicate our feelings through behaviours that are seen as ‘inappropriate’ so instead of support we are restrained or medicated. We are traumatised all over again”.

People First (Scotland)

“RCPCH Scotland members suggested that reduced availability of services and long waiting times for CAMHS referrals are the most significant barrier to recovery”.

Royal College of Paediatrics and Child Health Scotland

“COSLA is committed to continuing to develop a Trauma Informed Workforce across Local Government and work across local authorities and community planning partnerships to further implement and embed trauma informed practice. This work should continue to be supported in order that trauma informed practice becomes and remains standard”.

COSLA

Theme 2: External factors

Many respondents (i.e. individual respondents and organisation respondents, including all organisation subgroups) identify various external-related factors which can get in the way of recovery from traumatic or very difficult life experiences, including:

- Family and friends (e.g. a lack of awareness and understanding of the impact of trauma/complex trauma, victim blaming, being around others who are experiencing trauma.
- Current life circumstances (e.g. lifestyle, addiction, relationships, housing, negative influences in the person's life).
- Stigma and discrimination.
- Continuing or further abuse/trauma (e.g. running into person who caused trauma).
- Poverty and inequality.
- Cost of accessing private sector support services.
- Practical barriers, including access to childcare, transport, etc.
- Employers (e.g. not equipped to support staff who may be facing trauma).

Theme 3: Internal factors

Some individual respondents identify various internal factors (i.e. to do with themselves) which can get in the way of recovery from traumatic or very difficult life experiences, including: feelings of guilt and self-blame; own mindset/inability to accept what has happened; readiness to access support; putting pressure on yourself; not knowing where to go to ask for help and support; and flashbacks.

11.3 Question 8.3 - Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?

Less than one-fifth of all consultation respondents provide a response to **Question 8.3**. The points raised are reflected above or elsewhere in the report, and no additional themes are identified.

Note: the vast majority of consultation respondents either simply confirm whether their response to **Question 8.3** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable".

12 Children, Young People and Families Mental Health

12.1 Question 9.1 - What should our priorities be when supporting the mental health and wellbeing of children and young people, their parents, and families?

Around two-thirds of all consultation respondents answer **Question 9.1** and suggest priorities for supporting the mental health and wellbeing of children and young people, their parents, and families.

Theme 1: A repeat of views raised earlier

All consultation respondents (i.e. individual respondents and organisation respondents) provide a repeat of views made to earlier questions. There is consensus among consultation respondents for a focus on the mental health and wellbeing of children, young people, and their families, and this is commonly framed in terms of:

- Increased focus on early intervention and prevention to minimise the development of more significant mental health problems in later life (e.g. building confidence, self-esteem, good relationships, attachment and belonging across early years and school settings).
- Increased accessibility and availability of services for children and young people, their parents, and families. This should include access to support that is not short-term and rapid and easily accessible support for those in crisis.
- More community-based, non-medical supports.
- Increased and longer-term funding and expansion of mental health and wellbeing services and interventions for children, young people, their parents, and families.
- Promoting and supporting mental health and wellbeing in nurseries/schools/colleges, and building a whole-nursery, whole-school and whole-college approach. Raising awareness among parents/carers about what support is available in these/other settings and how to access it.
- Person-centred and whole-family approaches. A life course approach.
- Reducing waiting times for support, diagnosis, and treatment.

- Improved access to information about how to support good mental health and wellbeing from birth as well as increased support for preparing for parenthood, supporting parenting and early years.
- Trauma-informed care and support.
- Ensuring services cater for children and young people with different levels of need e.g. additional support needs, neurodiverse/neurodevelopmental disorders, sensory difficulties, hearing loss, care experienced, young carers, LGBTQI+ young people, ethnic minorities, young people who are not in school or who have aged out of Child and Adolescent Mental Health Services (CAMHS). Not a one-size-fits-all approach.
- Reducing stigma and discrimination.
- Increased integration of, and collaboration between, services.
- Clear pathways into services/supporting good transitions between services (e.g. including transitions between children into adult services).
- The voices of children, young people and their parents and families are placed at the centre of designing services.
- Ensuring that the social structures that contribute to mental wellbeing such as child/family poverty, financial security and wellbeing, housing, education, parental employment, and access to opportunity are central to any priorities.
- A rights-based approach, through the lens of the United Nations Convention on the Rights of the Child (UNCRC).

“This has to start at the very beginning of life and even before that to ensure that no baby is born into a situation where they are insecurely attached, where they are neglected physically and emotionally and then also traumatised rendering them vulnerable and at risk as they progress through life. Supporting the whole family is crucial to the ongoing wellbeing of children as it takes a village to raise a child, and no one should have to manage the care of a child on their own particularly in the present circumstances. I am thinking of the need for the Family Nurse partnership, but this is not available for every young person and their baby. Even without adversity, there are life events which happen which cause upset and trauma – parental separation and family break up can be devastating for children and everyone should be alive to the need to support families in this circumstance, whether in school, the community, network of friends and neighbours”.

Children’s Health Scotland

“Social, emotional and mental wellbeing should be embedded in all school policies and procedures. Policies and procedures should be reviewed regularly to make sure that they promote social, emotional and mental wellbeing positively and consistently. This should include making sure that they are consistent with relational approaches to social, emotional and mental wellbeing. There must also be mechanisms to monitor and evaluate the impact and effectiveness of the whole-school approach as part of the school improvement strategy”.

Carers Trust Scotland, on behalf of the National Carer Organisations

Theme 2: Child and Adolescent Mental Health Services

Some respondents (e.g. individual respondents and organisation respondents, including all organisation subgroups) make specific reference to CAMHS in their consultation response to **Question 9.1**.

Some of the points raised about CAMHS, in particular among individual respondents, are captured above in Theme 1 (e.g. waiting list times, a lack of resources, short-term nature of funding, workforce expansion and training, partnership working, and ensuring seamless transitions between services including into Adult Mental Health Services).

Additional points and/or concerns raised by organisation respondents (i.e. all organisation subgroups) include the following.

First, there is reported to have been increased demand for, and pressure on, CAMHS services over the years, and that this has been exacerbated by the impact of the COVID-19 pandemic on children, young people, and their parents/families. Lengthy waiting times and staff shortages means that some children and young people are in crisis before they are seen by a professional while others do not receive support as they do not meet the criteria. There is considered a need to reduce CAMHS waiting lists to prevent more suffering among children and young people, and to provide long-term care where required.

Second, there is considered a need to better understand the “different layers of support” rather than only focusing on CAMHS (i.e. a broader approach to how support is provided to children, young people, and their parents/families via other routes). While it is noted that funding and improvements across specialist CAMHS continues to be important, there must also be a focus on the interventions available across universal services and to explore ways to alleviate pressure on CAMHS.

Third, a concern raised by organisation respondents is that some CAMHS services do not extend to 18 years and there is not equality of access to specialist services across the country (e.g. adolescent in-patient care). A point made is that every local area should have a consistent range of CAMHS services available for children and young people, their parents, and families.

Wider points raised by organisation respondents include:

- It is suggested that the development of a self-assessment tool for services to complete in regards to the implementation of the CAMHS service specification may be beneficial.
- It is suggested that the CAMHS standards/service specification (and other existing programmes/services) should be subject to review and evaluation. A related point is that how CAMHS performance is assessed could be broadened.
- There could be improved linkages between programmes such as Getting it Right for Every Child (GIRFEC), the CAMHS service specification, Wellbeing framework and Neurodevelopmental service specification.
- Research into the negative impact of social media on young people is felt to be vital. It is suggested that health promotion programmes are needed to counteract the negative impact of social media and the NHS could use social media to promote these. This would require Public Health Scotland to engage more effectively with CAMHS services, with a view to increased population level self-management.

“There should be equality of access to specialist services across the country including in-patient care. At present there is no out of hours access to adolescent inpatient services except in Glasgow and Edinburgh. These services need to provide evidence based psychological therapies as well as other appropriate treatments such as medication”.

Royal College of Psychiatrists in Scotland

“There is an established Children’s Mental Health and wellbeing Taskforce with seven priority work streams looking at identified deliverables areas such as crisis support, early intervention, pathways aligned to Promise, neurodevelopment, education, and training, CAMHS specification. We would refer to the outputs of this government led work in relation to priorities for children and young people and would urge that any additional Mental Health workforce strategy outcomes are coordinated with existing streams of work”.

Social Work Scotland

"For transformation of mental health services to work, we need to invest in support for children and young people. Mental health is shaped in childhood and, in many cases, poor mental wellbeing starts with an undiagnosed communication disorder. Society is not set up for their needs (e.g., excluded from job interviews and workplaces), and lack of support in transition to adulthood leads to poor life outcomes….To improve children's mental health and interrupt the intergenerational cycle of poor life outcomes, we need to embed mental health services in schools, workplaces and community support organisations. This may require restructuring the current funding model for CAMHS".

The Royal College of Speech and Language Therapists

12.2 Question 9.2 - Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?

One-fifth of all consultation respondents provide a response to **Question 9.2**. The points raised are reflected above or elsewhere in the report, and no additional themes are identified.

Note: the vast majority of consultation respondents either simply confirm whether their response to **Question 9.2** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable".

12.3 Question 9.3 - What things do you feel have the biggest impact on children and young people's mental health?

Almost two-thirds (circa 62%) of all consultation respondents provide a response to **Question 9.3**.

Table 12.1 provides a summary of the things consultation respondents feel have the biggest impact on children and young people's mental health. Similar points are raised by individual respondents and organisation respondents.

A wide range of factors are identified by consultation respondents. The main influences are considered to be: parenting/carer role, family life/circumstances and home environment, poverty and deprivation, social media, and peer pressure.

Table 12.1: Respondents views on things they feel have the biggest impact on children and young people's mental health

Parenting/carer role (e.g. lack of stable, positive, nurturing relationships and parenting skills). Lack of positive and supportive role models	Stigma and discrimination
Family life/circumstances/home environment (e.g. finances, addiction, physical and mental health, relationship stress/conflict, housing)	Limited access to opportunities (e.g. education, employment, the range of activities/facilities that promote good mental health and wellbeing)
Poverty, inequality, and deprivation	Waiting list times for help with mental health and wellbeing/availability of support services when they are needed/not knowing where to go to access help and support
Social media	Undiagnosed mental health or neurodiversity issues
Peer pressure	Not feeling listened to or understood/not being believed
Trauma/adverse childhood and life experiences	Not having their rights respected
Bullying, including cyber/online bullying	Not feeling able/comfortable to talk about their mental health and wellbeing
Experience of school/education - exam pressure/exam results/educational attainment/pressure to succeed	Spending too much time online/accessing inappropriate content
Societal factors/community pressures	Health risk behaviours
A lack of confidence and self-esteem	Body image
Not feeling like they belong or fit in/not feeling accepted by others/not feeling connected to other people	Lasting effects of the COVID-19 pandemic
Feeling isolated/feeling excluded	Transition periods
Friendship groups or lack of them	Worries about the future (e.g. environment, health, employment, the wider world)

12.4 Question 9.4 - Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?

Around 14% of all consultation respondents provide a response to **Question 9.4**. The points raised are largely reflected above or elsewhere in the report.

Note: the vast majority of consultation respondents either simply confirm whether their response to **Question 9.4** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable".

Theme 1: Children and Young People's Mental Health and Wellbeing Joint Delivery Board

Albeit not mentioned to any great extent, a few organisation respondents (e.g. organisations that support specific target groups, other organisation) consider it important for the Scottish Government to consider the learning and legacy from the Children and Young People's Mental Health and Wellbeing Joint Delivery Board[24] when looking to finalise priorities for supporting the mental health and wellbeing of children and young people, their parents, and families.

"The Children and Young People's Mental Health and Wellbeing Joint Delivery Board, co-chaired by COSLA and Scottish Government has continued to progress the recommendations of the Children and Young Peoples Mental Health Taskforce over the course of the pandemic, working to develop and enhance community-based support and the delivery of the CAMHS and neurodevelopmental specifications, amongst other deliverables. The learning from this board, and that looking at perinatal and infant mental health should be taken into account when considering the next steps for children and young people within the strategy. Through the significant challenges of the pandemic, local authorities have continued to develop and deliver new and enhanced community based mental health services. Since launching in 2021, these services (overseen by the Board) have supported significant numbers of children and young people, delivering positive outcomes. Ongoing focus on such preventative services, as well as appropriate support at the right level of need, will help ensure children and young people get the right support at the right time".

COSLA

"With regards to children and young people, the Scottish Government must also outline what its intentions are for the legacy of the Children and Young People's Mental Health and Wellbeing Joint Delivery Board when it winds up in December 2022 and how the work from this group will be reflected in the new strategy".

Barnardo's

[24] Children and Young People's Mental Health and Wellbeing Joint Delivery Board

13 Your Experience of Mental Health Services

13.1 Question 10.1 - If you have received care and treatment for any aspect of your mental health, who did you receive care and treatment from?

Table 44 (**Supplementary Report**) provides the quantitative response to **Question 10.1**.

Table 13.1 provides a high-level summary, and key points to note are as follows:

- GP practice is the most common response for where consultation respondents have received care and treatment for any aspect of their mental health from, and notably for individual respondents.
- This is followed by 'other' and Community Mental Health Team.
- Question design means that the results may be skewed. For example, not all organisation respondents answer the question as some assume it was aimed at individual respondents.

