A Review of Mental Health Services in Scotland: Perspectives and Experiences of Service Users, Carers and Professionals

Report for Commitment One of the Mental Health Strategy for Scotland: 2012 - 2015
Acknowledgements

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Authors

Isabella Goldie, Joanne McLean, Amy Woodhouse, Jessica Shields, Julie Cameron, Hannah Biggs and Lee Knifton (Mental Health Foundation).

Specialist Reviewers

Hugh Hill, Rob Wrate, Graham Morgan, Gordon Johnston and Carolyn Little (the biographies of each of the Specialist Reviewers can be found in Appendix 1).

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Contact

For further information about this report email Lee Knifton, Head of The Mental Health Foundation for Scotland, at Lknifton@mentalhealth.org.uk
## Contents

1. Summary ............................................................................................................................. 5
2. Introduction ......................................................................................................................... 9
3. Methods ............................................................................................................................ 12
4. Findings ............................................................................................................................ 14

4.1 Scotland’s mental health and wellbeing: an overview .............................................. 14
4.2 Key mental health policy and programme developments ........................................... 16
4.3 The Mental Health (Care and Treatment) (Scotland) Act 2003 ............................... 18
  4.3.1 Views towards the Mental Health (Care and Treatment) Act 2003 .................. 19
4.4 Scotland’s mental health strategies and policy developments ...................................... 25
4.5 Welfare reform ............................................................................................................. 33
4.6 Service users and carers .............................................................................................. 34
4.7 Recovery ........................................................................................................................ 40
4.8 Stigma and Discrimination .......................................................................................... 43
4.9 Inequalities ..................................................................................................................... 47
4.10 Suicide prevention and self-harm ................................................................................ 51
4.11 Advocacy ...................................................................................................................... 53
4.12 Funding, commissioning and service design .............................................................. 55
  4.12.1 Mental health service funding ............................................................................ 55
  4.12.2 Strategic commissioning and integration of health and social care .................. 61
4.13 Mental Health Services Development and Delivery .................................................. 64
  4.13.1 Workforce and culture ....................................................................................... 64
  4.13.2 Acute mental health service experiences ........................................................... 66
4.14 Specialist services ....................................................................................................... 71
  4.14.1 Children and young people services ................................................................. 71
  4.14.2 Perinatal mental health services ........................................................................ 78
  4.14.3 Dementia services .............................................................................................. 80
  4.14.4 Older adults ........................................................................................................ 82
  4.14.5 Forensic ............................................................................................................... 84
  4.14.6 Prisons ................................................................................................................. 84
  4.14.7 Specialist services .............................................................................................. 85
  4.14.8 Crisis services ..................................................................................................... 88
  4.14.9 Psychological services ....................................................................................... 89
4.15 Transitions and continuity of care

4.15.1 Integrated Care Pathways

4.15.2 Transitions between services

4.15.3 Continuity of care

5 Discussion

6 Appendices

6.1 Appendix 1: Specialist reviewer biographies

6.2 Appendix 2: Methods

6.3 Appendix 3: National mental health strategies’ commitments

6.4 Appendix 4: NHS Board strategies and priorities

6.5 Appendix 5: Commitment One area reviews: Practitioners’ discussion guide
1 Summary

This review has been undertaken for Commitment 1 of The Scottish Government’s Mental Health Strategy for Scotland: 2012-2015 to ‘commission a 10-year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland’. The aim of this review is to encourage reflection on the successes and challenges of the current mental health system in Scotland. This is not a systematic review of the evidence on the provision, impact and effectiveness of mental health services. Instead it highlights the real life experiences of people using services, families and carers, practitioners, commissioners and stakeholders.

The research team included specialist researchers from the Mental Health Foundation and five expert reviewers who brought perspectives and experience from the third sector, clinical service provision and management, caring and lived experience of mental health conditions. In total our review took evidence from 384 participants with over half of the participants having a lived experience of using mental health services. Data was collected from five sources in a staged process:

- Documentary review of policy and service related literature.
- Service mapping.
- Site visits in inquiry areas of the following NHS Boards: Ayrshire & Arran, Forth Valley, Greater Glasgow & Clyde, Highland and Lothian, where 66 meetings were held with commissioners, managers, practitioners, voluntary sector representatives, service users and carers.
- Expert interviews with national policy makers, programme leads, subject specialists, academics, national voluntary sector representatives, user and carer organisations.
- Focus groups with people with lived experience of using mental health services and carers in Glasgow, Galashiels, Dumfries and Aberdeen.

Our report found broad support among participants for Scotland’s national strategic approach to mental health policy-making as responsive, enduring and collaborative. Legislation and many service developments have achieved a substantial positive impact. Public mental health programmes such as the Scottish Recovery Network, See Me, and Choose Life were seen as continuing to have an impact today. Regionally the picture was felt to be more variable, with the need for a more coherent framework to be adopted and implemented consistently, whilst acknowledging the reality of the geographic challenges.

The overall findings in this report indicate that the general direction of mental health services over the last ten years has been positive, with an appreciation that there has been change for the better. There continue to be challenges but respondents provided an extensive range of examples of where they felt progress had been made. These include:

- Advocacy services
- Dementia diagnosis
- Crisis services
- Early intervention for psychosis
- Specialist trauma services
• Support for veterans
• Support for early years including mother and baby units
• Access to psychological therapies
• Access to peer support
• Stigma and discrimination
• Suicide prevention
• Involvement and engagement with those who use services and who care for them
• Embedding of the recovery model into service delivery,
• More focus in policy and practice on mental health inequalities.

The report findings also highlight areas where there has been positive progress but where there are opportunities for further development. These are discussed in more detail in the report but include:

• A systematic approach to ensuring that prevention informs the way that we design and fund health systems, services and public mental health.
• Addressing mental health inequalities and responding to the mental health needs of vulnerable groups especially asylum seekers and refugees, ethnic minorities, carers, low-income households, homeless citizens, offenders, people with long term physical health conditions, LGBT citizens and looked after children and care leavers.
• Ending the mortality and morbidity gaps experienced by people with long-term mental health conditions.
• Building upon the successes of The Mental Health (Care and Treatment) (Scotland) Act 2003 to promote advance statements among service users, carers and staff.
• Ensuring that the increased uptake of advocacy in the last decade is accessible for marginalised communities and across different regions.
• Building upon the success of our strong national service user voice, including Voices of Experience, to ensure that involvement is more systematically inclusive at regional level for all aspects of strategic and operational planning.
• Ensure Scotland’s carer movement is supported to influence national and local policy, recognising the specific needs of those caring for someone with a mental health condition.
• Further develop and apply outcome-based measures that are co-produced with people who use services.
• Interactions with mental health professionals were broadly positive amongst service users, carers and representative groups. Ensure that any future restrictions on funding do not negatively affect staff culture by reducing staff time with service users.
• The Scottish Recovery Network has improved mental health services by raising aspirations of people with mental health conditions, engaging practitioners and promoting recovery-oriented practices. Continue to explore the relationship between recovery, citizenship and human rights approaches.
• Consider why peer support does not yet appear to have achieved its potential as a transformative approach and how we can increase ‘lived experience’ leadership.

• Tackling stigma and discrimination remains an overriding priority for service users. See Me was felt to have reduced stigma in the last decade. There was support to focus upon stigma in general and mental health services, job centres, schools, community groups and the police. Consider different approaches required for the stigma associated with different mental health conditions.

• Suicide rates in Scotland have fallen over the last decade, but remain higher among men and those from areas of multiple deprivation. There was broad support for suicide prevention as a national priority and for the approaches adopted by Choose Life (2002-12) and the Suicide Prevention Strategy (2013-16). We should ensure that suicide prevention training is taken up by all key workers.

• Self-harm in Scotland was viewed as a public health concern with associated implications for services. High levels of stigma, including blame, were reported in accident and emergency services. Promising initiatives to reduce self-harm and the stigma that can be apparent when seeking help, were identified to build upon.

• There were mixed experiences of local strategic planning for health and social care integration. However, there was optimism about the potential for integration to bring about positive change through clearer direction and greater involvement of service users and carers, provided it does not create further bureaucracy.

• The report outlines overall increases in national spending on mental health but with significant regional variation. However, several GPs, primary care mental health teams and NHS Board senior managers reported experiencing reductions in funding for specific services such as drop-in centres and counselling services, staffing and transport. Voluntary sector participants described uncertainty about the security of future funding but reported some positive experiences of securing funding through joint commissioning processes. Further exploration is needed to accurately understand the regional variance in spending on mental health.

• The past decade has seen a reduction in inpatient bed numbers, while occupancy rates have remained stable at around 80%. There was broad agreement that the conditions of inpatient facilities have been significantly improved. Significant variations exist across Scotland in bed numbers and average lengths of stay, which requires further analysis and consideration.

• Some participants with severe and enduring mental health conditions reported increased social isolation. This might be linked to unintended consequences of positive shifts towards more personalised approaches and centralised specialist services and needs to be monitored carefully.

• Participants report improvements in the transitions between CAMHS and adult services. Positive developments include specialist teams supporting looked after and accommodated young people, young people that self-harm and Early Intervention in Psychosis teams. However, access to such services remains limited, especially outside of major cities.

• Participants report increased demand in the past decade for CAMHS including inpatient psychiatric care. Admission of young people to adult wards has not
reduced and varies considerably by region. Suggestions for improvement included focusing upon prevention and early intervention, addressing gaps in crisis responses, and stronger connections between in-patient and community teams.

- Explore how to enhance transitions between hospital and community services, and between services across the life-course of paediatric, CAMHS, adult and elderly services.
- There was broad appreciation of the considerable achievements of Scottish Government policies, strategies and commitments in relation to dementia over the last ten years however it is important to renew our national focus upon older adults’ non-dementia related mental health in national government strategy.
- Specialist mental health services for veterans, trauma, homelessness and asylum seekers and refugees, have helped to address the multiple and complex needs of those who fall between gaps in existing services. This has been achieved through peer support approaches alongside holistic working to reconnect individuals with their communities through housing, employment and welfare support. Integration between health and social care was seen as an opportunity to address limited capacity, whilst informing the development of general services.
- The current refugee crisis makes the case for addressing the mental health needs of asylum seekers and refugees a priority. But the needs of all groups who experience very poor mental health should be addressed across policy directorates.
2 Introduction

The Mental Health (Care and Treatment) (Scotland) Act 2003 was passed by the Scottish Parliament in March 2003. The overarching aims of this legislation were to enshrine in law when and where people could be treated, provision for when people needed to be treated against their will and safeguards to protect the rights of the person receiving treatment. At that time, Dr Sandra Grant was invited by the Minister for Health and Community Care to undertake a review of services within Scotland to assess readiness for implementation of the terms of this new and ambitious legislation. The Sandra Gant Report, National Mental Health Services Assessment: Towards implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003\(^1\), made recommendations for improvements that went on to provide some strategic direction to newly emerging Scottish Executive [Government] mental health policy, including Delivering for Mental Health\(^2\), Towards a Mentally Flourishing Scotland\(^3\) and the Mental Health Strategy for Scotland: 2012-15\(^4\).

The central remit of the Sandra Grant Report was:

‘To undertake a comprehensive assessment of existing mental health service provision and consider how the current range of facilities, augmented by the substantial additional resources now coming on stream, can meet the objectives of the Mental Health (Care and Treatment) (Scotland) Act 2003.’

Stigma was the most frequently mentioned issue for service users and carers, alongside the inpatient environment and lack of crisis services. From the findings, a set of conclusions and recommendations were produced and are summarised below:

- Consultation and involvement around the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 had worked well and the report looked forward to the development of priorities for Joint Local Implementation Plans.
- The implementation of the Act could be inhibited by major staff morale, attitudinal and cultural problems. The report recommended that service users and carers work jointly with staff to ensure the principles of the Act were adhered to; front line staff should be given more authority, responsibility and accountability to lead change; and the Scottish Executive should avoid producing further mental health policies at that time to enable a focus on the implementation of the Act.

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\(^1\) Scottish Executive (2004) National Mental Health Services Assessment: Towards implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003
• Serious problems in accessing data about inpatient and community mental health services were identified and it was recommended that a mental health information strategy with an agreed minimum data set be collected and used to inform delivery and quality decision making.

• Inequities in access to standard levels of high quality service across Scotland were identified with recommendations for 24 hour support services; community support for everyone with a serious mental health condition; and access to local inpatient care which has a good physical environment and day activities, is age appropriate and provides for specialist needs.

• Workforce gaps were identified as potential barriers to fulfilling the obligations of the Act with recommendations for clarity on multidisciplinary roles, responsibilities of staff and senior managers and investment in developing skills to implement the Act.

• In the context of insufficient, non-standardised and unclear information about the funding of mental health services, there was a perception that services are underfunded. Without good information, making the case for increased funding was difficult. A national and local standardised and transparent financial recording system was recommended to enable tracking of spend and development of clear business cases for future investment alongside increased prioritisation of mental health service resource allocation.

The Scottish Government’s *Mental Health Strategy for Scotland: 2012-2015* sets out a range of commitments covering a spectrum of mental health improvement, services and self-management approaches, aimed at driving the delivery of effective care and treatment options for people with mental health conditions, carers and families. This report relates to Commitment 1 of the strategy ‘to commission a 10-year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland’.

The aim of this review is to encourage reflection on the successes and challenges of the mental health system in Scotland in 2014/15 based on the experiences of those who work within it and, crucially, are users of it. The review was not intended to form a systematic review of the evidence on the provision, impact and effectiveness of mental health services. Rather, the remit was to explore and capture the real life experiences of those using services and the reality of working in, managing and commissioning services, taking cognisance of the issues raised and identified by the Sandra Grant Report. The review attempts to describe mental health service developments over the past ten years, including national initiatives and local service models aimed at treating and supporting those with mental health conditions. Therefore whilst this report does not provide definitive conclusions about the nature or impact of mental health services across Scotland, it provides valuable insights to help support future national strategic direction and raises key issues that warrant further exploration.

The mental health service system is complex and as such comprises a high level of diversity of approach, opinion and experience both between and within different service areas and geographies. In recognition of this, the data informing this review is drawn from a range of sources, including local mental health service site visits, where staff and service users were consulted; interviews with mental health service experts working in the voluntary and statutory sectors; focus groups with service user and carer groups; published literature; and
service mapping data. The sources of the findings presented are referenced throughout this report. Throughout the review, particular attention was given to listening to what service users and carers had to say about their experience of services.
3 Methods

The review team

An important feature of this review was the diverse membership of the research team, who brought together a range of perspectives and experiences. The expertise selected for the research group included specialist mental health researchers from within the Mental Health Foundation and five expert reviewers who brought experience that included third sector and clinical service provision and management, caring and lived experience of mental health conditions. Expert reviewers brought to the process an informed view of services, gained from the reality of working within and using these services, and were selected through a competitive process based on their additional knowledge of national initiatives or experience working on other similar national reviews.

Data collection process

Data was collected from five sources in a staged process as follows:

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<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td>Stage 1</td>
<td>Documentary review of policy and service-related documents and literature</td>
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<tr>
<td>Stage 2</td>
<td>Service mapping survey: descriptive evidence</td>
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<tr>
<td>Stage 3</td>
<td>Local site visits: contextual evidence from service providers, those who use services and those who care for them</td>
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<tr>
<td>Stage 4</td>
<td>Expert opinion interviews: specialist professional evidence</td>
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<td>Stage 5</td>
<td>Service user and carers focus groups: evidence from experience</td>
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This approach enabled us to iteratively analyse different types of data drawn from a broad range of sources and perspectives. Data collection templates were developed for stages 3, 4 and 5 of the data collection process. Emergent themes from the literature and mapping data informed the focus of the site visits, which in turn informed the development of questions for the expert interviews and service user and carer focus groups. Questions focussed on the successes and challenges of the mental health system; key developments over the past ten years; drivers for and barriers to change; and the extent to which service users and carers are involved and feel that their needs have been met. The five stages of data collection and the limitations of the review are described in detail in Appendix 2.

Analysis

The data obtained was synthesised to draw out a series of central themes that have been applied to create a framework for the structure and content of this report. Data from the five sources was collated and, using a staged content process, was coded to generate and develop key themes. A triangulation approach was applied to the data analysis to validate strong emergent themes in the findings, through cross-verification between written materials,
local case studies, expert opinion and service user and carer data. This was an organic process but one that looked systematically at themes emerging within and across the evidence sources rather than the validation of specific statements. The main analysis was conducted by the Mental Health Foundation research team in consultation with the expert reviewers.

Strengths and limitations

This was not a systematic review of all existing evidence on the provision, impact and effectiveness of mental health services. This report does not provide definitive conclusions about the nature or impact of mental health services across Scotland. The data is not fully comprehensive or representative and therefore it is not possible to make generalisations from the findings with a strong degree of confidence. However the review provides valuable insights into the realities of working in, using and commissioning mental health services in Scotland today. The data reflects the complexities of the mental health service system. It represents a breadth of interests and individual views, from a range of service user, carer, professional, policy and managerial perspectives. When these perspectives are combined with documentary evidence, there is a rich body of evidence from which to draw conclusions and raise key issues that warrant further exploration.

The range of sources and perspectives included in the data collection and analysis processes enabled some triangulation and, hence, an added layer of rigour to the findings. This approach provided the review team with a broader understanding of the complexities of mental health service provision and use and what the current successes, priorities and concerns were for those involved. A further strength was the diversity of experience within the review team, which purposefully included individuals able to talk about their experiences as a service user, a mental health services clinician, a carer, and a voluntary sector mental health professional with previous NHS commissioning experience.

Efforts were made to ensure that those participating in providing data for the review were as representative of the above experiences as possible within the practical limitations of review resources. Site visits were selected to build in some representations of different geographical and specialist provision characteristics. Participation in the review for data collection stages 3, 4 and 5 was optional. The data provided throughout the process tended to focus on adult service provision and treatment, rather than prevention and early intervention. This was not entirely unexpected as more upstream approaches are still in an earlier stage of development. Therefore, although attempts were made to engage with emerging work on prevention and early intervention, it was not possible to do justice to this agenda within the scope of this review.
4 Findings

4.1 Scotland’s mental health and wellbeing: an overview

It is difficult to obtain accurate figures presenting the prevalence of mental health conditions in Scotland at any given time. One reason is that many people who have mental health conditions do not seek help from traditional mental health services. Large scale national surveys estimate the prevalence of mental health conditions at population level. The Scottish Health Survey monitors the health of people in Scotland and was carried out in 1995, 1998 and 2003. In 2008, the continuous Scottish Health Survey began and data was collected annually between 2008 and 2015. Since 2012 the survey provides data from a representative sample of the general population living in private households, however this may underrepresent people who do not live in private households, particularly older people and those with serious health conditions. The Attitudes to Mental Health in Scotland: Social Attitudes Survey 2013 provides self-reported data on the prevalence of mental health conditions across the life course. Data from both of these surveys is presented below.

The General Health Questionnaire (GHQ12) is a widely used self-completion screening instrument for common mental health conditions. The results of this questionnaire can be used to estimate the prevalence of mental health conditions at population level. A score of 4 or more indicates the possible presence of a mental health condition. The Scottish Health Survey has included the GHQ12 since 1995. GHQ12 scores are shown below by gender, by year, by age and by NHS Board. From the data presented in Figure 1, around 15% of the general population of Scotland has a GHQ12 score of 4 or more, suggesting the presence of a diagnosable mental health condition. This figure has remained stable between 2003 and 2012. Scores tended to be higher among women, with an average of 17% reporting a score of 4 or more, and lower among men, with an average of 13% reporting a score of 4 or more.

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6 Prevalence refers to the number of people experiencing a mental health condition at a single point in time.
The Scottish Government is also concerned with mental wellbeing levels across the whole population. Therefore, since 2008, the Scottish Health Survey has included the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), a scale of 14 positively-worded statements designed to provide a population measure of mental wellbeing. The average score of adults on the Warwick-Edinburgh Mental Wellbeing Scale is a national indicator of performance, with the goal of increasing the mean WEMWBS score for Scotland. The mean WEMWBS score for the population of Scotland recorded by the Scottish Health Survey in 2012 was 49.9 (Figure 2). These scores indicate broadly positive mental wellbeing across the population, with little difference between men and women or across the life course. These figures have remained consistent since 2008 and are comparable with the mean WEMWBS score of 51 calculated for the population of England by the Health Survey for England 2013. However, the validity of these findings has been questioned due to the lack of sensitivity in highlighting the difference in wellbeing among the groups most at risk of poor mental health. One recent example is the 2014 CMO report on public mental health by Dr Sally Davies [England]⁷.

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The 2013 Scottish Social Attitudes Survey provides the most up-to-date data on the self-reported incidence of mental health conditions\(^8\). Of the 1,497 participants, 21% reported ever having experienced a mental health condition. However, when asked to select the mental health condition that they had experienced from a list of diagnoses, 32% of respondents identified one or more items from the list. It may be that participants did not recognise their experience as a mental health condition and so did not identify as having experienced a mental health condition.