Table 13.1: If you have received care and treatment for any aspect of your mental health, who did you receive care and treatment from

Where did you receive care and treatment from (N=196)	Individuals	Organisation	All consultation respondents
GP Practice	73%	53%	69%
Other	36%	44%	37%
Community Mental Health Team	35%	35%	35%
Third Sector Organisation	23%	41%	27%
Psychological Therapy Team	22%	38%	24%
Inpatient care	12%	32%	16%
Peer support group	11%	35%	15%
Digital Therapy	10%	18%	12%
Child and Adolescent Mental Health Team (CAMHS)	9%	21%	11%
Perinatal Mental Health Team	4%	12%	6%
Forensic Mental Health Unit	0%	15%	3%

Multiple response question where respondents could select more than one option and all that applied. Percentages may total more than 100% as a result.

13.2 Question10.2 - If you selected ‘other’, could you tell us who you received care and treatment from?

Over one-third (37%) of all consultation respondents select ‘other’, and this includes the following:

- Some respondents note in their response that they have never received care and treatment for any aspect of their mental health, or they are responding as an organisation and so have not answered the question. Further, some respondents provide the name of the third sector organisation(s) that they have received care and treatment from.
- Where care and support has been received from an ‘other’ source, the most common responses are: private sector counsellor, therapist, clinical psychologist or clinical psychiatrist; employer assistance programme; occupational health; or from a university counsellor.

13.3 Question 10.3 - How satisfied were you with the care and treatment you received?

Over one-third (circa 37%) of all consultation respondents provide an answer to **Question 10.3**.

Question 10.3 is an open-ended question, and consultation respondents answer the question regarding the extent to which they were satisfied with the care and treatment received in a range of ways (i.e. it is not a rating scale question).

Based on a review of consultation responses, it appears that satisfaction with the care and treatment received for their mental health is highly variable:

- Some consultation respondents have had a positive experience of accessing care and treatment for their mental health and wellbeing. Some of the positive feedback is caveated in some way (e.g. satisfaction with care and treatment but a long waiting time to access the support). This is described further at **Section 13.4**. Further, a few respondents said that the care and treatment was “fair”, “average”, or it was of a “moderate” help.
- Some consultation respondents have not had a positive experience, and levels of satisfaction with care and treatment received for their mental health and wellbeing are low. This is also described further at **Section 13.4**.

Further, it is important to note that many consultation respondents have accessed care and support for their mental health and wellbeing from a range of sources, and their experience of different providers has been highly variable (i.e. satisfied with some but not all sources of care and treatment accessed).

13.4 Question 10.4 - Please explain the reason for your response above

Consultation respondents who have received care and treatment for their mental health and wellbeing identify a range of factors which are considered to have led to a positive experience, **Table 13.2**.

Table 13.2: Respondents views on factors that led to a positive experience of receiving care and treatment for their mental health and wellbeing

Had someone to speak with/able to speak openly and honestly	Access to support in a timely manner
Non-judgemental support	Tools and tips for self-care
Felt listened to and understood (including cultural understanding)	Supported by someone who was caring, empathetic, professional, and supportive
Was taken seriously	Control/self-determination
No stigma, prejudice, and discrimination	Access to support on a longer-term basis
Access to a range of support services that met my needs	Mixed mode of delivery (e.g. in-person, telephone calls, helpline, regular touchpoints)
Personalised service/support	Regular review of my progress
The care and treatment led to better mental health and wellbeing/more resilient to deal with things/was supported in my recovery	Was supported by employer to access support

Consultation respondents who have received care and treatment for their mental health and wellbeing also identify a range of factors which are considered to have led to a negative experience, **Table 13.3**.

Table 13.3: Respondents views on factors that led to a negative experience of receiving care and treatment for their mental health and wellbeing

Long waiting list times for assessment, diagnosis, and treatment, resulting in worsening mental health and wellbeing for some people	Being prescribed medication and no other forms of therapeutic, practical or peer learning support
The need to go private and pay for support (e.g. long waiting lists for NHS care/treatment)* / not being able to afford to go private	Stigma and discrimination in mental health and wellbeing services
Referrals - time taken for referral/not being referred for support with mental health and wellbeing/poor mental health impacting on ability to self-refer/not receiving the support needed at the time or not being connected to access support	Mode of delivery - no face-to-face engagement during COVID-19/more difficult to build connection between client and provider via telephone support
Lack of person-centred and flexible support	Having to retell my story to different support staff/providers
Short-term or time-limited or inconsistent support	Receptionists can act as gatekeepers to GPs (e.g. individual may not feel comfortable to discuss issues/concerns, lack of understanding among some frontline staff)
Lack of follow-up or aftercare support	Misdiagnosis/lack of collaborative approach to diagnosis
Feeling judged/not being believed or understood/not feeling respected/lack of empathy	Family members/carers not feeling involved in decision-making processes
Lack of understanding of mental health and wellbeing among some primary care workers	

Note: * Negative feedback from respondents is not about the support received from the private sector. Rather it concerns not being able to access support from the NHS when it was needed (e.g. in crisis).

“While I'm glad I'm allowed the medications that actually work, that's been the only thing they've offered and even that took years to get. I've repeatedly asked, even begged for therapy, and not once has that been offered”.

Individual respondent

“My GP didn't take me seriously when I went for mental health support. Not feeling understood or like my mental health was valued meant I got worse and it was only then that I was given support”.

Individual respondent

“Students have repeatedly reported that they had to wait too long for care. The academic calendar limits the amount of time they are in university. Staff have reported NHS staff not having sufficient resources. NHS staff have discharged students from hospital expecting university staff to provide a regular observation service for them. This has caused so much concern that the university has employed additional staff to support students in these circumstances”.

University of St Andrews

13.5 Question 10.5 - Mental health care and treatment often involves links with other health and social care services. These could include housing, social work, social security, addiction services, and lots more. If you were in contact with other health and social care services as part of your mental health care and treatment, how satisfied were you with the connections between these services?

Less than one-fifth (circa 17%) of all consultation respondents provide an answer to **Question 10.5**.

Question 10.5 is an open-ended question, and consultation respondents answer the question regarding the extent to which they were satisfied with the connections between mental health and wellbeing services and other health and social care services in a range of ways (i.e. it is not a rating scale question).

Based on a review of consultation responses, it appears that satisfaction is variable:

- Some consultation respondents have had a positive experience and express satisfaction with the connections between these services.
- Some consultation respondents have not had a positive experience, and levels of satisfaction with the connections between these services are low.

Further, some consultation respondents do not comment on their levels of satisfaction. Rather, they either note that connections between services are essential and/or suggest ways to improve the level of connectedness between different services.

This is described further at **Section 13.6**.

13.6 Question 10.6 - Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation? For example, positive experiences of close working, or areas where joint working could be improved.

Around 13% of all consultation respondents provide a response to **Question 10.6**, and the main points are described below. Common themes are identified by individual and organisation respondents. **Note:** a vast majority of consultation respondents either simply confirm whether their response to **Question 10.6** is as an individual or organisation respondent, do not provide a response, or answer “no”, “no other comments”, or “not applicable”.

Theme 1: Areas where joint working between services could be improved

Most consultation respondents identify a range of factors or areas where joint working could be improved, **Table 13.4**.

Table 13.4: Respondents views on areas where joint working could be improved

Improved information and data sharing	Response times – removing barriers such as lack of clarity on response times or lengthy response times
Shared IT systems and databases	Addressing stigma and discrimination
Improved interaction and liaison between services	Delivery of mental health training for non-mental health staff across health and social care
Improved communication between services	Flexible funding models
Streamlining and simplifying administration processes and procedures	Ensuring a strong commitment to listening to lived experiences and to understanding local needs
Building strong multi-disciplinary teams/staff continuity – reducing staff turnover	Increased co-location of services
Clear referral pathways and criteria – removing barriers such as strict referral criteria and extensive referral processes. Single referral pathway	

Theme 2: Positive experiences of close working between services

Some consultation respondents identify a range of factors which are considered to have led to a positive experience of close working between services, **Table 13.5**.

Table 13.5: Respondents views on factors that led to positive experience of close working

Joint assessment processes	Where there are strong connections and liaison with and between a range of statutory and non-statutory services
Holistic needs assessment	Development of shared learning materials and resources
Effective communication between services	Where mechanisms are in place to support continuous learning and improvement of services (involving key stakeholder groups and the voices of those with lived experience)
Clear referral pathways	Joint or shared learning experiences that transcends sectors, professions, and disciplines

“Additionally, genuinely recognising that people seek support across the sector that there is no ‘wrong’ door ensuring a compassionate based response, and then accountability for ensuring support is sought/individuals needs are met in a connected manner”.

Scottish Ambulance Service

“Ring-fenced funding limits the ability of organisations to work together across the system to address gaps and improve pathways for individuals. Where flexible funding models are adopted, this becomes possible. For example, utilising flexible funding over the pandemic some local authorities were able to set up mental health hubs addressing mental health need, supporting families, and providing support around the socio-economic determinants of mental health, further building on and enhancing local connections. A positive experience of services can be supported by good funding models”.

COSLA

There is also wider recognition of some of the wider barriers at play that may make improved joined working more difficult, as illustrated by the respondent quotes below:

“There are examples where joint teams across health and social work/care services work very well. But there are also examples where they struggle to function effectively in the face of a lack of a shared governance culture, professional boundaries remaining very strong despite merged senior leadership and a lack of understanding of what good looks like for different parts of the system. A myriad of different computer systems”.

NHS Lothian

“Families often tell us about difficulty accessing the right support, whether this be mental health, physical health, or social work. Often the needs are inter-related and they do not received a joined up service. Assessments of need are undertaken in a piecemeal way and only address one part of the issue. They often have to coordinate communication between agencies”.

Adoption UK Scotland (FASD Hub Scotland, Kinship Care Advice Service for Scotland)

14 Equalities

14.1 Question 11.1 Do you have any further comments on what could be done to address mental health inequalities for a particular group of people? If so, what are they?

Over half (circa 56%) of all consultation respondents answer **Question 11.1** which asks for suggestions regarding ways to address mental health inequalities for a particular group of people.

Note: Not all respondents provide finer grain detail on what steps could be taken and/or suggest what could be done to help particular groups of people. Rather, some note one or more of the following points in their consultation responses.

Consultation responses note that different groups of people access mental health services and support differently. Ongoing engagement with different groups of people/people with lived experience e.g. as listed in the Equality Act 2010 and other socially excluded/marginalised/ disadvantaged groups (and others, for example staff, carers, third sector, experts) is considered required to both better understand and identify ways in which inequalities in access, experience, and outcomes associated with mental health services and support can be reduced (i.e. a co-production approach to the planning and design of services).

Further, there is some suggestion that it would be important for the Scottish Government to:

- Retain priorities and intentions outlined in the Mental Health Strategy (2017) to improve equalities in mental health.
- Take stock of any published research in mental health inequalities in Scotland and further afield (recognising that the existing evidence base may be well/further developed for some but not all groups and that further research may be required).
- Take on board recent experience during the pandemic, of people with protected characteristics having poorer access to mental health care as well as poorer outcomes.
- Ensure coordination/linkages with relevant existing/proposed strategies and plans (e.g. Perinatal Mental Health; Women's Health Plan; Race Equality: Immediate Priorities Plan; Health and Social Care Strategy for Older People).
- Tap into learning and insights from wider forums and networks (e.g. National Rural Mental Health Forum, Scottish Ethnic Minority Older People Forum).

There is recognition within consultation responses that inequalities are often examined for a particular group of people (e.g. one characteristic such as age or race) and do not always account for the other intersectional characteristics which make-up an individuals' lived experience. It is considered important that the Strategy gives appropriate consideration to intersectional needs to ensure it is equipped to respond to the rights and needs of those facing multiple disadvantage and trauma.

The general consensus among consultation respondents is that tackling inequality needs to be prioritised and "explicitly centred" within the Strategy, and as such it must fully consider and address the different needs of different groups of people and other marginalised/socially excluded/disadvantaged groups. Related points include that a one-size-fits-all approach is not considered appropriate, and that existing health inequalities for specific groups have also been exacerbated by the pandemic.

Support, including prevention and early intervention, could be targeted at those at higher risk of poor mental health so that vulnerable people do not fall through the gap. Further, particular groups of people are referenced in consultation responses (e.g. those who share a protected characteristic and other socially excluded groups) – some but not all respondents go further and highlight the range of barriers these groups face in accessing support, and some but not all provide further detail of how these barriers could best be overcome. Where suggestions are made (e.g. tackle stigma and discrimination) these are also not always framed for a particular group of people.

As such, there is felt to be a need for population level interventions, tailored approaches and access to specialist services/staff for particular groups of people, and a greater emphasis on support and services that help the whole-person and which are joined up and holistic (whole-systems approach).

It is suggested that placing a sufficient focus on ensuring mental health support and services are more accessible may also help to reduce mental health inequalities – ensuring a focus on equity of services and improved outcomes for particular groups of people. Building capacity at a local/community level is considered important in this regard, as is increasing the availability and accessibility of community-based provision as a way to help reduce inequalities. However, there is also broader recognition that addressing the fundamental causes of inequalities goes far beyond the health service/mental health and wellbeing services and increasing access to services.