Several additional studies and surveys in the last decade highlight how poor mental health, including stigma and discrimination, is disproportionately more common among those who experience multiple disadvantages. For example, Glasgow Centre for Population Health\(^9\) utilised 51 indicators of mental health and wellbeing at individual, community and structural levels (ranging from social support to violence) to develop mental health profiles across Greater Glasgow and Clyde. Findings reinforced the evidence of severe mental health inequalities that exist, especially for experiences of depression, anxiety, addiction and violence, and the links between poor physical and mental health. It indicates the need to focus on reducing inequalities especially with regard to poverty and gender. The impact of poverty on mental wellbeing is also identified in the national Equally Well review in 2008\(^10\), including the high social, economic and health burden it imposes. The report also highlights the variance in mental health trends between men and women and inequalities in mental health experienced by LGBT citizens. Others who experience discrimination and adverse life circumstances, who may be more at risk of poor mental health outcomes, include looked after and accommodated young people; offenders, including female prisoners; survivors of abuse; teenage mothers in the first few years after childbirth; some ethnic minority communities\(^11\); and asylum seekers and refugees, who experience major issues related to social circumstances, discrimination and pre-migration trauma\(^12\).

### 4.2 Key mental health policy and programme developments

Since the Sandra Grant Report, a number of innovative programmes and policies have been created in Scotland, garnering international recognition for their role in moving the mental health landscape forward. The major milestones are described here to help orient the reader and contextualise the findings that follow:

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\(^8\) Scottish Government (2014) Attitudes to Mental Health in Scotland: Scottish Social Attitudes Survey 2013  
\(^9\) Shipton D and Whyte B (2011) Mental Health in Focus. Glasgow Centre for Population Health  
\(^12\) Quinn N (2014) Participatory Action Research with Asylum Seekers and Refugees Experiencing Stigma and Discrimination: the experience from Scotland. Disability and Society, 29,1, 58-70
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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| 2003 | Mental Health (Care and Treatment)(Scotland) Act 2003 passed  
National Programme for Improving Mental Health and Wellbeing Action Plan 2003-06 launched  
National Programme Team established in Mental Health Division  
SNAP Needs Assessment report of the mental health needs of children and young people  
Doing Well By People With Depression launches |
| 2004 | HeadsUpScotland commences  
Breathing Space extends Scotland-wide  
Scottish Recovery Network formally launched  
Well? What Do You Think Survey? |
| 2005 | Mental Health (Care and Treatment)(Scotland) Act 2003 implementation begins  
The Mental Health of Children & Young People: A Framework for Promotion, Prevention, and Care  
Launch of Scottish Mental Health First Aid across Scotland  
Launch of WellScotland website  
Mental Health Tribunal for Scotland created |
| 2006 | Delivering for Mental Health published  
GIRFEC launched  
Well? What Do You Think? Survey  
Doing Well By People with Depression finishes  
WEMWBS launched |
| 2007 | National Programme for Improving Mental Health and Wellbeing finishes  
SHAW becomes Scottish Centre for Healthy Working Lives  
Adult Mental Health Indicators launched |
| 2008 | HeadsUpScotland finishes  
Mental Health Collaborative launches  
End of Choose Life Phase Two  
Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem |
| 2009 | Equally Well published  
Early Years Framework published  
Towards a Mentally Flourishing Scotland 2009-2011 published |
4.3 The Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003\(^{13}\) came into force in 2005 and was recognised as one of the most advanced pieces of mental health legislation in the world, particularly with regards to respect for human rights\(^{14}\). In 2009, the McManus Review\(^{15}\) appraised the implementation of the Act, with specific regard to its adherence to the ten Millan Principles\(^{16}\) which informed the development of the Act. The McManus Review found many aspects of the Act’s implementation were working well and support for the Millan Principles was widespread, but problems remained. These included:

- Low take up of advance statements

• Patchy availability of independent advocacy
• Lack of clarity about the Named Person role and dissatisfaction with inability to opt out
• The number of multiple hearings occurring in the Mental Health Tribunal System, as well as a perception of excess formality and the availability, quality and style of legal representation.

The McManus Review outlined a series of recommendations to address these issues, which were subsequently supported by the Scottish Government 2010 consultation\(^17\). In 2010, the Scottish Government published its official response to McManus\(^18\), proposing key changes to the Act:

• A statutory duty on NHS boards and local authorities to promote the use of advance statements, hold up to date statements within patients’ medical records and send copies to the Mental Welfare Commission
• Provide clearer ‘total opt out’ from having a Named Person for service users
• Introduce a new system for compulsory treatment orders, based on medical reports obtained from an Approved Mental Health Professional and patient’s GP where possible
• Remove the existing 9 month Suspension of Detention limit in the Act
• Increase to 10 working days the current time limit of 5 working days from expiry of a short term detention certificate to a hearing for a Compulsory Treatment Order (CTO).

In its response to the McManus Review, the Scottish Government introduced the Mental Health (Scotland) Bill which was passed by parliament in 2015. They also described ways that other recommendations, which did not require changes to legislation, could be implemented.

### 4.3.1 Views towards the Mental Health (Care and Treatment) Act 2003

Review participants indicated strong ongoing support for the Mental Health (Care and Treatment) (Scotland) Act 2003, particularly with regard to its focus on the Millan Principles. Individual aspects of the Act that were specifically welcomed included the introduction of Tribunals, opportunities for advance statement and the right to independent advocacy. In


addition, the focus and tone that the Act had on empowerment and involvement was welcomed, viewed as having opened the door to give:

‘Service users more opportunity to challenge and to have more of a voice’.
- Staff, Panel Inquiry Area

Another positive element raised by review participants was that the Act had changed staff practice and approaches for the better. This was helped by holding widespread training on the legislation with existing staff and with students at undergraduate level.

Some review participants discussed how the introduction of the Act had initially brought substantial innovation to the sector. Staff from one NHS Board area discussed a play that was written and performed to inform people about the Act and experiences of the changes it instigated. In addition to discussing innovation, there was also widespread discussion by review participants about the extent to which the legislation had been fully implemented and ongoing gaps in implementation that were identified.

A number of issues arose relating to advance statements. These included:

- Perception that there is low knowledge and uptake of advance statements among service users
- Incidences of hospital staff ignoring or acting contrary to a patient’s expressed wishes without clear explanation or reason
- Advanced statements being lost and/or not placed in medical notes

Concern about the legitimacy given to advance statements was felt to be a factor in service users not using them19.

‘Will our advance statement be adhered to? [It] doesn’t seem worth it.’
- Service User, Panel Inquiry Visit

There were also concerns raised about the named person role, which was ‘not seen to be working well’ (carers service, panel inquiry visit). Despite general dissatisfaction that these elements of the Act had not met initial expectations overall, it was still felt that the Act had opened the door to greater service user and carer involvement.

‘Met a carer the other day, she was over the moon at the services she had received…she has been involved and consulted at every step of the process and can’t praise the staff highly enough.’
- Carer Service, Panel Inquiry Visit

Independent advocacy services were held in very high regard where they were available and were viewed as more legitimate because of the provision made within the Mental Health Act:

19 See also Mental Welfare Commission for Scotland for information on the use of advance statements and number of overrides [available at http://www.mwcscot.org.uk/publications/statistical-monitoring-reports/]
‘Advocacy is more accepted and it is less confrontational now – the issues are still there, but now people know what it is. With the Mental Health Act, people understand it. People challenge us less to find out why we are there in meetings. We need to keep that relationship.’

- Independent Advocacy Service, Panel Inquiry Visit

However, access to independent advocacy was felt by review participants to be limited and patchy, particularly for carers, children and young people, and older adults. Service users also indicated that seemingly different approaches were taken by different Tribunals and that levels of support around attendance were inconsistent. These views very much echo the findings of the earlier McManus Review, suggesting that, five years on from its publication, some of the same challenges with implementation of the Act persist.

Some review participants felt that the past 5 years had seen an erosion of some of the progress made by the Act. This was attributed to factors such as austerity and the impact it has had on service delivery; restructuring was seen to take time and energy away from service delivery. Wider initiatives, such as caring at home, have been very hard to implement, specifically in rural areas.

‘There was lots of innovation in the beginning when the act was being implemented but constant restructuring in the statutory sector has been a problem.’

- Staff, Panel Inquiry Visit

The number of new episodes of compulsory treatment in Scotland was the highest in the year 2013/14 compared with any other year since the Act was introduced. While the Mental Health Bill has provided an opportunity to revisit the Mental Health Act ten years on, it was felt that it did not appear to have fully explored the issue of how human rights can be further supported within law and practice.

‘I think there’s really interesting challenges ahead in terms of the noises the UN are making about the Convention on the Rights of Persons with Disabilities and what that means for compulsory treatment in mental health and suggesting that it’s discriminatory and that’s raised a lot of useful discussions which I think we should have been having a long time ago about the acceptability and prevalence of forced treatment.’

- Expert Interview

An approach reported as promising by several respondents was the Advance Statements Campaign, led by Mental Health Network (Greater Glasgow). People who have used

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20 See also Scottish Independent Advocacy Alliance (2014) A Map of Advocacy across Scotland. SIAA
21 Older adults are generally considered to be those aged 65 and over.
advance statements delivered short practical sessions and shared their experiences and resources to support others in developing their own advance statements\textsuperscript{23}.

**Use of the Mental Health Act**

Under the Mental Health (Care and Treatment) (Scotland) Act 2003, compulsory treatment may be provided to people who refuse to, or are unable to, consent to mental health treatment on a voluntary basis. People who are subject to a Compulsory Treatment Order (CTO) may receive this treatment in an inpatient setting (hospital-based) or on an outpatient basis, remaining in their own home (community-based).

Measured by incidence of CTOs\textsuperscript{24}, use of the Act has increased in Scotland in recent years, showing a general upward trend of 21\% over 5 years from 1765 CTOs in 2007/08 to 2137 in 2012/13 (Figure 8). The proportion of community-based CTOs has increased in recent years and now makes up around a third of all CTOs. However, the overall increase in number of CTOs and the relative stability of the number of hospital-based CTOs indicates that community-based CTOs may not be providing an alternative to hospital-based CTOs.

\textsuperscript{23} http://www.mhngg.org.uk

\textsuperscript{24} See also Mental Welfare Commission for Scotland for information on Compulsory Treatment Orders (CTOs) including what they are and how they are used. [available at http://www.mwcscot.org.uk/the-law/mental-health-act/compulsory-treatment-orders/]
Advance statements

Representatives of NHS Boards and mental health services reported that completion of advance statements was being actively encouraged with good uptake. While the potential for advance statements to improve involvement in care planning was acknowledged, advocacy and service user groups reported that advance statement uptake was low amongst their membership.

‘Advance statements are important and should be promoted more. But too many are overridden.’

- Panel Inquiry Visit

NHS Boards are required to notify the Mental Welfare Commission of instances when advance statements are overridden. Current good practice recommendations for overriding advance statements require the reasons for superseding the advance statement to be explained to the patient and for the patient and named person to be notified in writing. In addition, clinicians may override only on aspect of an advanced statement, for example, the
use of a certain psychotropic medication, whilst still following other aspects such as who looks after a patient's house. Most recent data from the Mental Welfare Commission states that they found advance statements to have been overridden 31 times in the 2013/14 time period and a total of 115 times since 2009. As data on the uptake of advance statements is not currently monitored, we are unable to discern the proportion that are superseded. However, there was a perception amongst service users that advance statements were being overridden too often and without explanation. This perception may be a factor in the limited uptake of advance statements.

**Human rights**

The extent to which the review participants made reference to their human rights was limited. This is perhaps unsurprising as Griesbach and Gordon (2013) found that few mental health services users in Scotland were aware of their human rights, including those who had experience of compulsory treatment orders. The participants who did specifically refer to human rights tended to talk about CTOs, both the process of being detained under a CTO and the principle of compulsory treatment itself:

> 'When you are under section and they bring you in under that section you have the illusion that you have powers that you can use and that can represent you but in fact you have nothing'

- Panel Inquiry Visit

One participant spoke about their experience going through the tribunal process, highlighting their difficulties in accessing appropriate representation and having their voice heard.

Representatives of the mental health services visited during the panel inquiry visits described current work to reduce the incidence of physical restraint, including working with patients and visitors to wards to support them after episodes where restraint has been carried out. As statistics on the incidence of restraint are currently not publicly available in Scotland, we cannot tell whether these actions were having an effect on the overall incidence of restraint. Reducing the incidence of restraint is an area of national interest, led by the Patient Safety Programme.

Knowledge around and provision for supporting the rights of carers was also identified as a current area of weakness.

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4.4 Scotland’s mental health strategies and policy developments

The Mental Health Division was established by the Scottish Executive in 2003 to work to: promote good mental health and improve mental health services as set out in the Mental Health Strategy; improve services for people living with dementia, their families and carers, as set out in the Dementia Strategy; reduce suicide and self-harm; assume responsibility for and aid development of mental health law; and support Scottish Ministers’ statutory role in respect of restricted patients. The Division has been responsible for the development of mental health strategies and action plans since 2003, as summarised below:

- **Delivering for Mental Health** (2006). The delivery plan for Scotland set out 3 HEAT targets and 14 commitments for the development of mental health services in Scotland, with timescales for implementation ranging from one to seven years.

- **Towards a Mentally Flourishing Scotland: Policy and Action Plan** (2009-2011). The mental health improvement policy and action plan set out 22 commitments to promote good mental wellbeing across the lifespan, reduce the prevalence of common mental health conditions, suicide and self-harm and improve the quality of life of those experiencing mental health conditions.

- **Mental Health Strategy for Scotland** (2012-2015). The current mental health strategy sets out 36 commitments across mental health improvement, services and recovery to support the delivery of effective, quality care and treatment for people with a mental health condition, their carers and families.

In addition to the above, strategies for suicide prevention and dementia were produced.

The HEAT targets established within Scotland’s mental health strategies and action plans are presented in figure 4.

<table>
<thead>
<tr>
<th>Target</th>
<th>Introduced</th>
<th>Timescale for delivery</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10</td>
<td>2006</td>
<td>2009/10</td>
<td>Target not achieved by 2009/10 and reconsidered in 2010 (see footnote).</td>
</tr>
</tbody>
</table>

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27 [http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health](http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health)

28 HEAT targets are NHS Scotland’s targets for performance in the areas of Health improvement, Efficiency, Access & Treatment. See the Scottish Government website for further information [available at: http://www.gov.scot/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/HEATstandards/]


| **Reduce readmissions (within one year)** for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009 | 2006 | 2010 | 25% reduction on year ending Dec 2004 baseline
|---|---|---|---|
| **Deliver 18 weeks referral to treatment for psychological therapies from December 2014.** | 2013 | 2014 | Data from ISD shows that this target was met for 84.2% of patients in the quarter ending March 2015.
| **Suicide prevention** | |
| **Reduce suicides in Scotland by 20% by 2013** | 2002 | 2013 | Between 2000-02 and 2011-13, there has been an overall downward trend of 19.5% in suicide rates.
| **Reach 50% key frontline staff in mental health, substance misuse services, primary care, and accident and emergency trained in suicide prevention** | 2007 | 2010 | 52% key frontline staff trained by 2010
| **Child and adolescent mental health services** | |
| **Deliver 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks from December 2014** | 2010 | 2013/14 | 96% seen within 26 weeks against a target of 90% (as of end 2013)
| **Dementia** | |
| **Improve diagnosis rates for dementia** | 2008 | 2012 | By March 2012 in Scotland, around 64% of people with dementia were being diagnosed.
| **Deliver expected rates of dementia diagnosis by 2015/16. All people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support.** | 2013 | 2015/16 | No data yet available

Figure 4: Mental health related HEAT targets in Scotland (2003-2014)

The HEAT targets for access to psychological therapies, access to child and adolescent mental health services, and the provision of post dementia diagnosis support and rates of

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31 The target was withdrawn because of a lack of certainty that implementing evidence-based prescribing behaviour and improving access to non-drug treatments would lead to a reduction in antidepressant usage.

32 NHS Scotland (2012) HEAT Targets Due for Delivery in 2010/11: Summary of Performance

33 http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/data-tables.asp?id=1457#1457

34 http://www.scotpho.org.uk/health-wellbeing-and-disease/suicide/data/scottish-trends

35 NHS Scotland (2012) HEAT Targets Due for Delivery in 2010/11: Summary of Performance

36 NHS Scotland (2014) HEAT Targets Due for Delivery in 2012/13: Summary of Performance
dementia diagnosis have now become Local Delivery Plan (LDP) standards. LDP Standards are priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance.

We conducted a thematic analysis of the 72 individual commitments published across the three Scottish mental health strategies and action plans. We found:

- 51 commitments aimed at adults; 14 aimed at children and young people; and 7 aimed at older adults, of which 4 related to dementia
- A consistent emphasis on addressing persistent issues such as young people’s admissions to adult psychiatric beds, the physical health of people with mental health conditions and mental health related stigma and discrimination
- A consistent emphasis on service improvement in the following key areas: recovery and peer support, access to psychological therapies and crisis services
- Strategic commitment to dementia and suicide prevention in parallel strategies
- An increasing focus in more recent years on indicated target groups where there has been recognised gaps, such as infants, older adults, women with borderline personality disorder and veterans

There is a lack of data available to measure policy impact and develop firm conclusions about the effectiveness of different approaches in terms of improving mental health and wellbeing. This lack of evidence on policy impact is one that is not unique to Scotland, making it difficult to effectively learn from other countries.

In addition, some commitments, such as young people’s admissions to adult wards require further action. Other commitments, such as creating a suicide register for Scotland, have been achieved and priorities have progressed accordingly. Among review participants, there were many positive views about the direction of mental health policy in Scotland over the last ten years. Many welcomed the overall direction taken within Scotland, with progress being built on over time and commitments and priorities adjusted accordingly. There was also a sense that mental health was ‘much higher on the agenda’ across health policy and beyond.

‘I really like the way in which Scotland sets a policy, it looks to see what’s happening, makes it deliverable, makes it achievable, sees what’s happening and then moves on to the next stage’

- Expert Interview

HEAT targets (now replaced by Local Delivery Plan standards)

37 A full list of the 72 commitments is presented in Appendix 3
Among review participants, there was a marked difference in awareness of HEAT targets, with staff and managers having knowledge and most service users and carers being:

‘Unaware of HEAT targets and the importance the NHS placed upon them’

- Service User, Panel Inquiry Visit

However, there was wide support for many of the principles underpinning the targets, such as reducing waiting times. Although staff had positive views about the HEAT targets and acknowledged the role they played in driving forward improvements, difficulties in the implementation of the 18 week target for access to psychological treatment was discussed in three of the panel inquiry areas.

‘The 18 week target is a challenge’

- Staff, Panel Inquiry Visit

Although the HEAT targets focussed the agenda of NHS Boards within an environment of finite resources, it was also raised that this may be to the potential detriment of other areas that required improvements or redesign, but do not have a HEAT target attached.

Several participants felt that the current Mental Health Strategy appears more fragmented and less calculated than previous strategies, due to its attempts to address a large number of specific issues and individual target groups.

‘I’m slightly disappointed with the 2012-2015 Mental Health Strategy because I don’t think it moved us on sufficiently. I think it’s quite a disparate set of commitments that actually I’m not sure the total is more than the sum of the parts.’

- Expert Interview

Participants also suggested that there was less emphasis on promotion and prevention than in previous strategies, which was viewed as a backward move for wider mental health improvement. This appears to be reflected in the evidence provided throughout the review process, whereby wider public mental health approaches, such as prevention, did not feature strongly.

**Approaches to improvement**

The Scottish Government published *Better Health Better Care* in December 2007\(^\text{40}\). This set out an Action Plan for NHS Scotland over the 5 year period to 2012 to deliver more effective, efficient and productive services. As part of its commitment to improving mental health services, *Better Health, Better Care* announced the launch of the Mental Health Collaborative to drive change within the NHS mental health system. The Collaborative ran from 2008 to 2011 and was the first concerted national effort to embed improvement methodologies within NHS mental health systems across Scotland. It aimed to support NHS Boards and their key partners to use improvement approaches and techniques to deliver the

underpinning improvements required to enable delivery of three HEAT targets in relation to
dementia diagnosis, psychiatric readmissions and antidepressant prescribing. It delivered
this through:

- Supporting staff working across mental health services to develop the knowledge and
  skills required to use improvement approaches and techniques
- Supporting the application of these techniques to deliver Mental Health HEAT targets
- Supporting staff to share their experiences of using these techniques to deliver
  improvement through a variety of methods, including events, networks, case studies,
  websites and newsletters

Findings from an internal evaluation and programme closure event indicated that the
Collaborative had developed the skills of participants in using data to drive improvement
within NHS mental health services and supported local NHS Boards with delivering on HEAT
targets. Since the end of the Collaborative in 2011, the Quality and Efficiency Support
Team (QuEST) Mental Health Programme has taken forward the improvement agenda,
foocusing on the areas of improving dementia care; improving access to psychological
therapies and child and adolescent mental health services (CAMHS); and effective and
efficient community mental health services.

Currently, this includes the following programmes:

- Dementia Demonstration Programme in three community health partnerships (CHPs)
  across Scotland (Perth & Kinross, Midlothian and North Lanarkshire)
- Scottish Dementia Improvement Programme, to support sites in Scotland in testing
  models of integrated care based on ‘8 Pillars’ model of community support
- Supporting the implementation of Demand, Capacity, Activity and Queue (DCAQ)
  techniques to improve access times for psychological therapies.