Action to further develop and retain a diverse health and social care/mental health and wellbeing workforce (representative of the populations they serve), grow capacity, and provide additional support for workforce development to ensure the workforce has the skills and capabilities to advance mental health equalities, are also considered a key part of the mix.

A suggestions is that this could be considered in the context of access to education and training with new routes into professions being maximised (e.g. increased apprenticeships).

Improved referral systems, transitions between services (i.e. young people and adult, adult and older people's mental health and wellbeing services), partnership working, and communication between statutory and non-statutory provision are also considered vitally important.

Theme 1: Particular groups of people identified

A prevalent view among consultation respondents (i.e. individual respondents and organisation respondents, including all organisation subgroups) is that the Mental Health and Wellbeing Strategy needs to place sufficient focus on "higher risk groups" for poor mental health and wellbeing, "hard to reach groups", "marginalised", and/or particular groups of people.

These respondents identify a range of factors or categories that put some groups of people at a higher risk of poor mental health:

- Socio-economic factors (e.g. income, employment).
- Specific characteristics (e.g. gender, ethnicity, disability, sexuality).
- Socially excluded groups (e.g. people with mental health issues, care experienced young people, people affected by substance misuse, people experiencing homelessness).
- Geography (e.g. deprived areas, remote and rural communities).

Table 14.1 lists the groups of people referred to in consultation responses, and people that have a protected characteristic is most frequently mentioned.

Table 14.1: Respondents views on particular groups of people who experience mental health inequalities

People with protected characteristic(s)	Perinatal
People experiencing poverty	Women experiencing menopausal symptoms
Children and young people	People with experience of homelessness
People with severe, complex, and enduring mental illness	Veterans
Care experienced (young) people	People with neurodevelopmental conditions
Parents/carers of family members with mental health issues	Survivors of trauma and/or abuse
People affected by substance misuse	Refugees and asylum seekers
People living with long-term conditions	Unpaid carers
People living in remote and rural communities	

“There needs to be a proactive approach to engaging with communities of place, interest and shared characteristics at higher risk of poor mental health to inform the development of preventative, early intervention and other services so that people can access appropriate supports with confidence”.

Scottish Recovery Network

“It is imperative that the strategy recognises and acknowledges the disproportionate impact of health inequalities on marginalised population groups. An intersectional approach to inequality is necessary to ensure that the strategy is equipped to respond to the rights and needs of those facing multiple disadvantage and trauma. This should include those living with protected characteristics listed under the Equality Act 2010, as well as other marginalised groups”.

The Health and Social Care Alliance Scotland (the ALLIANCE)

“Addressing inequalities has been a high priority within previous plans to support mental health and wellbeing and should remain central within the new strategy. Protected characteristics were addressed separately within previous plans, this strategy should take an intersectional, human rights-based approach embedding these principles across the breath of the work”.

COSLA

“The production of an Equalities Action Plan would enable appropriate mental health responses and actions in each community and also give appropriate consideration to intersectional needs. Substantial programmes are required on women’s mental health, the mental health of Black people and People of Colour, LGBT+ people, and people with disabilities. These should be developed and designed working with people with lived experience from these groups and communities”.

Scotland’s Mental Health Partnership

Theme 2: Ensuring that mental health and wellbeing support and services meet the different needs of particular groups of people

Related to Theme 1 is a prevalent view among consultation respondents (i.e. individual and organisation respondents) that the Mental Health and Wellbeing Strategy should ensure that mental health and wellbeing support services cater for the different needs of (and different levels of need) groups of people at a higher risk of poor mental health.

A point raised by these respondents includes the importance of providing continuums of support for marginalised population groups, as well as:

- Access to information in different formats (e.g. where English is not an individual’s primary language, to support individuals with communication difficulties, etc).
- The provision of, and improved access to, specialist services and staff.
- Access to longer-term support and improved follow-up/aftercare support.
- Advocacy support and additional support to help particular groups of people engage with appropriate professionals.
- Addressing wider long-standing barriers to accessing support (e.g. digital connectivity, public transport).

Table 14.2: Characteristics and respondent feedback on inequalities (some examples)

Characteristic	Consultation respondent feedback
Age	• Babies currently have poor access to mental health services. To ensure further progress (building on the work by the Perinatal and Infant Mental Health Programme Board), it is essential to be explicit about infants in the Mental Health and Wellbeing Strategy with clear and measurable outcomes. Alongside this, work should continue to create specialised parent-infant relationship teams to cover all areas of Scotland so that every baby, regardless of where they live, can access services. • Children and young people require access to services which could intervene early to prevent mental health issues escalating. • Greater investment is required for children and young peoples' mental health services, including help to address the impact of COVID-19 and to reduce waiting times. • Young children often experience anxiety on behalf of their parents when they observe but do not understand or cannot alleviate their parent's distress. It is important that parents/carers are equipped to understand this and have the tools and support they need to reassure their child through secure attachment and protective parenting at a time when they themselves are under stress. • Some young people may not know where to go, or how to access support for their mental health and wellbeing. • There is a need to address loneliness and isolation among older people. • Older people may be living with complex health conditions or chronic illness. These factors increase the risk of developing depression. • Older men may also feel less valued or productive to society (for instance after retirement), have poor physical ill health, and can often they find it very difficult to open up about their mental health. • Older women are living for longer - also means older women are more likely to live alone, making them vulnerable to feelings of isolation and loneliness, and that they may be living with complex health conditions or chronic illness. These factors increase the risk of developing depression. Additionally, older women face the double discrimination of ageism and sexism which may impact on their mental health. Older women often act as unpaid carers, which can put strain on their menta health, sometimes caring for those older and younger than them at the same time. • According to research conducted by Support in Mind Scotland with older people who use their services, they found a 75% reduction in access to Community Psychiatric Nurse support for people on reaching the age of 65. The research also highlighted the lack of community mental health services and projects for people 65 and over, due to restrictions applied by funders. • The 'Falling Off a Cliff at 65: Mental Health in Later Life' research partnership commissioned NHS Health Scotland, now Public Health Scotland, to identify the key issues in mental health diagnosis of people aged 65 and over. It found: depression in older people was under-diagnosed and under-treated; there were several diagnostic assessment tools available for use with elderly patients; evidence showed that older people were less likely to be referred to specialist services compared with younger people; Patients aged 60 and over were identified as being less likely to seek medical help for their mental health as well as being less likely to receive adequate treatment if they did, in comparison to younger adults; and there was limited evidence on the treatment of older people's mental health beyond dementia and depression suggesting that further research in this area was required.

Disability	• Fund work to improve provision of psychological therapy services and help meet set treatment targets: Evidence suggests that psychological interventions with older people are effective, despite this, older people do not often have access to appropriate psychological approaches and treatments. • Disabled people and their families face barriers to accessing assessment and support for mental health and wellbeing. • When accessing support disabled people and their families do not always feel listened to or supported in the right ways. • Disabled children and young people can be isolated from peers which can have adverse effects on mental health and wellbeing. • There is a need for continuums of support that contain options which are particularly attractive to specific groups e.g. text-based services for those who have an autism spectrum condition, deaf population. • Individuals with communication difficulties for any reason are liable to be overlooked or may be offered inappropriate help if they have not received the assistance they need to express themselves. All services should have facilities to address the full range of communication aids as standard and not requiring additional demands on service users to search for this. • There may be a need for health advocacy to be available for those who find difficulty in ensuring that their 'voice' is heard or whose health literacy is limited. • People with a learning disability and their families can have negative experiences and be less satisfied with the support they receive for mental health and wellbeing. • People with learning disability have a significantly higher chance of developing serious mental illnesses. To ensure equity of outcome, there is the need for specialist learning disability services, with clinical staff who have expertise in this area. Further, some services may not cater for this group. • Those affected by physical disabilities have higher risk of poorer mental health. • The 2015 review of learning disability units in Scottish hospitals found that 35% of the patients had a delayed discharge, frequently associated with a lack of appropriate facilities for patients or the challenges associated with coordinating responses to complex needs. People with learning disability who come into contact with the criminal justice system may be unable to effectively participate in the criminal justice process, or are unable to cope within a custody setting, there is the need for specialist forensic learning disability provision to meet their needs. • Advocacy support. • There could be a greater focus on those with 'hidden disabilities' e.g. mild learning disabilities, communication difficulties and neurodiversity. • Invest further in self management approaches to support and encourage disabled people (as well as people living with long-term conditions and unpaid carers) to access information and to develop skills to manage their condition or to support the person for whom they care.

Ethnicity	• Rates of mental health problems can be higher for some Black, Asian and Minority Ethnic groups and there is evidence that the COVID-19 pandemic is having a greater negative impact on the mental health of children and young people from these backgrounds than their white peers. The disparity in access to services is demonstrated in the fact that Black, Asian and Minority Ethnic young people are twice as likely to be referred to mental health services through social care/youth justice than through primary care . Members report under-representation of some ethnic and religious groups seen in services. Whilst this is sometimes recognised, solutions to reach these families are denied due to other pressures on the service. • Negative experiences of accessing services and unconscious bias. • Structural and systemic changes are needed to tackle racial inequalities. • Support and services need to be designed with Black and minority ethnic people and their needs in mind – consultation and co-production. • Anti-racist practice. • Increased and more appropriate engagement with lived experience and expert non-governmental organisations, and the use of cross-departmental approaches that better address the structural nature of mental health inequalities • Expand equalities training schemes, establish anti-racist training programmes for all new and existing staff, and ensure that equalities training occurs throughout all stages of career development, rather than delivered as a one-off exercise. • Training programmes must be linked explicitly to wider work on improvements in services, policies and practices. • Action to ensure that experiences are improved for BME people on both the providing and receiving ends of mental healthcare services. • Addressing language barriers, loneliness and isolation. • Culturally competent/sensitive services and translation are very important with regard to race and ethnicity. • Advocacy support. • A recent survey carried out by the Mental Welfare Commission indicated that almost one-third of respondents reported that they had seen or experienced racism. • There is also a need to improve access to talking therapies for people from diverse racial and ethnic backgrounds, especially where English is not their primary language.
Gender	• Services do not always account for the specific needs of women. • Areas of women's health have a direct impact on mental health and wellbeing, including perimenopause and menopause; endometriosis; impact of hormonal contraception; mental health impacts of miscarriage, infertility, and baby loss; mental health impacts of Premenstrual Syndrome (PMS) and Premenstrual Dysphoric Disorder (PMDD). • There is a need to recognise the specific challenges faced by women, including those from marginalised communities. Further work is needed to break down barriers to talking about and seeking help, and to carry out holistic wellbeing assessments at key life stages, including puberty and menopause.

	• Within forensic mental health services, there is significant inequity in service provision for women. A number of women with learning disability and forensic needs are placed out of area (often in England), or inappropriately in assessment and treatment units. There are is a lack of low secure and community services for this small group of individuals, who have a highly level of needs requiring specialist service provision. • Men - addressing stigma in accessing mental health and wellbeing support. For example, higher suicide rates. • Transgender people can often experience prejudice and lack of understanding when accessing services. • Insufficient awareness and recognition of non-binary identity needs. • There is no access to inpatient facilities for males/those identifying as male with an eating disorder diagnosis in Scotland. • Limited access to psychological services specifically related to gender identity and the impact on body image e.g. people who identify as non binary aiming for a neutral gender image and struggling with weight gain which makes their body image look more male or female in form but are referred for weight management or nutrition support. • Increased access to therapeutic support for gender non-conforming children and those with dysphoria.
Religion or belief	• While it is true that for many people, religion is an important source of wellbeing, it is also true that for many others, religion has caused serious harm to both their mental and physical wellbeing. It is extremely important that potential religious harms to mental wellbeing are identified and addressed without fear of accusations of 'religion-phobia' or 'religious illiteracy'.
Sexual orientation	• LGBT+ people can struggle to access support for their mental health as professionals view the issue through the lens of the young person's sexuality. LGBT+ people do not always feel they have been treated with dignity and respect when accessing services. • LGBT+ people experience higher rates of mental ill health, particularly anxiety, depression and eating disorders, than the general population. There is also a higher rate of suicidal ideation and self-harm: 20-25% compared with 2.4% in the general population. • Improve access to services for LGBT+ children and young people. LGBT+ people, including those under age 18, suffer disproportionate levels of mental ill health and are less likely to receive high quality care and treatment. Support was expressed for government proposals to strengthen the UK's legislative frameworks to prevent and tackle discrimination against LGBT+ people. Further action is required to improve access to services through the provision of non-judgemental and inclusive care for all who identify as LGBT+.
Other	• Other marginalised groups can face barriers to accessing healthcare services, including mental health and wellbeing services. For example, people experiencing homelessness, care experienced young people, kinship care, migrants, refugees and asylum seekers, people living in deprived areas, people living in remote and rural communities, veterans, people living with long-term conditions, unpaid carers, etc. • People with mental health problems and/or substance misuse problems can face barriers to accessing mental health support. • Reducing the impact of inequalities based on social deprivation should also be a priority. Recent reports from the Mental Welfare Commission on Community Treatment Orders, Advanced Statements and Mental Health Act monitoring suggests that compulsion is more widely used in areas of higher social deprivation, and that those engaging with Advanced Statements are predominantly from more affluent areas • Greater outreach support.