Other national programmes incorporating system improvement techniques include Releasing
Time to Care and the Mental Health Patient Safety Programme. The Scottish Patient
Safety Programme for Mental Health, established in August 2012, is a four year programme
with an overarching aim of minimising the harm experienced by individuals in receipt of care

42 Ibid
44 Alzheimer Scotland (2011) Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support
45 Releasing Time to Care focuses on improving ward processes and environments to help nurses and therapists
  spend more time on patient care, thereby improving safety and efficiency. NHS Institute for Innovation and
  Improvement (NHS III), 2009
46 Scottish Patient Safety Programme. www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-
  health. Accessed 1/10/2015
from mental health services. This currently entails a focus on adult psychiatric inpatient units and forensic inpatient units, including both admission and discharge processes. The programme states the aim should be that: ‘Patients are and feel safe, Staff are and feel safe’. Cultivating learning among those delivering and in receipt of care and using that knowledge to improve safety are the programme’s core values. Through collaboration and innovation from staff, service users and carers and the use of quality improvement and improvement science over the last three years, significant reductions in self harm, violence and aggression and restraint are starting to be seen across a number of areas in Scotland.

The Scottish Intercollegiate Guidelines Network (SIGN)

SIGN develops evidence-based clinical practice guidelines for the NHS in Scotland. This is derived from a systematic review of the scientific literature and is designed as a vehicle for accelerating the translation of new knowledge into action to reduce variations in practice, and improve patient outcomes. Since 2003, the following SIGN Guidelines relating to mental health have been published:

<table>
<thead>
<tr>
<th>SIGN Guidelines</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of schizophrenia</td>
<td>2013</td>
</tr>
<tr>
<td>Management of perinatal mood disorders</td>
<td>2012</td>
</tr>
<tr>
<td>Non-pharmaceutical management of depression</td>
<td>2010</td>
</tr>
<tr>
<td>Management of attention deficit and hyperkinetic disorders in children and young people</td>
<td>2009</td>
</tr>
<tr>
<td>Management of patients with dementia</td>
<td>2006</td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>2005</td>
</tr>
<tr>
<td>The management of harmful drinking and alcohol dependence in primary care</td>
<td>2004</td>
</tr>
</tbody>
</table>

Figure 5 – SIGN guidelines relating to mental health published since 2003

NHS Board priorities

Through the mapping process, this review identified local strategies and actions plans from NHS Boards and/or local councils, covering eight Board areas that were specific to mental health care and set out priorities or commitments to improving mental health within local areas. For areas where mental health strategies were not identified, this was due to some embedding mental health within wider health services or public health strategy. Although these areas did not have specific outcomes and priorities for mental health care, most prioritised issues to tackle wider determinants of health and related issues such as inequalities. The identification of local strategy and action plans was challenging and it was not always clear whether this was due to documents not being publicly available or not existing. This difficulty reflects a wider issue of limited publicly available information related to mental health services.

Common features within the strategies we did identify were:

- All showed commitment to improve access to services in some way
• Some showed commitment to developing or continuing recovery-based practices, with fewer stating increasing opportunities for peer support within this
• Some described processes to move towards community-based services and away from traditional hospital-based treatment
• Some showed commitment to engaging those who did not access services
• Some showed commitment to extending out of hours provision
• Some showed increasing uptake of talking therapies and alternatives
• Mainly in rural areas, there was commitment to supporting people who experience mental health conditions through telehealth and new technologies.

In addition, a smaller number of documents referred to the development or redesign of specialist services such as crisis, trauma and early intervention psychosis support.

Priorities identified in local strategies are mainly targeted at adult or general mental health. Only a few documents include commitments specifically targeted at services for children and young people or older adults. For children this may indicate a preference at a national level for taking a holistic approach and a reluctance to focus down too early on mental health needs (as reflected in strategies such as Getting it Right for Every Child, where the importance of mental health is explicit but content and target audience is much broader, with few child and youth specific mental health targets). However, the reason for a lack of focus on older people is less clear, with the notable exception of dementia strategies and targets.

A small number of local strategies identified the mental health of groups with specific needs, including those who experience eating disorders or learning difficulties; those who are in prison or have experience of the criminal justice system; and people with complex needs. A common theme across all of the strategies was a commitment to improve the mental health and wellbeing of NHS Board area populations through community initiatives, mentally healthy workplaces, arts and culture. Most strategies also included plans to support the wellbeing of people who experience mental health conditions, with eight strategies committing to work to reduce stigma and discrimination. Six strategies acknowledged the health inequalities experienced by people with mental health conditions and laid out plans to improve physical health outcomes.

Information and monitoring systems

In 2004, the Sandra Grant Report described ‘serious and major problems in accessing adequate data about mental health services’:

‘Basic details about bed numbers proved difficult to access, including those for intensive psychiatric care, adult acute admission or longer stay. National data streams do not discriminate at a level below the general psychiatric specialty and often it was necessary to phone wards direct to get the data needed for this review.'
The sheer complexity and size of local authority and voluntary sector provision is such that the Review Team learnt not to attempt a comprehensive list.¹⁴⁷

Considerable progress has been made in some areas and new datasets are now available, including those provided by the Mental Health Benchmarking Project, mapping of the CAMHS and Psychology workforces and Scottish Suicide Information Database (ScotSID). However, many of the Sandra Grant Report’s criticisms remain valid. In particular it is still difficult to identify and assess a comprehensive picture of mental health provision across Scotland, within the NHS or across all agency providers, including NHS, LA and voluntary sector organisations.

In 2012, ISD and the Scottish Government Mental Health and Reshaping Care Division carried out a scoping exercise to identify the extent to which NHS boards collected and recorded clinical outcomes within psychological services. The outcome of this scoping exercise highlighted that there was a range of clinical outcome measures currently being used across psychological services, such as CORE, CGI-I, CGI-S, HONOS, GCI, HADS, PHQ9 and GAD7. CORE was the most commonly used clinical outcomes measure. There was variation, however, in how clinical outcomes were collected and recorded, with some boards able to record clinical outcomes electronically and others collecting clinical outcomes on paper and storing this within patient notes.⁴⁸ In 2013 the scoping exercise was repeated and found improvements in the extent to which outcomes data was collected, but the same constraints in terms of electronic systems for recording and reporting data.⁴⁹ Work is ongoing to support the implementation of appropriate systems. Participants in the review highlighted the lack of co-ordination of information systems across different professions as problematic:

“We have information systems in the NHS that no one else can see, we’ve got records dotted all over the place. Even where people are working in the same team, a multi-agency team, social workers have their records system and NHS has their records system’

- Expert Interview

There were also questions raised about the type of information that was collated, what was ‘valued’ by services, what information about mental health services was prioritised and what was not:

“We measure bed usage, we measure quite hard things, we measure how long it takes someone to get an appointment, how many nurses you have, how many Community Mental Health Teams you have. We don’t really effectively and routinely

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⁴⁸ ISD (2012) Findings from Scoping Exercise to Identify the Capability of Routine Clinical Outcome Collection and Reporting within NHS Board Electronic Clinical Systems
⁴⁹ Scottish Government (2014) Routine Collection of Recording of Clinical Outcomes within Mental Health Services
measure either outcomes or experiences and that suggests to me that we still don’t value them as much as the system and the mechanics of the system.’

- Expert Interview

‘The word we hear every day is outcomes – the outcomes for service users and services are different – services look at employment and education, service users look for softer outcomes like confidence and self-esteem, these are ignored – people are seen as dependant on services and seen as not moving forward if they use them much.’

- Service User, Panel Inquiry Visit

Some examples of good practice in this area have arisen in the voluntary sector, such as I-ROC, developed by Penumbra50. It was suggested that there may be scope for such tools to be integrated within statutory NHS mental health services.

4.5 Welfare reform

The UK welfare system has undergone considerable changes in the last ten years. The Welfare Reform Act (2007) involved the removal of Incapacity Benefit (IB) and the Personal Capability Assessment (PCA) and their replacement with Employment Support Allowance (ESA) and the Work Capability Assessment (WCA). The Welfare Reform Act (2012) brought with it a range of further changes, including the introduction of Universal Credit, Personal Independence Payment (to replace Disability Living Allowance) and what has become known as the ‘Bedroom Tax’. The Scottish Government has estimated that the UK Coalition Government’s changes to welfare since 2010 will reduce benefit expenditure in Scotland by around £2.5 billion in 2014/1551 and the Scottish Government’s welfare reform tracking study found negative impacts of welfare reform on mental health, especially with regard to the ongoing uncertainty and stress of being reassessed, the length of time for decisions to be made and the process of future reassessments52.

The GPs at the Deep End, a group representing 100 general practices serving the most deprived communities in Scotland, have published several reports on the effects of UK-wide austerity measures and welfare reform on the work of general practice in areas of high deprivation. A central concern of the Deep End practices has been the perceived negative impact upon the mental health of their patients53. They highlight the Work Capability Assessment as ‘the most demeaning of all the reforms’ because of the excessive stress they

50 http://www.penumbra.org.uk/innovation/personalised-services/
53 Blane D & Watt G (2012) GP experience of the impact of austerity on patients and general practices in very deprived areas, GPs at the Deep End Report 16
perceived it to place on the most vulnerable individuals in society. The findings from the Deep End report were upheld by review participants, who consistently described the anxiety and stress caused by welfare reform as well as negative impacts on individual finances.

‘Welfare reform has made it worse, it has put a huge pressure on people – when I get letters I get frustrated about it and it can play on my mind for ages, you have to phone them up and go through all these details and then I can lose all my benefits until they sort it out – I cannot manage the phone it can be incredibly complicated.’

- Service User, Panel Inquiry Visit

‘[Welfare reform is] making peoples’ lives a lot worse, putting people through unnecessary worry – it makes people much more ill.’

- Service User Focus Group

Many participants highlighted that the Scottish Government has put in place a number of mitigation activities to attempt to minimise the negative impact of welfare reform in Scotland, including bedroom tax mitigation and the Scottish Welfare Fund. Review participants also emphasised the work of the Citizens Advice Bureau and local mental health organisations in relation to the support they are providing on benefits. Participants highlighted good practice that had taken place where the NHS was working in partnership with specialist organisations, such as Money Matters, to offer advice about benefits to mental health service users. Although useful, it was recognised that these activities cannot take away the anxiety and concern felt by those affected by welfare reform.

‘Welfare reform has had a big impact on demand or mental health services…The council has enhanced its advice service with Scottish Legal Aid Board money.’

- Staff, Panel Inquiry Visit

Many discussions on welfare reform stressed the impact of austerity and cuts to services more generally. This included the rise in the number of food banks, felt to be an indicator of the levels of poverty and hardship being felt by families and individuals across the country. The detrimental impact of this was seen to highlight the links between poverty and mental health conditions, and increasing demand on mental health services due to an increase in stress and anxiety.

‘Welfare reform is affecting very vulnerable people badly and also some of the benefit system changes…threatening letters or stoppages when folks are unwell. This is being picked up by advocacy.’

- Advocacy Service, Panel Inquiry Visit

4.6 Service users and carers

The history of the mental health service user movement in Scotland predates the Sandra Grant Report, and is a complex narrative of individuals coming together regionally and nationally to achieve change. The introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003 is cited as an example of people who had used services influencing
policy makers and legislators to make positive changes to mental health care and treatment. Getting the right to independent advocacy enshrined in the Act has been viewed as an achievement of the user movement\textsuperscript{54}. Since 2006, a national voice for service users across Scotland has been provided by Voices of eXperience (VOX), Scotland’s national mental health service user led organisation. Throughout Scotland, there is a number of well-established user groups, actively influencing policy both locally and nationally, including HUG in Highland, Lanarkshire Links, Mental Health Network (Greater Glasgow), Acumen in

<table>
<thead>
<tr>
<th>Group</th>
<th>NHS Board Area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voices of Experience (VOX)</td>
<td>Scotland-wide</td>
</tr>
<tr>
<td>Scottish Dementia Working Group</td>
<td>Scotland-wide</td>
</tr>
<tr>
<td>Bipolar Scotland</td>
<td>Scotland-wide</td>
</tr>
<tr>
<td>New Horizons</td>
<td>Borders</td>
</tr>
<tr>
<td>Klacksun</td>
<td>Forth Valley</td>
</tr>
<tr>
<td>Mental Health Network (Greater Glasgow)</td>
<td>Greater Glasgow &amp; Clyde</td>
</tr>
<tr>
<td>Acumen</td>
<td>Highland (Argyll)</td>
</tr>
<tr>
<td>HUG</td>
<td>Highland</td>
</tr>
<tr>
<td>Lanarkshire Links</td>
<td>Lanarkshire</td>
</tr>
<tr>
<td>Advocard</td>
<td>Lothian</td>
</tr>
<tr>
<td>Plus Perth</td>
<td>Tayside</td>
</tr>
</tbody>
</table>

Argyll & Clyde and Plus Perth and more (see Figure 6 for more of these groups).

Figure 6 - Prominent mental health service user groups operating in Scotland

However, some previously active groups have ceased to function in this period, such as Edinburgh Users Forum. Oor Mad History (2010) charts the history of the Lothian Mental Health Service User Movement, describing the changes that have taken place and highlighting the challenges of creating a unified voice across the diverse user population. The project highlighted the progress and achievements of the mental health service user movement in Scotland over the last ten years. This progress was upheld by many review participants, who highlighted a strong user voice as a positive achievement within Scotland.

‘There is a lot of promise in the user and carer movement. I think that with enough resources and with an ethical basis for the workers who work in it, we could have a really good and vibrant community’

- Expert Interview

\textsuperscript{54} CAPS (2010) Oor Mad History: A Community History of the Lothian Mental Health Service User Movement. Edinburgh: CAPS
The involvement of users and carers and the representation of their views in the development of the Mental Health Strategy for Scotland: 2012-2015 was seen by the review participants as an example of good practice. Service users who took part in the review reported having attended meetings to give input on the strategy. VOX have also taken on a leadership role within delivery of certain commitments of the current mental health strategy (especially 1, 2 and 5). Some commitment to user and carer representation in developing local strategies was also identified by review participants, with Lothian and Forth Valley mental health strategies being highlighted as particular examples.

Taken as a whole, user and carer involvement in national strategy planning was identified by the review participants as a positive aspect of the mental health system in Scotland. Those working in the sector identified an increasingly strong commitment on the part of the Scottish Government to take the user and carer voice into account over the last ten years.

‘I think we’ve seen the user and carer voice having far more of a role in shaping policy and practice across mental health services and that would be in terms of involvement in local regional planning, national government planning.’

- Expert interview

While there is a general agreement that the involvement of service user and carer representatives at national strategic level has increased over the past ten years, the impact of this at a local and regional level in practical terms was questioned by many.

‘We’ve seen greater valuing of people’s experience, at policy level rather than at practice level.’

- Expert interview

Some good examples of meaningful engagement were reported in specific situations, most commonly in relation to new building hospital facilities, where service users and carers felt that their suggestions carried influence and often resulted in changes to final designs. But in many other situations, it was felt that consultation was tokenistic, allowing a box to be ticked before senior managers did what they had always intended to do:

‘It was never very clear what the point of the service user involvement was – we talk about positive, well-received services and then they close them anyway – they had decided it had run its course and wasn’t achieving the council’s outcomes – but, if it was achieving the individual’s outcomes, surely that counts too.’

- Service user, panel inquiry visit

Overall, concerns were expressed about the extent to which the increased importance placed on user and carer views at policy level had translated into practice. There was a clear desire not only to be heard but also to have real influence within decision making.

‘We could do so much better on getting a whole range of opinions and if we based it on what we know service users want and feel they want and could combine that with an evidence base, we could have something really good.’

- Expert Interview
Several participants perceived that there was a gap between strategic management and operational management, with little quality assurance or checking that implemented procedures followed agreed policies. This has led to some frustration where service user and carer organisations feel that, despite their efforts and involvement, little change has taken place in practical terms.

It was recognised by review participants that other mechanisms such as collective advocacy, peer support and distinct leadership roles need to be established in order for user and carer involvement to flourish.

However, while positive overall, there was recognition from our sample that Scotland’s mental health carer movement has developed at a slower pace and smaller scale than the service user movement, and there is currently no formal national route for mental health carers to influence policy and practice within Scotland. Instead, review participants described a move towards carers being engaged within policy development in a more generalist way, bringing all carers together, irrespective of the needs of those they care for, and with less emphasis on the specific needs and priorities of those who care for people with mental health conditions in particular. A similar trend away from mental health specialism and towards more generalist services was also observed by advocacy services. Some participants suggested that this should be addressed, while others advocated more prominence being given to mental health carer perspectives:

‘Carers tend to get all lumped in together. If you’re a carer, you’re a carer and that’s it. I think what I’ve personally seen over the last three years and my own understanding is that we need to be absolutely clear that people who are supporting people with mental health problems have very specific issues to deal with and I think that our feeling would be that some of those issues do need a specific focus and the direction of travel towards a generic carers policy or strategy is actually doing a disservice to people who are coping with very challenging conditions that are not understood by a lot of local practitioners. They’ve got mental health services, understanding compulsory treatment, caring for someone in a very restrictive environment, named persons, advance statements, all issues that are very complicated. I think for family members and carers, that’s where the specialism comes and where in some of the policy we think there’s a gap.’

- Expert Interview

This can result in less focus on involvement of people caring for adults with mental health conditions.

‘We still struggle to respond to and support carers in the way that say carers of children or young people are much more involved in the day to day decisions about things or carers of people with dementia have had a lot of focus but I’m not sure that carers or supporters of people who are adults who have mental health problems.’

- Expert interview

Some carers felt that they were often missed out at a strategic level, only becoming involved after the important decisions had been taken. Several reported becoming demoralised after giving up time to become involved in groups that had little capacity to achieve meaningful
change. The lack of a co-ordinated national voice for carers of people with mental health conditions was highlighted as one reason why carers input may not have developed at the rate it could otherwise have achieved. The current mental health strategy includes a commitment to increase the involvement of families and carers in policy development and service delivery (Commitment 2). Implementation of this Commitment is being led in partnership with VOX.

**Involvement in service design**

Structures that support a co-ordinated and consistent approach to user and carer involvement appear to be absent or partial within many localities. As a result, some NHS Boards report significant service user input whereas others report very little. Analysis of the data gathered about this subject highlighted disparities between the conceptualisations of service user and carer involvement articulated by service representatives and the service users themselves. When talking about involvement, those working directly within mental health services tended to describe avenues for service users to provide feedback, such as patient satisfaction forms and complaints procedures. Others mentioned initiatives such as lived experience input into training of medical and nursing students, and in recruitment processes. A small number of services mentioned service user representatives holding seats on policy development groups. This was somewhat at odds with what service users and carers considered to be good involvement practice, which tended to focus on service user representation at all levels of health care decision making. Service users were generally dissatisfied with the current situation, describing involvement as ‘spasmodic’ and claiming that ‘we don’t get a say in the services we want’. Some participants felt that there was a lack of support and infrastructure for service user involvement in Scotland and this meant it was now lagging behind the rest of the UK. These findings hint at a lack of clarity around the definition and implementation of service user and carer involvement, as well as differing understandings of what counts as good involvement practice.

‘They know they should be doing it and they, on the face of it, they say, “Yeah we do involvement, we’ve been doing it for years,” but then you scratch the surface a little bit.’

- Expert interview

Service user and carer involvement within voluntary and third sector organisations seemed to be far more aligned to the definition of involvement held by service users. Voluntary organisations that participated in the review gave examples of service user and carer membership of steering groups, representation at management level and co-design of services.

**Hard to reach groups**

Concerns were raised by review participants about the extent to which current processes were accessible to individuals who experience severe and enduring mental health conditions. For these individuals, it was felt that attending public meetings or sitting on steering groups were not appropriate methods of engagement. This issue was discussed in particular with respect to advocacy provision for individuals receiving treatment on dementia
wards. The lack of support to involve those for whom English is not their first language was also highlighted.

‘I think [with] hard to reach patients, it’s because we’re not giving it to them in a form or in a location that they want.’

- Expert Interview

Representing a united voice

Representatives of advocacy organisations and user groups that participated in the review noted the difficulties in balancing and communicating the diverse range of views expressed across service users:

‘I think one of the difficulties that the service user movement has is that there are so many service user voices and trying to convey a united voice is actually extremely difficult, and, as I’m sure you know, some of those individuals can be extremely vociferous who maybe don’t represent the views of the majority of people.’

- Expert Interview

Review participants felt that there was a need to further develop advocacy to ensure that the full spectrum of experiences are represented. In addition, it was raised that although it is important that services are informed by the lived experience of those using them, this approach must be balanced against ensuring that services are developed in line with best practice and available evidence:

‘We could do so much better on getting a whole range of opinions and if we based it on what we know service users want and feel they want and could combine that with an evidence base, we could have something really good’

- Expert Interview

Future for participation and involvement

The need to ensure that involvement has a purpose was raised by review participants, with one stating that there is a ‘need to be clearer about what is meant by involvement, why we want to do it and what we hope to get as a result of doing it’.

There was a sense that review participants were calling for new ways to enhance involvement. Expectations for involvement appear to have evolved since the Sandra Grant Report with fuller partnership models and full co-production viewed as the way forward.

‘The concept of co-production could go beyond traditional involvement as long as it’s co-production in the way that’s understood. It was important when there was nothing to have someone going along and sitting in groups but I think we need to have a more representative body.’

- Expert Interview

Looking to the future, a number of review participants expressed the view that a more sophisticated approach to service user involvement which is ‘about more than involvement. Participation, leadership, change’ is now needed. It was suggested that sustainable and
continuous service user involvement should be built in to all stages of service planning, design, implementation and evaluation. Greater provision of mental health specific collective advocacy at national and regional level was seen as an important avenue through which involvement could be supported.

4.7 Recovery

‘Being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.’

The origins of the recovery movement within Scotland were shaped by the work of individual services users and groups such as Ron Coleman, the Hearing Voices Network and the Highland Users Group, strongly influenced by work in America and New Zealand. Since 2004, the Scottish Recovery Network (SRN), supported by Penumbra, has been the main official vehicle for taking recovery work forward in Scotland.