Theme 3: A repeat of views raised earlier

Some consultation respondents (e.g. individual respondents, health improvement, mental health and other organisations, and organisations that support specific target groups) provide qualitative feedback that relates to points raised to earlier consultation questions, namely:

- Challenging stigma, prejudice, and discrimination.
- A stronger focus on prevention and early intervention.
- Involving people with protected characteristics and lived experience in service design processes.
- The relationship between poverty/deprivation and mental health and wellbeing.
- Increased and longer-term funding for mental health and wellbeing services.
- More localised and community-based support services and approaches.
- Addressing geographic variations in access to mental health and wellbeing services.
- Placing mental health on an equal footing with physical health.
- Integrated service provision and improved joint working.
- Workforce diversity and workforce development.

“There are many groups at higher risk of poor mental health, mainly driven by inequalities in power, wealth and income and many of groups with protected characteristics. This is likely due to the intersectoral nature of more challenging life circumstances, multiple stresses, accessibility, stigma and discrimination. The strategy needs to highlight the priority of addressing inequalities up front. This needs to be woven throughout the strategy and not a standalone section e.g. how do we know that the interventions or actions undertaken are reaching the right people, are we assessing whether, in fact, the activities undertaken are widening inequalities? What are the data telling us in terms of trends and patterns in inequalities: are they improving or getting worse? There cannot be a one size fits all approach”.

Public Health, NHS Greater Glasgow & Clyde

“The production of an Equalities Action Plan would enable appropriate mental health responses and actions in each community and also give appropriate consideration to intersectional needs. Substantial programmes are required on women’s mental health, the mental health of Black people and People of Colour, LGBT+ people, and people with disabilities. These should be developed and designed working with people with lived experience from these groups and communities”.

Scotland's Mental Health Partnership

Theme 4: Review of the existing evidence base to help identify ways to address mental health inequalities

Some individual respondents and health improvement organisations (e.g. The Royal College of Psychiatrists in Scotland, Faculty of Rehabilitation of the Royal College of Psychiatrists in Scotland) use the same or similar wording in their consultation responses to highlight various points including:

- "The 2017 Mental Health Strategy outlined a number of laudable intentions to improve equalities in mental health. We would urge that these remain priorities with a clear delivery plan for implementation.
- There is considerable published evidence, supplemented by recent experience during the pandemic, of people with protected characteristics having poorer access to mental health care as well as poorer outcomes.
- Reducing the impact of inequalities based on social deprivation should also be a priority. Recent reports from the Mental Welfare Commission on Community Treatment Orders, Advanced Statements and Mental Health Act monitoring suggests that compulsion is more widely used in areas of higher social deprivation, and that those engaging with Advanced Statements are predominantly from more affluent areas.
- Data collection of the experiences of individuals with protected characteristics is currently variable across health boards and must be improved".

Theme 5: Population level interventions

A few individual respondents feel that the Mental Health and Wellbeing Strategy should focus on improving the mental health and wellbeing of the population as a whole rather than having a particular focus on specific population groups. An alternative viewpoint is that there is a need for both.

15 Funding

15.1 Question 12.1 - Do you think funding for mental health and wellbeing supports and services could be better used in your area?

Table 45 (**Supplementary Report**) provides the quantitative response to **Question 12.1**.

Table 15.1 below provides a high-level response, and key points to note include that:

- **88% of all consultation respondents think funding for mental health and wellbeing supports and services could be better used in their area**. This includes a similar proportion of individual and organisation respondents. A majority of all organisation subgroups, most notably education, training and skills, health improvement, and organisations who support specific target groups think that the funding could be better used in their area.

- **12% of all consultation respondents do not think funding for mental health and wellbeing supports and services could be better used in their area**. This includes a similar proportion of individual and organisation respondents. Among organisation respondents, mental health and other organisations are more likely to feel that the funding could not be better used in their area.

Table 15.1: Do you think funding for mental health and wellbeing supports and services could be better used in your area

Respondents (N=307)	Yes	No
Individual	79%	21%
Organisation	78%	22%
Total	**88%**	**12%**
Organisation Breakdown		
Health Improvement	83%	17%
Mental Health	65%	35%
Organisations who support specific target group(s)	82%	18%
Education, Training and Skills	92%	8%
Other	75%	25%

15.2 Question 12.2 - Please explain the reason for your response above

Qualitative feedback from consultation respondents who think funding for mental health and wellbeing supports and services could be better used in their area is outlined below.

Theme 1: Funding

Many individual respondents and organisation respondents (all organisation subgroups) raise wider points about funding models and the level/nature of funding for mental health and wellbeing supports and services. This includes the following points:

- Mental health and wellbeing support and services are felt to have been underfunded.
- Increased funding of mental health and wellbeing support and services is needed in the context of the current unprecedented increase in demand, including increased funding within different settings (e.g. community, education).
- There is also considered to have been a lack of longer-term sustainable funding for mental health and wellbeing support and services, and that this can limit service development, planning and efficacy, and lead to temporary gaps in services.
- Funding for mental health services is yet to achieve parity with funding arrangements for services for physical health conditions.
- Mental health has been identified as a public health priority – but there is no specific funding aligned to public mental health across the country, which often means very little dedicated specialist capacity to progress public mental health programmes and partnerships.
- Siloed funding streams (and reporting structures aligned with these) from Scottish Government for different aspects of mental health work, do not encourage joint, whole system working.
- There is a lack of appetite to fund innovative work.
- The nature of third sector funding means grants and trusts often fund projects within an area without awareness of wider provision.

“There isn't enough funding for mental health supports in general - it is a post code lottery depending on what support (if any) you get”.

Outside the Box

“Short-term grant funding creates uncertainty and leads to challenges in procurement, governance, and recruitment. This becomes more problematic where confirmation of funds is provided at late notice. For instance, it is difficult to recruit and retain staff in short-term posts, it limits the ability to plan and develop year-on-year and leads to stop-start service delivery. Longer term funding would allow for less time to be spent on recruitment and procurement, enable more effective planning and improve the use of public funds.

Ring-fencing, and reporting requirements of funding make it more difficult for local authorities and partners to be responsive to local need. These processes also make it more difficult to combine funds and work across policy areas, for example on mental health as part of whole family support, or with partners to jointly resolve issues such as support for individuals on mental health waiting lists. Funding issued as ring-fenced, separate pots are harder to bring together as interlinked, impactful provision on the ground with funding often issued by different parts of Government on connected issues. There needs to be a greater focus on outcomes, not inputs and outputs, less directed funding, and a reduced reporting burden, to afford Local Government the flexibility to make decisions based on local need”.

COSLA

Related points raised by some individual respondents include:

- There is considered to be a lack of awareness of what mental health and wellbeing support and services are available in their local community (e.g. outwith the GP).
- There is also felt to be a lack of awareness and understanding of how funding for mental health and wellbeing support and services is spent in their local area.
- There is felt to be variable levels of mental health and wellbeing spend (per person) across different NHS Boards and a perceived inequity of provision of services within smaller and more remote/rural Boards.

Some individual respondents go on to suggest that community-based mental health and wellbeing support and services could benefit from being more widely promoted so that people know what is available in their area and how they can access support and services.

Theme 2: How funding could be better used

Common suggestions put forward by individual respondents and organisation respondents for ways in which funding for mental health and wellbeing support and services could be better used in their area include the following:

- A stronger focus on prevention and early intervention.

- A whole-systems approach.
- Ensuring equitable access to mental health and wellbeing support and services (and consistency of provision across Scotland).
- Improving availability of mental health and wellbeing support and services.
- Tackling mental health inequalities.
- Increased and longer-term sustainable funding for the third sector.
- More community-based support and services, including outreach.
- Tackling the impact of COVID-19 on mental health.
- Reducing waiting lists.
- Growing an appropriately skilled (and diverse) mental health and wellbeing workforce.

Qualitative feedback from consultation respondents who think funding for mental health and wellbeing supports and services could not be better used in their area is outlined below.

Theme 3: A repeat of points raised above

Much of the feedback from these consultation respondents (both individual and organisation respondents) highlights similar points to those identified by consultation respondents who think funding for mental health and wellbeing support and services could be better used in their area:

- Mental health services and support are underfunded, and gaps in service provision can put people at risk.
- There is a need for increased and more sustainable funding for mental health and wellbeing support and services, including for the third sector.
- There could be a much stronger focus of funding aimed at early intervention and prevention.
- Increased and longer-term sustainable funding for the third sector.
- More community-based supports and services.

Finally, a few individual respondents who answer “No” to **Question 12.1** say that they are either:

- Not aware of how funding for mental health and wellbeing support and services are currently spent in their area.
- Not in a position to comment or provide an informed view.

15.3 Question 12.3 - Is there anything else you'd like to tell us about this, whether you're answering as an individual or on behalf of an organisation?

Less than one-fifth (circa 18%) of all consultation respondents provide a response to **Question 12.3**. The points raised are reflected above or elsewhere in the report, and no additional themes are identified.

Note: a vast majority of consultation respondents either simply confirm whether their response to **Question 12.3** is as an individual or organisation respondent, do not provide a response, or answer "no", "no other comments", or "not applicable".

16 Our Mental Health and Wellbeing Workforce

There are no questions under this Part 13 of the consultation.

Part 14 (Chapter 17) to Part 17 (Chapter 20) present the findings to consultation questions relating to the mental health and wellbeing workforce.

17 Our Vision and Outcomes for the Mental Health and Wellbeing Workforce

The consultation asks respondents whether they agree or disagree with the 28 short-term outcomes identified in the Consultation Document for the mental health and wellbeing workforce.

We have attempted to classify each theme by the by the five pillars of the workforce journey, where appropriate - Plan, Attract, Train, Employ and Nurture. More information about which can be found in the National Workforce Strategy for Health and Social Care[25].

17.1 Question 14.1 - Do you agree that these are the right short-term (1-2 years) outcomes for our mental health and wellbeing workforce?

Question 14.1 asks consultation respondents whether they agree or disagree with the nine short-term outcomes for the mental health and wellbeing workforce under the Plan and Attract pillars of the workforce journey.

Table 46 to Table 54 (**Supplementary Report**) provides the quantitative response to **Question 14.1**.

Table 17.1 on the next page provides a high-level overview, and key points to note include:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each short-term outcome under the Plan and Attract pillars. On average 87% of all consultation respondents agree with each short-term outcome.
- While most individual and organisation respondents agree with each of the short-term outcomes, organisation respondents tend to be more positive. On average 92% of organisation respondents agree with each short-term outcome under the Plan and Attract pillars. This compares to 84% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each short-term outcome. This is highest among mental health organisations.

[25] The Scottish Government, Health and social care: national workforce strategy, 11 March 2022.

- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the short-term outcomes. This ranges from a low of 2% of all consultation respondents to a high of 6%.

Table 17.1: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following short-term outcomes for people (Plan and Attract)?

Outcome	Agree	Neutral	Disagree
Plan: Improved evidence base for workforce planning including population needs assessment for mental health and wellbeing. (N=339)	87%	10%	4%
Plan: Improved workforce data for different mental health staff groups. (N=339)	85%	12%	3%
Plan: Improved local and national workforce planning capacity and capability. (N=337)	90%	6%	4%
Plan: Improved local and national workforce planning capacity and capability. (N=336)	91%	7%	2%
Plan: User centred and system wide service (re)design. (N=338)	84%	11%	4%
Plan: Peer support and peer worker roles are a mainstream part of mental health services. (N=336)	81%	13%	6%
Attract: Improved national and international recruitment and retention approaches/mechanisms. (N=334)	87%	9%	4%
Attract: Increased fair work practices such as appropriate channels for effective voice, create a more diverse and inclusive workplace. (N=337)	88%	9%	3%
Attract: Increased awareness of careers in mental health. (N=336)	87%	10%	3%

17.2 Question 14.2 - Do you agree that these are the right short-term (1-2 years) outcomes for our mental health and wellbeing workforce?

Question 14.2 asks consultation respondents whether they agree or disagree with the 10 short-term outcomes for the mental health and wellbeing workforce under the Train pillar of the workforce journey.

Table 55 to Table 64 (**Supplementary Report**) provides the quantitative response to **Question 14.2**.

Table 17.2 provides a high-level overview, and key points to note include that:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each short-term outcome under the Train pillar. On average 87% of all consultation respondents agree with each of the short-term outcomes.

- While most individual and organisation respondents agree with each of the short-outcomes, organisation respondents tend to be more positive. On average 91% of organisation respondents agree with each short-term outcome under the Train Pillar. This compares to 84% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each short-term outcome. This is highest among mental health organisations at 94%.
- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the short-term outcomes. This ranges from a low of 1% of all consultation respondents to a high of 5%.

Table 17.2: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following short-term outcomes for people (Train)?