The move towards recovery-based practice has been supported by national mental health strategy commitments over the last ten years and there are several important programmes with evidence of impact, including Wellness Recovery Action Planning, the Scottish Recovery Indicator and the introduction of formalised Peer Support:

**Wellness Recovery Action Planning (WRAP):** Self-management tool underpinned by a number of core principles, including hope, personal responsibility, education and self-awareness, self-advocacy and support from others, facilitated through one-to-one or group settings in services or self-help groups. Only facilitators who undertake official training can offer WRAP training and SRN have trained and supported over 50 facilitators across Scotland. A 2010 evaluation of lived experience facilitators found it very relevant, effective and creating substantial and positive impact on many participants.

**The Scottish Recovery Indicator (SRI):** Tool to aid the development of recovery focused services. SRI 2 is a revised version introduced in 2011. This assesses provision of ten service indicators including: basic needs met, goals addressed, personalised services, strength based, socially inclusive, user and carer involvement, advanced planning, self-management, staff supported and valued, recovery focused. Assessment draws upon 6 sources of evidence including: assessments, care plans, service information, views of providers, service users and informal carers. By 2014, 350 SRI 2 reviews were completed.

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56 [http://www.scottishrecovery.net/WRAP/wellness-recovery-actions-planning.html](http://www.scottishrecovery.net/WRAP/wellness-recovery-actions-planning.html)
across a range of services and settings, including community mental health teams, acute inpatient and forensic settings, addictions services, dementia services, primary care mental health teams and rehabilitation services. Almost half (49.1%) of completions were from the Greater Glasgow and Clyde NHS Board area, followed by Lanarkshire (14%). Only 5.2% were from Grampian, 2.9% were from Tayside and 2.6% were from Lothian, suggesting that the roll out of SRI 2 has been much more effective in the West of Scotland than in other areas. SRI has evaluated positively in relation to the promotion of the recovery agenda and in driving service improvement more generally. Specific impacts related to SRI 2 implementation range from minor changes including the updating of outmoded service leaflets to more radical changes, such as more detailed, personalised assessments and care plans, and an increased adoption of a strengths based approach.

Peer Support: Scotland’s first formal mental health peer support service ‘Plan 2 Change’ was launched in Craigmillar, Edinburgh in 2007 by Penumbra, NHS Lothian and SRN. It was followed in 2008-2009 by a Peer Support Worker Pilot programme as part of Delivering for Mental Health. Within this peer support programme, workers were trained and employed as paid members of staff within mental health services in five NHS Board areas. The evaluation highlighted benefits for service users, peer support workers and mental health teams along with challenges and learning points, including integrating peer support roles within multidisciplinary teams, a lack of clear role definitions and being reminded of own past difficulties when supporting service users through similar situations. Developments since then include the creation of an accredited Professional Development Award in Mental Health and Peer Support with the Scottish Qualifications Authority; a values framework for peer working; experts by experience guidance; and a new peer learning network. However, peer support has not achieved its potential as a transformative approach. This has been identified as being partly due to entrenched negative views within some professional groups.

Most participants in this review felt that the articulation and greater profile of the concept of recovery had played an important role in shaping mental health services in Scotland over the last ten years. This was both in relation to opening up greater opportunities and raising aspirations of people with mental health conditions but also in helping to influence how staff viewed their roles. The Scottish Recovery Network was recognised as being a catalyst for taking the recovery agenda forward and supporting the drive for local change towards more recovery orientated services:

‘I think that recovery itself has moved from being a concept that was very much on the margins and was seen, in some quarters, as a bit left field and potentially even

59 http://www.sri2.net/images/files/Completes%20to%20July%202014%20infographic%20combined.pdf
dangerous to being something that is very much at the centre of our dialogue on mental health services and more widely and I think for me that’s the biggest change.’

- Expert Interview

There was agreement among review participants that the recovery movement had been particularly successful in introducing a ‘language of recovery’ that is now central and widely used within mental health services. However, there was some note of caution, particularly among service users, that simply because services used the language of recovery did not mean that they fully supported or implemented these principles.

Most respondents felt that recovery had positively influenced service development by instigating a move towards goal-orientated short-term interventions and away from open-ended support through traditional drop-in centres. For some respondents this was felt to be very contentious as, on the one hand, it was recognised that goal-orientated support had brought with it a range of benefits, including supporting people to make progress towards achieving their life goals. However, there were concerns that the move towards goal-oriented approaches that were expected to deliver results in short timescales did not take into account important ongoing support needs of people with long term mental health conditions and the role that drop-in centres play in providing for these.

‘If you just do the right things … you will be a good, functioning, well, productive person without acknowledging that for some people they’re going to be ill for ten, twenty years and maybe all their lives and don’t necessarily need to take that personal responsibility to get rid of what might just be a genetically inherited thing.’

- Expert Interview

It was clear from the review responses that, although many had welcomed the role that recovery had played in Scotland, there are differing perceptions of how recovery can best be applied to practice. For example, The Charlie Reid Centre in Glasgow was highlighted as a service that was closed because it provided an ongoing service that was not viewed or valued by commissioners as recovery or goal-oriented, a viewpoint that was questioned by some review respondents. There were also respondents who felt that the concept of recovery might not be for everyone and that the recovery movement did not acknowledge this. Some respondents were concerned that this could potentially alienate some people, who could be perceived as having ‘failed’ because they had not recovered. Service user focus group participants discussed these concerns in detail noting that:

‘Recovery has been hijacked….it is no longer asset based – it is not even about coping in some cases.’

‘Recovery is too [often] misunderstood or misappropriated – people are blamed for not making progress. We need to lose the tick box targeted way of making progress.’

A further issue raised by some participants was that the role of peer support could be more central to recovery services, typified by the comment:

‘We’re still seeing far less emphasis on a personalised approach with the person being supported by peers, being considered to be an expert in their own experience.’
Expert Interview

4.8 Stigma and Discrimination

The Sandra Grant Report found that stigma and discrimination were the problems most frequently mentioned by mental health service users and their carers, who stressed the need for: continued work with See Me; service user led training with professionals, public, employers and young people; improved media reporting; openness on the issues within mental health services; and acceptance of diversity.

For the last decade, See Me has been Scotland’s national programme to tackle mental health stigma and discrimination. While it has achieved some successes, evidence from the Scottish Social Attitudes Survey and wider data on outcomes and life chances has made it hard to demonstrate clear and consistent reductions in stigma and discrimination across Scotland. Consequently, an independent review in 2011 culminated in the re-founding of the programme for 2013-16 as a transformative anti-stigma and discrimination programme placing people with lived experience at the centre. This new phase of See Me is funded by the Scottish Government and Comic Relief, and managed by the Mental Health Foundation and Scottish Association for Mental Health. The programme aims to:

- Reduce self-stigma for people with mental health conditions
- Reduce stigma and discrimination among communities and organisations with the potential to have a positive effect on people with mental health conditions
- Increase societal understanding that people can and do recover from mental health conditions
- Ensure that people who experience mental health conditions are able to participate in society and live full lives without fear of discrimination.

The approach for this next period of the See Me programme was informed by the best available knowledge of what works to address stigma and discrimination, including best practice guidance based on a three year EU-wide research programme. This approach aims to: link social marketing with social contact and community development approaches; apply partnership approaches to ensure that activities are targeted at organisations and communities who can best effect change; and adopt co-production methods to ensure that the programme systematically works in partnership with people with lived experience in planning, delivery and evaluation. The programme intends to shift from changing attitudes and knowledge to meaningful changes in behaviour, based upon a human rights model and the building of a social movement for change. The programme is supported by a robust evaluation and evidence-generation.

64 Knifton L, Goldie I and Quinn N (2012) The Aspen Project: Challenging stigma and discrimination against people with depression, Best practice guidelines, values and resources
Scotland has led important innovations in this field, for example in the use of the arts to tackle discrimination. The Scottish Mental Health Arts and Film Festival began in 2007 and is a collaboration of over 300 individuals and agencies which engages over 20,000 citizens each year. This is now replicated in Europe and the US, and research in this timeframe indicates it reaches high proportions of people in low income areas and from diverse communities, as well as having a positive effect on attitudes and behavioural intent.\(^{65,66}\)

The review participants reported mixed views about whether mental health stigma and discrimination has reduced over the past ten years based on their experiences, presenting a complex picture both of progress and a prevailing problem. Several participants highlighted that the increasing voice of those with a lived experience was having a positive impact on attitudes. Examples given were the involvement of service users in professional training and in some aspects of service design. Participants felt that there was positive change, which included: reduced taboo due to greater visibility and campaigns; some conditions being viewed much more positively and with greater knowledge and understanding e.g. dementia; and a positive shift in views towards particular groups such as service personnel and those affected by trauma

‘There are a lot more campaigns, it is less taboo. There is stuff in doctors’ surgeries. Social media makes a difference.’

- Service User, Panel Inquiry Area

‘Stigma is huge but is becoming less taboo - there is greater awareness, mental health in the forces is better promoted. There is a change in society in the way they feel about people who go to war and what they go through.’

- Service Provider, Panel Inquiry Area

Despite this, experiences of stigma and discrimination were commonly reported by service users and carers across the review, in particular: within health settings; when dealing with the police; Job Centres; in school and within local community groups, including examples from some faith communities. Participants described how this has impacted on their own behaviour, by engendering self-stigma and inhibiting help-seeking.

An important point raised was that attitudes seem to have improved for people with conditions that have an ‘obvious cause’ e.g. trauma or brain injury/disorder, but not for people with other conditions. This was felt to be the case when conditions and associated behaviours raised strong emotions such as fear or anger or where there were beliefs around blame:


\(^{66}\) Knifton L, Goldie I and Quinn N (2012) The Aspen Project: Challenging stigma and discrimination against people with depression, Best practice guidelines, values and resources
‘Stigma still [exists] and [there are] issues around personality disorders and self-harm.’

- Service User, Panel Inquiry Area

The impact on those who experience stigma and discrimination also continues to be profoundly painful and alienating:

‘Neighbours don’t speak to you– if people see us coming they cross the road if XX is with us. If they would only speak to him, he would speak back.’

- Carer, Panel Inquiry Area

‘We go to church…the minister came to visit, I let him know there was someone ill in the house. He didn’t come back for another year. I felt very let down.’

- Carer, Panel Inquiry Area

**Stigma and discrimination in public services**

Participants reported very mixed experiences in terms of stigma and discrimination from the police with calls for better understanding within the police force about mental health. There was also concerns expressed that the police are called in when A&E staff cannot cope with people who may be distressed, sometimes leading to arrests rather than treatment. This appeared to be an area where some innovative work was being undertaken, with examples of liaison work with custody officers. One example is where Police Scotland are working in partnership with the NHS to pilot projects in Ayrshire and Arran where mental health nurses will be available in custody suites.