Outcome	Agree	Neutral	Disagree
Train: Long term workforce planning goals are reflected in and supported by training programmes provided by universities, colleges and apprenticeships. (N=336)	91%	7%	4%
Train: Increased student intake through traditional routes into mental health professions. (N=336)	84%	12%	4%
Train: Create alternative routes into mental health professions. (N=336)	84%	13%	3%
Train: Create new mental health roles. (N=338)	76%	18%	5%
Train: Improved and consistent training standards across Scotland, including trauma informed practice and cultural competency. (N=337)	95%	4%	1%
Train: Our workforce feel more knowledgeable about other Services in their local area and how to link others in to them. (N=336)	93%	4%	3%
Train: Our workforce is informed and confident in supporting self-care and recommending digital mental health resources. (N=336)	82%	13%	5%
Train: Develop and roll out mental health literacy training for the health and care workforce, to provide more seamless support for physical and mental health. (N=338)	89%	8%	2%
Train: Improved leadership training. (N=334)	83%	13%	3%
Train: Improved Continuing Professional Development (CPD) and careers progression pathways. (N=334)	89%	8%	2%

17.3 Question 14.3 - Do you agree that these are the right short-term (1-2 years) outcomes for our mental health and wellbeing workforce?

Question 14.3 asks consultation respondents whether they agree or disagree with the nine short-term outcomes for the mental health and wellbeing workforce under the Employ and Nurture pillars of the workforce journey.

Table 65 to Table 73 (**Supplementary Report**) provides the quantitative response to **Question 14.3**.

Table 17.3 on the next page provides a high-level overview, and key points to note include that:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each short-term outcome under the Employ and Nurture pillars. On average 89% of all consultation respondents agree with each short-term outcome.
- While most individual and organisation respondents agree with each of the short-term outcomes, organisation respondents tend to be more positive. On average 92% of organisation respondents agree with each short-term outcome under the Employ and Nurture pillars. This compares to 87% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each short-term outcome. This is highest among mental health organisations at 96%.
- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the short-term outcomes. This ranges from a low of 1% of all consultation respondents to a high of 4%.

Table 17.3: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following short-term outcomes for people (Employ and Nurture)?

Outcome	Agree	Neutral	Disagree
Employ: Consistent employer policies. (N=334)	87%	11%	2%
Employ: Refreshed returners programme. (N=333)	78%	19%	3%
Employ: Improved diversity of the mental health workforce and leadership. (N=333)	85%	11%	4%
Nurture: Co-produced quality standard and safety standards for mental health services. (N=335)	87%	10%	3%
Nurture: Safe working appropriate staffing levels and manageable workloads. (N=337)	96%	3%	1%
Nurture: Effective partnership working between staff and partner organisations. (N=335)	93%	6%	2%
Nurture: Improved understanding of staff engagement, experience and wellbeing. (N=336)	93%	6%	2%
Nurture: Improved staff access to wellbeing support. (N=336)	90%	8%	2%
Nurture: Improved access to professional supervision. (N=331)	90%	8%	2%

17.4 Question 14.4 - Do you have any comments you would like to add on the above outcomes?

Question 14.4 asks consultation respondents if they have any comments they would like to add to the short-term outcomes for the mental health and wellbeing workforce outlined in **Questions 14.1 to 14.3**. Just over one-third of consultation respondents provide a response, and the most common themes by pillar are outlined below.

Pillar 4 - Employ

Theme 1: Staff Retention

Some consultation respondents (primarily among mental health organisations and individual respondents) feel that more action is needed by government to retain the existing mental health and wellbeing workforce. A prevalent view among these respondents is that a considerable number have left (or plan to leave) the mental health and wellbeing workforce due to low morale, excessive workloads, and burnout.

Theme 2: Improve working conditions

Some consultation respondents (mostly individual respondents, and a few organisations who support specific target groups and other organisations) call for improved working condition for the mental health and wellbeing workforce. The reasons for this are largely similar to those outlined above (i.e. low morale, excessive workloads, burnout).

Pillar 2 - Attract

Theme 3: Increased recruitment of those with lived experience

A few consultation respondents (all organisation subgroups) would like to see the recruitment of more people with lived experience as part of the mental health and wellbeing workforce. A point made is that design and delivery of mental health and wellbeing services may be better informed when it involves and engages people with lived experience of using the services.

Theme 4: Further clarity required on new mental health roles

A few consultation respondents (individual respondents, health improvement and mental health organisations) request further clarity/detail from the Scottish Government on the outcome 'Create new mental health roles'.

Theme 5: Increased recruitment of mental health and wellbeing staff

A few respondents (e.g. individual respondents) feel that more people need to be recruited into the mental health and wellbeing workforce to ensure high-quality care is provided.

Pillar 3 - Train

Theme 6: Increased mental health and wellbeing training

A few respondents (mental health organisations and organisations who support specific target groups) suggest that more mental health and wellbeing training is needed across the health workforce to increase levels of knowledge and understanding of how best to support people with poor mental health throughout the health service. This was judged particularly important for those not involved in specialist mental health and wellbeing roles.

Additional points

Theme 7: Increase funding

Some respondents (mostly individual respondents and mental health and other organisations) call for increased funding for mental health and wellbeing support and services in order for the short-term outcomes for the mental health and wellbeing workforce to be achieved.

The main points raised by these respondents include:

- The redesign of services is felt to be premature when existing services are underfunded.
- There is support for increased funding for the third sector.
- Pay for the mental health and wellbeing workforce should have parity with the physical health workforce.

Theme 8: Concerns around digital service delivery

A few consultation respondents (mainly individual respondents) are concerned about a permanent shift to the use of online and remote technologies in the delivery of mental health and wellbeing services. A point made is that this mode of delivery may not be appropriate in all cases, and that in-person support is also needed.

17.5 Question 14.5 - Do you agree that these are the right medium-term (3-4 years) outcomes for our mental health and wellbeing workforce?

Question 14.5 asks consultation respondents whether they agree or disagree with the eight medium-term outcomes specified in the Consultation Document for the mental health and wellbeing workforce.

Table 74 to Table 81 (**Supplementary Report**) provides the quantitative response to **Question 14.5**.

Table 17.4 on the next page provides a high-level overview, and key points to note include:

- A vast majority of all consultation respondents agree (i.e. either agree or strongly agree) with each medium-term outcome for the mental health and wellbeing workforce. On average of 89% of all consultation respondents agree with each medium-term outcome.
- While most individual and organisation respondents agree with each of the medium-term outcomes, organisation respondents tend to be more positive. On average 93% of organisation respondents agree with each medium-term outcome for the mental health and wellbeing workforce. This compares to 86% for individual respondents.
- As noted above, a vast majority of all organisation subgroups agree with each short-term outcome. This is highest among mental health organisations at 98%.
- Few consultation respondents disagree (i.e. either disagree or strongly disagree) with the medium-term outcomes. This ranges from a low of 2% of all consultation respondents to a high of 4%.

Table 17.4: Do you agree that the Mental Health and Wellbeing Strategy should aim to achieve the following medium-term outcomes for people?

Outcome	Agree	Neutral	Disagree
Comprehensive data and management information on the Mental Health and wellbeing workforce. (N=327)	84%	16%	4%
Effective workforce planning tools. (N=324)	85%	12%	3%
Good understanding of the gaps in workforce capacity and supply. (N=326)	91%	5%	4%
Improved governance and accountability mechanisms around workforce planning. (N=322)	86%	11%	4%
User centred and responsive services geared towards improving population mental health outcomes. (N=323)	89%	8%	3%
Staff feel supported to deliver high quality and compassionate care. (N=326)	93%	5%	3%
Leaders are able to deliver change and support the needs of the workforce. (N=325)	92%	6%	2%
Staff are able to respond well to change. (N=323)	91%	7%	3%

17.6 Question 14.6 - Do you have any comments you would like to add on the above outcomes?

Question 14.6 asks consultation respondents if they have any comments they would like to add to the medium-term outcomes for the mental health and wellbeing workforce outlined in **Question 14.5**. Just under one-quarter of consultation respondents answer this question, and the most common themes are outlined by pillar (where appropriate) below.

Theme 1: A repeat of views raised earlier

Many consultation respondents restate points they made to **Question 14.4**. In summary:

- Increased funding for mental health and wellbeing support and services in order for the short-term outcomes for the mental health and wellbeing workforce to be achieved.
- Exploring ways to support people with lived experience of mental health issues into the mental health and wellbeing workforce.
- More mental health and wellbeing training is needed across the health workforce to increase levels of knowledge and understanding of how best to support people with poor mental health throughout the health service.

Theme 2: Outcomes should be more specific and measurable (Pillar 1: Plan)

Some respondents (individual respondents and mental health organisations) feel that the medium-term outcomes for the mental health and wellbeing workforce could be more specific and need to be measurable.

Further, these respondents call for more detail to be provided by the Scottish Government on how the medium-term outcomes would be measured.

Theme 3: Outcomes are too long-term

A few respondents (individual respondents and mental health organisations) believe that the three-four-year timeframe for many of the medium-term outcomes for the mental health and wellbeing workforce is too long and that they could realistically be short-term outcomes.

Question 14.7 - Are there any other short- and medium-term outcomes we should be working towards? Please specify.

Question 14.7 asks consultation respondents whether there are any other short- and medium-term outcomes the Strategy should be working towards. Almost one-quarter of consultation respondents answer this question.

Theme 1: A repeat of views raised earlier

Most consultation respondents (individual and organisation respondents) reiterate points that they made to **Question 14.4** or to earlier consultation questions. In summary:

- Investment is needed to grow the mental health and wellbeing workforce.
- Increased funding for mental health and wellbeing support and services in order for the short-term outcomes for the mental health and wellbeing workforce to be achieved.
- An increase in pay is required to recruit and retain the mental health and wellbeing workforce.
- More mental health and wellbeing training is needed across the health workforce to increase levels of knowledge and understanding of how best to support people with poor mental health throughout the health service.
- Tackling stigma and discrimination faced by people with mental health issues.
- Raising awareness and understanding of mental health (e.g. population level, wider health and social care sector, among employers, etc).
- A whole-system or holistic approach to mental and physical health and wellbeing.

18 The Scope of The Mental Health and Wellbeing Workforce

18.1 Question 15.1 - The mental health and wellbeing workforce includes someone who may be…?

The consultation asks respondents who they think is part of the mental health and wellbeing workforce. **Table 82** (**Supplementary Report**) provides the quantitative response to **Question 15.1**.

Table 18.1: The mental health and wellbeing workforce includes someone who may be…

Someone who may be (N=301)	Individual	Organisation	All respondents
A highly specialised Mental Health worker, such as a psychiatrist, psychologist, mental health nurse or counsellor	97%	95%	**96%**
Employed	96%	96%	**96%**
A social worker or Mental Health Officer	87%	89%	**87%**
Someone with experience of using mental health services, acting as a peer support worker	83%	94%	**87%**
Voluntary	82%	86%	**83%**
Any health and social care or public sector worker whose role is not primarily related to mental health but contributes to public mental health and wellbeing	76%	80%	**77%**

Table 18.1 provides a high-level overview, and key points to note include that:

- A majority of all consultation respondents consider each of the pre-defined options as being part of the mental health and wellbeing workforce, albeit to varying degrees.
- A highly specialised 'Mental Health worker (e.g. such as a psychiatrist, psychologist, mental health nurse or counsellor)' and those who are 'employed' are the most common responses.
- 'Any health and social care or public sector worker whose role is not primarily related to mental health but contributes to public mental health and wellbeing' is identified by fewer consultation respondents as being part of the mental health and wellbeing workforce (albeit still a majority of all consultation respondents).

- There are some differences when individual and organisation respondent responses are examined. For example, less individual respondents consider 'someone with experience of using mental health services, acting as a peer support worker' to be part of the mental health and wellbeing workforce.

18.2 Question 15.2 - The mental health and wellbeing workforce includes someone who may work / volunteer for…?

Question 15.2 asks consultation respondents to choose from a list of pre-defined organisations which are considered to host the mental health and wellbeing workforce (i.e. employees or volunteers).

Table 83 (**Supplementary Report**) provides the quantitative response to **Question 15.2**.

Table 8.2 provides a high-level overview of responses, and key points to note include:

- A majority of all consultation respondents consider each of the pre-defined options as hosts of the mental health and wellbeing workforce, albeit to varying degrees.
- 'The NHS' is the most common response (95% of all consultation respondents), followed by 'the social care sector', the third and charity sectors' and 'social care services.
- 'The private sector' is identified by fewer consultation respondents as a host of the mental health and wellbeing workforce (68% of all consultation respondents), albeit still a majority.
- There are some differences when individual and organisation respondent responses are examined. For example, less individual respondents consider 'the private sector' to host the mental health and wellbeing workforce.

Table 18.2: The mental health and wellbeing workforce includes someone who may work / volunteer for…

Someone who may work/volunteer for (N=302)	Individual	Organisation	All respondents
The NHS	96%	92%	**95%**
The social care sector	84%	91%	**86%**
The third and charity sectors	84%	91%	**86%**
Social care services	84%	87%	**85%**
Wider public sector (including the police, criminal justice system, children's services, education)	76%	89%	**80%**
The private sector	62%	80%	**68%**
Other	14%	23%	**17%**

18.3 Question 15.3 - If you selected 'other', please specify.

17% of consultation respondents selected 'other' at **Question 15.2**, and the most common responses include:

- The population as a whole (i.e. through their day-to-day interactions with other people).
- Educators (i.e. employees in education settings, including nurseries, schools, colleges, and universities. **Note**: this can be captured under 'wider public sector' at **Question 15.2**.

Other responses include:

- Those with lived experience.
- Employers.
- Unpaid carers.

18.4 Question 15.4 - The mental health and wellbeing workforce includes someone who may be found in…?

Question 15.4 asks consultation respondents to choose from a pre-defined list of places/settings at which they consider members of mental health and wellbeing workforce may be found.

Table 84 (**Supplementary Report**) provides the quantitative response to **Question 15.4**.

Table 8.3 provides a high-level overview of responses, and key points to note include that:

- A majority of all consultation respondents consider each of the pre-defined options as places/settings where members of the mental health and wellbeing workforce may be found, albeit to varying degrees.
- The most common responses are 'hospitals' and 'GP surgeries' followed by community and education settings.
- 'Employment settings' is identified by fewer consultation respondents as a place where they may find members of the mental health and wellbeing workforce (85% of all consultation respondents), albeit still a majority.
- There are some differences when individual and organisation respondent responses are examined. For example, less individual respondents consider 'employment settings' as somewhere they may find members of the mental health and wellbeing workforce.

Table 18.3: The mental health and wellbeing workforce includes someone who may be found in…

N=303	Individual	Organisation	All respondents
Hospitals	96%	90%	**94%**
GP surgeries	93%	92%	**93%**
Community settings (such as care homes)	91%	92%	**91%**
Educational settings (such as schools, colleges or universities)	90%	93%	**91%**
Justice system settings (such as police stations, prisons or courts)	87%	91%	**88%**
The digital space, providing internet or video enabled therapy	84%	89%	**86%**
Employment settings	83%	90%	**85%**
Other	12%	31%	**18%**

18.5 Question 15.5 - If you selected 'other', please specify?

Almost one-fifth of consultation respondents selected 'other' (18%) at **Question 15.4**. Responses include the following, and all can be captured under the pre-defined list of places/settings outlined above: community settings, private sector business; third sector organisations; educational establishments; religious organisations; and leisure organisations.

18.6 Question 15.6 -The mental health and wellbeing workforce includes someone who may…?

Question 15.6 asks consultation respondents to choose from a list of pre-defined actions which they think members of mental health and wellbeing workforce may undertake.

Table 85 (**Supplementary Report**) provides the quantitative response to **Question 15.6**.

Table 18.4 provides a high-level overview of responses.

Table 18.4: The mental health and wellbeing workforce includes someone who may…

Someone who may (N=296)	Individual	Organisation	All respondents
Provide ongoing monitoring of diagnosed mental illness	94%	90%	**93%**
Provide treatment and/or management of diagnosed mental illness	93%	91%	**92%**
Provide support to families of those with mental illness	94%	89%	**92%**
Complete assessments for the presence or absence of mental illness	91%	89%	**91%**
Undertake work to prevent the development of mental illness	89%	89%	**89%**
Undertake work to address factors which may increase the risk of someone developing mental illness	86%	86%	**86%**
Provide direct support on issues which affect wellbeing, but might not be directly related to a diagnosed mental illness, such as housing, financial issues, rights	81%	84%	**82%**
Other	15%	29%	**19%**

Key points to note include:

- A majority of all consultation respondents consider each of the pre-defined options as something that members of mental health and wellbeing workforce may do, albeit to varying degrees.
- Over 90% of consultation respondents consider that members of mental health and wellbeing workforce may ‘provide monitoring of a mental illness’, ‘provide treatment of a diagnosed mental illness’, ‘provide support to families of those with a mental illness’ or ‘complete assessment for the presence or absence of a mental illness’.

- ‘People who provide direct support on issues which affect wellbeing but might not be directly related to a diagnosed mental illness’ is the option selected by fewest consultation respondents (82%), albeit still a majority.

18.7 Question 15.7 - If you selected ‘other’, please specify.

19% of consultation respondents selected ‘other’ at **Question 15.6** and the most common responses include the following:

- Some respondents believe that everyday interactions between people should be considered forms of mental health support, and therefore everyone should be considered part of the mental health and wellbeing.
- Listening and talking to people with poor mental health and wellbeing.

19 Solutions to our Current and Future Workforce Challenges

19.1 Question 16.1 - How do we make the best use of qualified specialist professionals to meet the needs of those who need care and treatment?

Question 16.1 asks consultation respondents how to make best use of qualified specialist professionals to meet the needs of those who need care and treatment. Over half (56%) of consultation respondents answer this question, and the most common themes are outlined below. We have attempted to classify each theme by the by the five pillars of the workforce journey, where appropriate - Plan, Attract, Train, Employ and Nurture.

Pillar 4 - Employ

Theme 1: Improved triage procedures

Many respondents (mostly individual respondents, mental health and health improvement organisations) consider that there may be scope for greater/improved use of a triage approach to help mental health and wellbeing specialists/professionals focus on where their care is needed most. The general sentiment is that specialists are a valuable resource and that other members of the mental health and wellbeing workforce could perform initial triage and refer the most suitable for care by specialist professionals.

Theme 2: Additional investment in the mental health and wellbeing workforce

Many respondents (mostly individual respondents, health improvement organisations and organisations who support specific target groups) believe that additional funding is required to make best use of mental health and wellbeing specialists. Related points are that mental health and wellbeing services have been underfunded and that there are a range of workforce challenges (e.g. recruitment, retention, pay and conditions) that need to be addressed.

Theme 3: Reduce administrative burden

Some respondents (mostly individual respondents) feel that the administrative burden placed on mental health and wellbeing specialists/professionals could be reduced in some way and/or picked up by other members of the workforce, as appropriate. A point made is that this would allow mental health and wellbeing specialists/professionals to focus more on their time on patient care.

Pillar 2 - Attract

Theme 4: Employ more qualified specialist professionals

Many respondents (individual respondents and mental health organisations) feel that there is a need to grow the mental health and wellbeing workforce. Points made include that there are insufficient staff numbers in this field to deal with increasing demand, and that the existing mental health and wellbeing workforce have high workloads and are experiencing burnout.

"There is a deficit in trained, qualified consultant psychiatrists in Scotland, with many vacancies and posts being filled temporarily by expensive locum doctors who generally provide only service. The important service development work is then left to the few substantive consultants who remain committed to the service they work in. Acknowledging that these substantive consultants are unable to achieve everything alone, identifying the circumscribed pieces of work they can focus on and supporting this work is essential, as is working with all MDT colleagues and 3rd sector services collectively for clear, identified aims."

Royal College of Psychiatrists in Scotland Addictions Faculty

Pillar 1 - Plan

Theme 5: Provide more mental health and wellbeing services in community settings

Some respondents (mostly individual respondents) feel that specialist mental health and wellbeing professionals could better meet the needs of those who need care and treatment by providing more mental health and wellbeing services in community settings such as schools and GP practices. A point made is that this would make services more accessible and allow people to access such services in settings in which they are more familiar or comfortable.

Theme 6: Improved communication

Some respondents (mostly individual respondents and a few health improvement organisations) believe that there is a need for improved communication between different NHS departments/ organisations to ensure a patient led approach.

Pillar 3 - Train

Theme 7: Continuing professional development

Some respondents (mostly individual respondents and a few health improvement organisations) highlight a need for increased investment to support continuing professional development for qualified specialist professionals, including to ensure the ongoing use of best practice.

19.2 Question 16.2 - How do we grow the workforce, in particular increasing the capacity for prevention and early intervention, which enables individual needs to be recognised and addressed in a timely, appropriate manner?

Question 16.2 asks consultation respondents how government can grow the workforce and increase the capacity for prevention and early intervention. Over half (57%) of all consultation respondents answer this question, and the most common themes are outlined below.

Pillar 2: Attract

Theme 1: Increase the number of training places available

Some respondents (mostly individual respondents and a few mental health organisations) believe that in order to grow the mental health and wellbeing workforce, there needs to be an increase in the number, range and funding of training courses. Most of these respondents identify the need for an increased number of university and college places for growing the workforce.

“Ongoing, sufficient investment in training is essential. That includes establishing more entry points to professions and training opportunities for professionals to develop their skillsets. For example, the SSSC Mental Health Officer Report 2021 highlighted a significant shortage of full-time MHOs in Scotland. 26 out of 32 local authorities are understaffed on this role, leading to almost 3,000 hours lost hours per week. Training to become an MHO takes considerable time. It is a specialist profession that social workers qualify to become. The length of time needed to train the workforce needs to be factored into workforce planning.”

Scottish Association of Social Work

Theme 2: Sector attractiveness and clear career progression pathways

Some consultation respondents (individual respondents, mental health and health improvement organisations) feel that many job roles in the mental health and wellbeing sector are not viewed as attractive and that there is also a lack of clear career progression pathways. There is considered to be a need to address sector attractiveness challenges and increase awareness of career development opportunities to help develop a stronger talent pipeline (e.g. through increased engagement in schools).

“Prevention and early intervention are often seen as lower skilled jobs and qualified professional staff are rarely employed in these areas/agencies, other than in a consultative, training or supervisory role. A shift to see prevention and early intervention as requiring the same level of skill and promoting the use of professionals in services (statutory, voluntary and this sector) would go a long way to providing high quality services that support children, young people and families at the time they need the support and avoid the need for specialist services later.”

Adoption UK Scotland

Pillar 4 - Employ

Theme 3: Increased remuneration and improve working conditions

Many respondents (individual respondents and organisation respondents, including all organisation subgroups) believe that the main ways to grow the mental health and wellbeing workforce are to increase the level of renumeration and improve working conditions. It is suggested that this could help attract, recruit, and retain staff.

“In the case of nursing, ensure safe staffing becomes a reality in Scotland and paying nursing staff fairly and appropriately.”

Royal College of Nursing Scotland

Pillar 3 - Train

Theme 4: Widen out the provision of mental health and wellbeing training

Some respondents (mainly individual respondents and health improvement organisations) call for mental health and wellbeing training to also be provided to those outwith the mental health and wellbeing workforce. A point made is that the provision of such training to other frontline service providers and the general public could help support a greater focus on prevention and early intervention.

Pillar 1 - Plan

Theme 5: Harness third sector capacity

Some consultation respondents (individual respondents, mental health and other organisations) believe that harnessing the capacity of the third sector could help to grow the mental health and wellbeing workforce, particularly with regards to placing a stronger focus on early intervention and prevention. Further, these respondents call for increased and longer-term funding for the third sector and better integration of the public and third sector community health approaches.

Question 16.3 - How do we protect the capacity for specialised and complex care roles in areas like forensic mental health?

Question 16.3 asks consultation respondents how the Scottish Government can best protect the capacity for specialised and complex care roles in are like forensic mental health. Around two-fifths of consultation respondents answer this question (38%), and the most common themes are outlined below.

Theme 1: A repeat of points raised earlier

Many consultation respondents raise similar points to those made at **Question 16.1 and Question 16.2**:

- Increased renumeration for the mental health and wellbeing workforce (Pillar - Employ).
- Increased training places (Pillar - Attract).

Pillar 1 - Plan

Theme 2: Focus staff resources on where they can make the biggest impact

In a related point to that in **Question 16.1** - around improved triage procedures, some consultation respondents (mainly health improvement organisations) comment on the need to focus staff resources in areas where they can make the largest impact. The skills of those in specialised and complex care roles such as forensic mental health are valuable and limited and should be focussed on those with the highest levels of need, with patients requiring lower levels of intervention being handled by wider members of the workforce. Further, a few respondents highlight the need for additional administrative staff in order to ease the administrative burden on higher level staff.

A related issue highlighted by some respondents is that there needs to be protection of, if not an increase in budgets for those in specialised and complex care roles. Many of these respondents are concerned that increased focus and investment in primary care should not come at the expense of these roles.

“Need to consider which roles can be undertaken by which professions to ensure that specialised and more complex care provision is not used where it is unnecessary/or not used to best effect. There are limited staff available who have these skills sets and sufficient experience and they need to be utilised in an efficient manner.

There should be communication that goes along with this to further highlight to the public that good care does not always equate to a doctor or consultant level. There is still an expectation that care comes from these professional groups and this needs to be more universally challenged."

Aberdeen City Health and Social Care Partnership

Theme 3: Focus on prevention and early intervention

A small number of respondents (individual respondents and health improvement organisations) comment a focus on prevention and early intervention would help to protect the capacity for specialised and complex care roles by addressing mental health issues at an early stage and preventing them from escalating to needing more complex care.

19.3 Question 16.4 - How do we widen the workforce to fully integrate the contribution of non-professionals and experts by experience, including peer support workers without sacrificing quality of care?

Question 16.4 asks consultation respondents how the Scottish Government can best widen the workforce to fully integrate the contribution of non-professionals and experts by experience, including peer support workers without sacrificing quality of care. Half of consultation respondents answer this question, and the most common themes are outlined below.

Pillar 3 - Train

Theme 1: Ensure non-professionals and experts by experience have sufficient training

Many consultation respondents (mainly individual respondents and some mental health organisations) feel that there would be a requirement for any non-professional entering the mental health and wellbeing workforce to receive adequate and appropriate levels of training for their role and to ensure that the minimum standards of care provision are met.

"Competency frameworks and appropriate training whilst recognising the importance of lived experience in developing connections between peers and patients."

NHS Ayrshire and Arran Mental Health Physiotherapists

Pillar 5 - Nurture

Theme 2: Ensure there is robust oversight and supervision

Many respondents (mainly individual respondents and mental health organisations) believe that integrating non-professionals and experts by experience into the mental health and wellbeing workforce would require to be accompanied by robust oversight and supervision mechanisms in order to ensure that care is provided in an appropriate and effective manner.

“Non-professionals, experts by experience and peer support workers should be working in the community attached to GP surgeries and referrals could be made after assessment by GP or a mental health professional. Regulation, clear governance, and supervision should be a requirement for all these workers”

NHS Ayrshire and Arran Alcohol and Drug Services

19.4 Question 16.5 - How do we support a more inclusive approach to workforce planning, recognising that many different workers and services provide mental health and wellbeing support?

Question 16.5 asks consultation respondents how the Scottish Government can support a more inclusive approach to workforce planning, recognising that many different workers and services provide mental health and wellbeing support. Just under two-fifths of consultation respondents answer this question (38%), and the most common themes are outlined below.

Note: there was some ambiguity with this question. Most consultation respondents interpret it as being inclusive of the different types of workers (e.g. doctors, nurses, health visitors, volunteers, etc), whilst a few interpret it as creating a more inclusive and diverse workforce (e.g. ethnic minorities, LGBTIQ+, etc).

Theme 1: A repeat of points raised earlier

Many consultation respondents raise similar points to those raised above, including:

- Increase sector attractiveness and ensure clear progression pathways (Pillar – Attract).
- Increase remuneration for the mental health and wellbeing workforce, and increase levels of funding for mental health and wellbeing services (Pillar – Employ).

Pillar 1 - Plan

Theme 2: Multi-agency collaboration

Many consultation respondents (individual respondents and mental health organisations) believe that an increase in collaboration between different agencies could help to support a more inclusive approach to workforce planning. This includes increased collaboration between the public sector, and between the public and third sectors. This would be with a view to increasing understanding of capacity and needs across the mental health and wellbeing sector to allow efficient distribution of resources, as well as helping to share best practice.

Pillar 2 - Attract

Theme 3: Inclusive recruitment practices

Some consultation respondents (mainly individual respondents and mental health organisations) support a more inclusive approach to recruitment in order to attract a more diverse mental health and wellbeing workforce. These respondents suggest simply adopting inclusive recruitment practices may be insufficient and that there is a need for cultural change within the workforce to instil values of non-discrimination and cultural awareness.

19.5 Question 16.6 - With increasing demand on mental health services, how do we prioritise creating capacity for re-designing services to better manage the impacts of COVID-19, and other systemic pressures?

Question 16.6 asks consultation respondents how the Scottish Government can prioritise creating capacity for re-designing services to better manage the impacts of COVID-19, and other systemic pressures. Just over two-fifths of consultation respondents answer this question, and the most common themes are outlined below.

Theme 1: A repeat of points raised earlier

Many consultation respondents raise similar points to those raised earlier:

- Grow the workforce (Pillar – Attract).
- Focus staff resources where they can have the largest impact, a stronger focus on prevention and early intervention, and harness third sector capacity (Pillar – Plan).
- Increase remuneration for the mental health and wellbeing workforce, and increase funding for mental health and wellbeing services (Pillar – Employ).

Pillar 1 - Plan

Theme 2: Involve the entire mental health and wellbeing workforce in service design

Some respondents (mostly individual respondents) feel that all members of the mental health and wellbeing workforce should be actively involved in service re-design, ranging from senior consultants to health visitors as well as those with lived experience. A point made is that those with frontline experience of delivering mental health and wellbeing services and those who access such services and support have valuable experience and knowledge to input into the process.

Theme 3: Make greater use of online and telephone service delivery

Some respondents (individual respondents and mental health organisation) believe that a greater use of online and telephone service delivery could help to ease the burden on frontline services. While many of these respondents recognise the importance of face-to-face service delivery, there it is suggested that there could be greater use of remote and telephone delivery in certain circumstances and to help prioritise scarce resources.

19.6 Question 16.7 - How do we better support and protect the wellbeing of those working in all parts of the system?

Question 16.7 asks consultation respondents how the Scottish Government can better support and protect the wellbeing of those working in all parts of the system. Just under half (48%) of consultation respondents answer this question, and the most common themes are outlined below.

Theme 1: A repeat of points raised earlier

Many consultation respondents (individual and organisation respondents) raise similar points to those made earlier:

- Increase workforce remuneration, improve working conditions within the sector, and increase funding for mental health and wellbeing services (Pillar – Employ).
- Grow the mental health and wellbeing workforce (Pillar – Attract).
- Involve the entire mental health and wellbeing workforce in service re-design (Pillar – Plan).

Pillar 5 - Nurture

Theme 2: Improve access to workforce wellbeing services

Many respondents (individual respondents, health improvement, mental health, and other organisations) suggest that better access to workforce wellbeing services is key in protecting wellbeing in the mental health and wellbeing workforce. Some of these respondents recognise that there are a range of existing workforce wellbeing services, however, some staff may not be aware of them and/or lack the time or opportunity to use them due to high workloads.

Theme 3: Improve workforce culture

Some respondents (individual respondents, mental health and health improvement organisations) believe that an improvement in workforce culture could help to support wellbeing in the mental health and wellbeing workforce. These respondents feel that the mental health and wellbeing workforce could be treated with more respect by their superiors and that all interactions should be based on compassionate listening and understanding. Further, some respondents feel that there could be a greater level of understating for members of the workforce that are experiencing mental health and wellbeing issues.

Pillar 4 - Employ

Theme 4: Improve workplace communication and supervision

Many respondents (mainly individual respondents and organisations who support specific target groups) believe that improving communication and supervision across the mental health and wellbeing workforce could support improved workforce wellbeing. A concern raised by these respondents is that workforce wellbeing may be overlooked or unnoticed at times and/or some members of the workforce may not know where to turn if they have any issues.

“Good communication with an effective and empathetic team and line manager are key to maintaining the overall wellbeing within service teams. Regular check-ins with staff can help to spot when stress is climbing. Providing team members with good feedback when they have delivered work can help buttress a person’s sense of self-worth and self-esteem.”

Cyrenians

20 Our Immediate Actions

20.1 Question 17.1 - In addition to developing our workforce vision and outcomes, we are also seeking views on what our immediate short-term actions (in the next year) should be for the mental health and wellbeing workforce.

Question 17.1 asks consultation respondents whether they agree with the proposed immediate short-term actions for the mental health and wellbeing workforce.

Table 86 (**Supplementary Report**) presents the quantitative response to **Question 17.1**.

Table 20.1 below provides a high-level overview of responses.

Table 20.1: Immediate short-term actions (in the next year) for the mental health and wellbeing workforce (% agree)

Immediate short-term actions (N=296)	Individual	Organisation	All respondents
Scope alternative pathways to careers within the workforce, beyond traditional university and college routes, such as apprenticeship pathways into mental health nursing	80%	84%	**81%**
Undertake an evaluation of our Mental Health Strategy 2017 commitment to fund 800 additional mental health workers in key settings, including A&Es, GP practices, police station custody suite and prisons, to ensure that the lessons learnt inform future recruitment.	82%	76%	**80%**
Take steps to increase the diversity of the mental health workforce, so it is reflective of the population that it cares for	76%	87%	**79%**
Develop targeted national and international recruitment campaigns for the mental health workforce	79%	77%	**79%**
Improve capacity in the mental health services to supervise student placements to support the growth of our workforce	77%	76%	**77%**
Work with NHS Education Scotland (NES) to improve workforce data, including equalities data, for mental health services in the NHS, by the end of 2023	66%	71%	**68%**

Key points to note from **Table 20.1** include that:

- A majority of all consultation respondents agree with each of the short-term actions for the mental health and wellbeing workforce. This varies from a low of 68% to a high of 81%.
- This is some variation in levels of agreement between individual respondents and organisation respondents, but nothing significant. The same is largely true when responses from organisation subgroups are examined.
- A point to note is that mental health organisations are more likely to express agreement than all organisation respondents and all other organisation subgroups for the action "Take steps to increase the diversity of the mental health workforce".

20.2 Question 17.2 - Do you think there are any other immediate actions we should take to support the workforce? Please specify.

Question 17.2 asks consultation respondents for any other immediate actions that should be taken to support the mental health and wellbeing workforce. Just over one-third of consultation respondents answer this question, and the most common themes are outlined below.

Pillar 4 - Employ

Theme 1: Increased renumeration

A prevalent view (primarily among individual respondents but also all organisation subgroups) is that increased salaries are required to help address talent attraction, recruitment and retention challenges experienced in the sector. A related point raised by some of these respondents is a perceived need to address/mitigate tax and pension issues (relating specifically to senior consultants) in order to retain talent and reduce levels of early retirement.

"Current taxation is a disincentive to psychiatrists continuing to practice beyond retirement age. This adds to staffing shortages."

NHS Greater Glasgow and Clyde

Theme 2: Staff retention

Some mental health organisations feel that the short-term actions for the health and wellbeing workforce do not have a sufficient focus on recruitment and retention, and that there could be a better balance.

A point raised is that there could be a greater focus on addressing talent retention issues, and this is often framed in the context of COVID-19 (e.g. staff burnout, staff illness and absence, early retirement).

Pillar 5 - Nurture

Theme 3: Improve access to workforce wellbeing services

Some individual respondents and mental health organisations feel there could be a short-term action relating to increased provision of wellbeing services for the mental health and wellbeing workforce. Suggestions for wellbeing services include:

- Stress management and self-care support.
- Wider access to mental health and wellbeing services and support.
- Ensuring that the mental health and wellbeing workforce is listened to and valued.

Pillar 1 - Plan

Theme 4: Better integrated care

A few respondents (mostly individual respondents) suggest there could be better integration of services so that they do not operate in isolation – leading to better patient-centred care and increased job satisfaction. For example, the following are referenced in terms of potential for greater integration: physical health and mental health; hospital nursing and social care; health and criminal justice.

Theme 5: Harness third sector capacity

A few respondents (mental health organisations) feel there could be a greater focus on harnessing and further developing the capacity of the third sector to help ease the burden on the public sector. Points raised include that the third sector brings considerable knowledge and expertise and can be more agile and flexible in service delivery than statutory provision.

20.3 Question 17.3 - Do you have any further comments or reflections on how to best support the workforce to promote mental health and wellbeing for people in Scotland? Please specify.

Question 17.3 asks consultation respondents for any other comments or reflections on how to best support the workforce to promote health and wellbeing for people in Scotland.

Over one-fifth of consultation respondents answer this question, and the most common themes are outlined below.

Theme 1: Reiteration of previous points

Many consultation respondents (individual and organisation respondents) raise similar points to those made at **Question 17.2**:

- Increased renumeration, and a stronger focus on staff retention (Pillar – Employ).
- Workforce wellbeing services (Pillar – Nurture)

Pillar 3 - Train

Theme 2: Increased mental health and wellbeing training

A few respondents (primarily individual respondents and a few health improvement and mental health organisations) suggest there is a need for an increased level of mental health and wellbeing training throughout the wider health and social care workforce (i.e. not only the mental health and wellbeing workforce). The point made is that this could help raise awareness and understanding of mental health and wellbeing issues and reduce stigma among healthcare providers.

Pillar 4 - Employ

Theme 3: Improve working conditions

A few individual respondents feel there is a need to create better working conditions for the mental health and wellbeing workforce e.g. increased annual leave entitlement, more flexible working arrangements.

20.4 Question 17.4 - Do you have any examples of different ways of working, best practice or case studies that would help support better workforce planning? For example, increasing the use of advanced practitioners. Please specify.

Question 17.4 asks consultation respondents if they have any examples of best practice or case studies that could help support better workforce planning. Just over one-quarter of all consultation respondents answer this question, and the most common themes are outlined below.

Pillar 3 -Train

Theme 1: Increased mental health and wellbeing training

As mentioned at **Question 17.3**, many respondents who provide a response to **Question 17.4** consider there to be a need to roll out mental health and wellbeing training more widely across the health and social care sector and workforce.

Pillar 1 - Plan

Theme 2: Ensuring the mental health and wellbeing workforce is listened to

A few individual respondents note in their response that it is important for the mental health and wellbeing workforce to be listened to, to help inform and improve service design and delivery (in particular frontline workers and those with lived experience of mental health issues). These respondents think this could help the workforce feel valued.

Pillar 2 - Attract

Theme 3: expand the mental health and wellbeing workforce

Some individual respondents suggest there needs to be more mental health and wellbeing workers embedded in community settings (e.g. schools and GP practices are mentioned). This is with a view to improving access to mental health and wellbeing services in communities. Further, some individual respondents also call for an increase in the number of advanced practitioners across mental health and wellbeing services.

Theme 4: Case Studies

Health improvement and mental health organisation respondents provide various examples of specific services and approaches which could be used as case studies to support better workforce planning. Examples provided include:

Scotland:

- CAMHS Unscheduled Care Nurses, NHS Lothian.
- Milestone, Edinburgh.
- Community Listening Service, NHS Tayside.
- Staff Wellbeing Service, NHS Tayside.
- Peer Support Worker Tests of Change, Renfrewshire Health and Social Care Partnership and NHS Greater Glasgow and Clyde.
- Primary Care Peer Workers, Angus.
- South Ayrshire Self-Harm

- The Neuk Perth, Crisis Centre.
- The Primary Care Improvement Programme, NHS Lanarkshire.
- Distress Brief Intervention Pilot Programme.
- The Rivers Centre.

Elsewhere in the UK:

- Bromley by Bow Service.
- iHV Perinatal and Infant Mental Health Champions' training programme.

International:

- Alaskan Nuka System.
- The Trieste System.

Please also refer to **Appendix E**.

21 Final Thoughts

21.1 Question 18.1 - Is there anything else you'd like to tell us

Question 18.1 asks consultation respondents if they have anything else they would like to add to their consultation response. Just over two-fifths of all consultation respondents answer this question, and the most common themes are outlined by below.

Theme 1: Reiteration of previous points

Most consultation respondents raise similar points to those made elsewhere in the report, as summarised below:

Services:

- A stronger focus on reducing income and health inequalities.
- Integration of physical and mental health and wellbeing services.
- A stronger focus on prevention and early intervention.
- An increased focus on those with severe/long-term mental health conditions.
- Expand mental health and wellbeing provision in community settings.
- Increased funding for mental health and wellbeing services to deal with increasing demand.

Mental health and wellbeing workforce:

- Grow the mental health and wellbeing workforce.
- Increase recruitment of those with lived experience.
- Increase renumeration.

Theme 2: Consultation is too long and complicated

Some respondents (individual respondents and health improvement organisations) feel that the Mental Health and Wellbeing Strategy consultation was too long and could have benefitted from being streamlined in some way. Further, some of these respondents feel that the language used in the Consultation Document may have been inaccessible for some people, particularly for the general public and service users. A suggestion is for greater use of plain English in future documents.

On the other hand, a few respondents welcomed the fact that the consultation was detailed and comprehensive.

Appendix C provides tables on levels of satisfaction with the consultation.

Appendix A: Individual Respondents

Table A.1: Age

Age (N=252)	Number	Percentage
18 to 24	8	3%
25 to 49	115	46%
50 to 64	101	40%
65 and over	28	11%

Excludes blank and not answered responses.
EKOS coded into age-groups based on responses to the question - What was your age on your last birthday?

Table A.2: Do you have a physical or mental health condition or illness lasting or expected to last 12 months or more?

Physical or mental health condition (N=238)	Number	Percentage
Yes	133	54%
No	105	43%
Prefer not to say	7	3%

Excludes don't knows, blank and not answered responses.

Table A.3: Does this condition or illness affect you in any of the following areas?

Type of organisation (N=133)	Number	Percentage
Mental health	96	72%
Mobility (e.g., walking short distances or climbing stairs)	44	33%
Stamina or breathing or fatigue	34	26%
Learning or understanding or concentrating	31	23%
Memory	29	22%
Socially or behaviourally (e.g., associated with autism, attention deficit disorder or Aspergers' syndrome)	21	16%
Other	21	16%
Dexterity (e.g., lifting or carrying objects, using a keyboard)	18	14%
Hearing (e.g., deafness or partial hearing)	15	11%
Vision (e.g., blindness or partial sight)	2	2%
None of the above	22	17%

Question was asked if respondent stated yes to question set out at Table A.2.
Multiple response question where respondents could select more than one option and all that applied.

Table A.4: Does your condition or illness reduce your ability to carry-out day-to-day activities?

Does condition affect day-to-day activities (N=139)	Number	Percentage
Yes, a lot	51	37%
Yes, a little	60	43%
Not at all	28	20%

Question was asked if respondent stated yes to question set out at Table A.2.

Table A.5: What is your sex? If you are considering how to answer, use the sex recorded on one of your legal documents such as a birth certificate, Gender Recognition Certificate, or passport. Please tick one

Sex (N=246)	Number	Percentage
Female	174	71%
Male	64	26%
Prefer not to say	8	3%

Excludes blank and not answered responses.

Table A.6: Do you consider yourself to be trans, or have a trans history?

Trans or have a trans history (N=242)	Number	Percentage
Yes	5	2%
No	229	95%
Prefer not to say	8	3%

Excludes blank and not answered responses.

Table A.7: Which ethnic group do you belong to?

Ethnic group (N=116)	Number	Percentage
Scottish	74	64%
Other British	25	22%
Other ethnic group	8	7%
Indian, Indian Scottish or Indian British	3	3%
Any mixed or multiple ethnic group	2	2%
African, African Scottish or African British	1	1%
Irish	1	1%
Pakistani, Pakistani Scottish Or Pakistani British	1	1%
Polish	1	1%
Arab, Arab Scottish or Arab British	0	0%
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	0	0%
Black, Black Scottish or Black British	0	0%
Caribbean, Caribbean Scottish or Caribbean British	0	0%
Chinese, Chinese Scottish or Chinese British	0	0%
Gypsy/Traveller	0	0%

Excludes blank and not answered responses.

Table A.8: Which of these options best describes how you think of yourself?

How you think of yourself (N=226)	Number	Percentage
Heterosexual/Straight	202	89%
Bisexual	10	4%
Gay/Lesbian	8	4%
Other	6	3%

Excludes blank and not answered responses.

Table A.9: What religion, religious denomination or body do you belong to?

Religion (N=235)	Number	Percentage
None	153	65%
Church of Scotland	31	13%
Other Christian	21	9%
Roman Catholic	16	7%
Pagan	6	3%
Jewish	3	1%
Muslim	2	1%
Buddhist	1	0%
Sikh	1	0%
Hindu	1	0%

Excludes blank and not answered responses.

Appendix B: Publishing of Consultation Responses

Of the 495 validated consultation responses:

- 172 selected “publish response (with name)”, including 123 organisation respondents and 49 individual respondents.
- 247 selected “publish response only (without name)”, including 67 organisation respondents and 180 individuals.
- 51 selected “do not publish”, including 15 organisation respondents and 36 individual respondents.
- 25 respondents did not provide a Respondent Information Form, including 21 organisation respondents and four individual respondents.

Appendix C: Satisfaction with the Consultation

Table C1: How satisfied were you with this consultation?

Satisfaction (N=216)	Individuals	Organisations	Total
Very satisfied	40%	36%	39%
Slightly satisfied	43%	40%	42%
Neither/nor	0%	0%	0%
Slightly dissatisfied	10%	22%	14%
Very dissatisfied	7%	1%	5%

N=149 individuals and 67 organisations responded. Excludes blank responses.

Table C2: How would you rate your satisfaction with using this platform (Citizen Space) to respond to this consultation?

Satisfaction (N=216)	Individuals	Organisations	Total
Very satisfied	60%	45%	55%
Slightly satisfied	30%	37%	32%
Neither/nor	0%	0%	0%
Slightly dissatisfied	7%	15%	10%
Very dissatisfied	3%	3%	3%

Note: 149 individuals and 67 organisations responded. Excludes blank responses.

Appendix D: Outcomes

Table D.1: Mental health and wellbeing

Early intervention for those identified with a mental health condition	Reduction in self-harm
Improved mental health and wellbeing.	Reduction in attempted suicide
A reduction in the number of people adversely affected by poor mental health and wellbeing	Reduction in suicide rates
People can have open and honest conversations about their mental health and wellbeing at all levels	People who live with mental health problems or illness have an increased sense of belonging and self-worth are included and have their rights respected
More people feel able to reach out for help and support	People across Scotland have knowledge, understanding and empathy around mental health and mental illness.
Increased understanding and awareness of mental health, mental wellbeing, and mental illness	People are confident to have conversations about mental health and mental illness
Promoting and supporting good mental health	People can speak openly about their mental health problems or illness without judgement or fear of being dismissed or treated unfairly.
People are happier	People are treated with compassion and receive the right help and support fast
People feel equipped to look after their own mental health and wellbeing	People who experience mental health problems or illness experience fair and equitable access to and experience of services and sources of support
People are better able to cope/manage	Reduction in self-harm
Less stigma and discrimination	People supported at home or as close to home as possible through their own self-management of through the support of people around them including institutions such as schools, colleges or workplaces

Table D.2: Mental health and wellbeing supports and services

People know where to go to get support for mental health and wellbeing	Services provide a seamless care as possible even where different teams or professions are involved in providing the service
More accessible services and support	Services have a learning culture that identifies what works and put it into practise and stops doing what doesn't work
Reduced waiting times for mental health services	People feel listened to by health professionals
Person-centred care	Satisfaction levels with mental health services
People can access the type of support that works for them and their life when and where they need it	Increased links/connections/coordination/ integration between primary care, community services and the third sector
Services follow a human-rights approach	Local communities supported by universal services working together in partnership to address factors that support mental wellbeing and reduce mental distress
Services have peers or people with lived experience of mental illness as part of the service	A cohesive, whole system approach
Services promote choice to support the needs of the person	

Table D.3: NHS

Reduction in mental health referrals	Reduction in the cost of poor mental health on the NHS
Reduction in admissions to mental health hospitals/units	A well-trained workforce
Lower inpatient population	A diverse workforce
Reduction in prescribed medication (e.g. for depression and anxiety, etc)	

Table D.4: Wider outcomes

Reduced health inequalities.	Reduction in absenteeism in the workplace or school
Poverty reduction.	Increased productivity
Improved life circumstances.	Reducing addiction
Increased adoption of healthy behaviours (e.g. physically active, eating well, etc).	Reduced rates for detention under the Mental Health Act
Improvement in the physical wellbeing of people with mental health problems	Violence and crime reduction
Access to good quality housing	Reduced reoffending rates
Improved quality of live	Poverty reduction
People are living more fulfilled lives	Increased life expectancy / reduction in the life expectancy gap
Increased levels of participation in society	Fewer deaths related to mental illness
People are more resilient	Reduced mortality
Increased employment rates	Lower prison population
Less bullying	Lower levels of homelessness

Appendix E: Case Study Examples

This appendix relates to Part 20 (our Immediate Actions) and Question 17.4 - Do you have any examples of different ways of working, best practice or case studies that would help support better workforce planning? For example, increasing the use of advanced practitioners. Please specify.

Table E1: Workforce Planning Case Studies

Case Study	Respondent Description	Further Information
Scotland		
CAMHS Unscheduled Care Nurses, NHS Lothian	These nurses support the Paediatric Emergency Department in Edinburgh and invest significant time in the care of patients.	https://weare.nhslothian.scot/camhs/
Milestone, Edinburgh	A multi-agency partnership that provides a step-down service (12 week programme) for people with Alcohol-related brain damage (ARBD) who have been discharged from hospital. The service is managed by the third sector with input from Primary Care, Psychologist and Allied Health Professionals.	https://www.waverleycare.org/news/spotlight-milestone
Staff Wellbeing Service, NHS Tayside.	-	https://www.nhstayside.scot.nhs.uk/YourHealthWellbeing/PROD_337142/index.htm
Peer Support Worker Tests of Change, Renfrewshire HSCP and NHS GGC	Peer workers and the third sector deliver high quality support which meets needs and delivers positive outcomes for people.	https://www.matter-of-focus.com/evaluation-of-the-peer-support-test-of-change-east-renfrewshire-health-and-social-care-partnership/
Primary Care Peer Workers, Angus	This service places people with lived experience in GP Practices, providing recovery focussed support that promotes self-management.	https://www.academymedicalcentre.co.uk/mhwns.htm
South Ayrshire Self-Harm	These services place third sector staff in schools, working alongside young people, schools and families in a holistic way.	https://southayrshirecmhw.co.uk/services/penumbra/
The Neuk Perth, Crisis Centre	Employ wellbeing mentors.	https://anchorhouseperth.org/the-neuk-mental-health-crisis-centre/

The Primary Care Improvement Programme, NHS Lanarkshire	It has an excellent model for developing and training Advanced and Trainee Advanced Nurse Practitioners.	-
Distress Brief Intervention Pilot Programme	Programmes such as Distress Brief Intervention (DBI) can support people in distress to access support quickly – initiatives and approaches such as this can intervene early, reduce distress for people and reduce the number of people on waiting lists across much of Health and Social Care.	https://www.gov.scot/publications/evaluation-distress-brief-intervention-pilot-programme/
The Rivers Centre	-	https://pubmed.ncbi.nlm.nih.gov/31730228/
IHV Perinatal and Infant Mental Health Champions' training programme	The Institute of Health Visiting (IHV) is currently delivering a bespoke training programme, commissioned by NHS Education for Scotland, to train 220 perinatal and infant mental health champions within health visiting and maternity services. The aims of the training are to build advocacy for both perinatal and infant mental health, making a clear link between infant and parental mental health through developing an understanding of the evidence around perinatal and infant mental health (PIMH).	https://ihv.org.uk/training-and-events/training-programme/pimh-champions-training/
Elsewhere in the UK		
Bromley by Bow Service	-	https://www.bbbc.org.uk/services/
International		
Alaskan Nuka System	-	https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska
The Trieste System	-	https://www.coe.int/en/web/bioethics/-/trieste-model-open-door-no-restraint-system-of-care-for-recovery-and-citizenship-