The Department of Work and Pensions was highlighted as an area where stigmatising attitudes and behaviour of staff can be a deterrent to people with mental health conditions seeking benefits:

‘The disrespect, the condescending attitude was horrific…Many people I know in the 18-25 age group are now refusing to sign on because they are so belittled by the Job Centre, they say they would rather go into debt and live off the food bank than go to the Job Centre’

- Service User

A lack of understanding and/or ability of school staff and other young people to appropriately support young people with mental health conditions in schools was also raised as a stigma-related concern. A number of projects were identified as making important contributions to school-based stigma work at a regional level. The Highland User Group SPEAK project was one example given and was felt to be making good progress in tackling stigma and discrimination in schools.

‘People look at you like a freak in school when you are really down, you feel embarrassed to phone or reach out for help. Its stigma and how you view yourself”

- Young Service User, Panel Inquiry Area
Stigma was highlighted in A&E services and other health settings. GPs were perceived by some as difficult to engage on the issue of stigma and in general there was felt to be low trust in GPs from people with mental health conditions.

Some participants felt that general hospitals were unwilling to work with people holistically by dealing with mental health conditions alongside providing physical healthcare. Importantly it was also felt by some that embedding mental health services within general hospitals if done well could have the benefit of being less stigmatising, as well as resulting in more efficient care pathways.

There were mixed views of the extent to which stigma and discrimination are manifest within mental health services, with some participants observing lack of empathy and unfair treatment whilst others experienced staff going ‘above and beyond’ to provide excellent support. One participant stated that they had been treated with a lack of compassion and abrupt and dismissive behaviour by mental health staff, and that a difficult situation was only resolved by a ‘special’ member of staff. The participant in this case queried why the good practice displayed by this staff member should not be standard. The issue of self-stigma was raised by some in relation to the low use of and overriding of advance statements. These respondents suggested that these practices create and reinforce the ‘why try?’ or ‘what’s the point?’ feelings experienced by some mental health services users and therefore reinforces self-stigma.

Participants raised a continuing problem of lack of access to treatment for those who are under the influence of alcohol and/or drugs and when suicidal. There was felt to be a lack of understanding that alcohol and drugs can at times be used as coping mechanisms. It was felt that this could inhibit help-seeking, especially among those who have had prior difficult experiences when accessing services.

Overall, participants reported a range of positive and negative attitudes and behaviours among different profession types, grades and services, but no clear pattern emerged. There was also a sense that in some situations staff may lack insight into how the service user feels and therefore can be unintentionally insensitive.

Many participants felt that it was possible to change attitudes but some felt that the problem was so ingrained in society and services that there was less hope for achieving significant change. A number of suggestions for the focus of anti-stigma and discrimination work were made, including:

- More education sessions between key professionals who come into contact with those with mental health conditions (e.g. police, psychiatrists and other doctors, nurses, employers, DWP/Job Centre staff) and local service user, carer and advocacy groups. These sessions would create a platform from which to create contact opportunities and explore the impact of attitudes, behaviour and beliefs surrounding people who live with mental health conditions.
- Engagement with schools on addressing stigma and discrimination amongst young people and within the school setting involving pupils, staff and families. There were specific mentions of addressing the stigma and discrimination experienced by pupils whose parents have a mental health condition.
• Work within important settings where people could be supported to disclose mental health conditions in order to gain greater levels of support (e.g. workplaces, further education and schools).

The next phase of national anti-stigma and discrimination work undertaken through See Me is in early stages of development. However, See Me is launching new mental health stigma and discrimination programmes in 2015, targeted at the workplace (See Me in Work), schools (See Me in School) and the health and social care sector, reflecting the priorities for action identified by the participants in this review67.

4.9 Inequalities

Socio-economic contributors to mental health inequalities

Over the last decade, mental health inequalities have emerged as one of the major public health issues in Scotland. Mental health is one of the key factors that contributes to Scotland’s wider health inequalities through its relationship to suicide, social opportunities, health related behaviours and impact upon physical health outcomes. People who develop enduring mental health conditions are more likely to experience social and economic inequalities, and those who experience disadvantage due to social or economic circumstances are at increased risk of poor mental health. This creates a vicious cycle that is magnified when people experience multiple disadvantages68. Throughout the last decade, the evidence base concerning health inequalities across the UK has advanced considerably exemplified through the work of Pickett and Wilkinson (2010)69 and Marmot’s ongoing work on social determinants70.

Over the past ten years there has been an improved understanding of the relationship between social inequalities and mental health. In 2010, NHS Health Scotland published its Dimensions of Diversity report that presented the evidence of what is known about health conditions in relation to 13 different population groups. While recognising that problems persist in terms of obtaining accurate data about specific populations, such as BME communities, the authors concluded that some sections of the population experienced poorer health than others and that this was rarely because of a biological susceptibility not shared by other sections of the population. They suggested a specific connection between poor mental health and experiences of ‘personal prejudice, collective discrimination and

67 https://www.seemescotland.org
69 Ibid
Research from Scotland since 2004 highlights how the burden of poor mental health falls disproportionately upon those who experience multiple disadvantage. Glasgow Centre for Population Health research illustrates that mental health inequalities exist due to both poverty and gender. The burden of poverty on mental health is also identified in the national Equally Well review in 2008. Further research has shown how vulnerable communities experience poor mental health due to life circumstances and discrimination, and that services, including mental health services, often fail to meet their needs. This includes transgender and LGBT people, care leavers, carers, low-income households, settled ethnic minority communities in Scotland, prisoners, female offenders and their families, asylum seekers and refugees, people with long term physical health conditions and other vulnerable citizens.

The Sandra Grant Report acknowledges the need to provide different services to different people, but less emphasis is placed on addressing the different mental health outcomes for specific populations in Scotland. Yet, while wider government social and public policies have clearly prioritised equality, this has not always been as explicit in mental health programmes and targets. Specifically, targets and objectives that have been framed in overall population terms have not been explicit in aiming to reduce disparities and inequities. For example, national aims to reduce population rates of suicide, psychological therapy uptake or discrimination have not included explicit targets in relation to factors such as income and poverty, gender and sexuality.

Inequalities in care provision and outcomes of mental health service users

The introduction of the Equality Act (2010) placed requirement on all public bodies to consider the impact of policies and services on the needs of individuals with the following ‘protected characteristics’: age, disability status, ethnicity, gender/sex, religion/belief, sexual

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72 Shipton D, Whyte B (2011) Mental Health in Focus. Glasgow Centre for Population Health


74 Glasgow Anti-stigma Partnership (2009) There’s more to me: a report on lesbian, gay and bisexual people’s beliefs, attitudes and experiences in mental health


76 Knifton (2012) Understanding and addressing the stigma of mental illness with ethnic minority communities, Health Sociology Review, 21, 3, 287-98


orientation and transgender identity. Findings from our service mapping across Scotland present a few examples of specific tailored mental health services aimed at the equalities groups included within the Equalities Act, many of which are provided by the voluntary sector within large centres of population. But GPs at the Deep End, a group of the 100 most deprived practices in Scotland, have produced a number of reports describing the complex interplay of physical health, mental health and social needs of patients visiting their practices. They suggest the inverse care law acts as a significant constraint to supporting the mental health needs of patients from deprived communities and argue for more resources to allow for longer patient consultations.

In her conclusions, the Sandra Grant Report recognised that the quality and quantity of available services for people with mental health conditions differs across Scotland. One of the most significant geographical differences mentioned by service users in this review was in relation to the mental health estate. In some areas, new build provision was seen as having provided significant improvements to the level of service, with single rooms and en-suites as standard. But in other areas there are major issues with the poor environment of older buildings still in use. The provision of low and medium secure residential care in some areas has now eliminated the need for young people to be accommodated in the State Hospital and this was very much welcomed by carers. However, the lack of local inpatient CAMHS provision was a real issue in some NHS Board areas, with young people sometimes being accommodated out of area in regional units. It was felt that this could lead to considerable distress for the young people and also caused time and financial issues for families, friends and carers.

‘People being sent out of their area down to Dundee, Aberdeen for eating disorders … so they are having to move 250 miles away from all their friends and relatives which is not very nice, especially if you’re young and just trying to grow up’

- Expert Interview

However, some boards do provide travel support for families who are on benefits and can cover some of the costs of visits when families remain involved.

‘There is an impact on families for a child being placed out of the area. Some are very involved and can stay locally and hotel bills are met by the home health board. Others visit less often and stay in touch by phone, text’

- Review Visit

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80 http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/reports/
81 The principle that the availability of good medical or social care tends to vary inversely with the need of the population served
Out of hours provision was identified as a need by service users in several areas. Service user participants in the review also drew attention to the fact that there are also a number of specialist services that are not available in every area, e.g. for those with personality disorders or eating disorders. Telehealth was highlighted as a mechanism for improving the reach of mental health support into rural and remote areas.

Physical health outcomes for people with severe mental health conditions are poor. People with a diagnosis of schizophrenia or bipolar disorder can die up to 20 years younger than those without these diagnoses, due primarily to physical health conditions\(^83\). Individuals with long term physical health conditions are at increased risk of developing mental health conditions such as depression\(^84\). These relationships between poor physical health and poor mental health are even stronger if you live in an area of high deprivation\(^85\).

Successive Scottish mental health strategies have made commitments to addressing these health inequalities, including supporting the development of physical health assessments and monitoring for people with severe mental health conditions, reviewing the evidence around health improvement approaches for people with mental health conditions, and encouraging the development of mental health support and treatment for people with long term physical conditions\(^86\). NHS Health Scotland have supported a number of Test of Change projects to support the delivery of Commitment 28 of the current mental health strategy, which commits to work with boards and other partners to support a range of health improvement approaches for people with severe and enduring mental health conditions, including developing a national standard for monitoring the physical health of people being treated by clozapine.

In terms of positive changes in the last 10 years, review participants pointed to the increased availability of psychology services for those who had experienced physical health conditions, such as cancer, coronary heart disease, stroke or pain. However some service users also expressed disappointment that pain management courses they had participated in had made little reference to mental health:

‘\textit{Mental health isn’t taken into consideration}’

- Service User Focus Group

In this review’s section on stigma and discrimination, some of the attitudinal and behavioural barriers that individuals with mental health conditions can experience when receiving health care within general health settings, such as A&E, were highlighted. More generally, some

\(^83\) Rough E (2014) Recognising the importance of physical health in mental health and intellectual abilities: Achieving parity of outcomes. London: British Medical Association


review participants felt that health inequalities were an important issue that warranted more attention, to ensure policy commitments were transferred into better services for individuals:

‘I don’t think the inequalities agenda is being addressed. As I say, at a policy level people are talking about it now but in practice, on the ground, it’s not happening for people who are really unwell and their families’

- Expert Interview

4.10 Suicide prevention and self-harm

Suicide prevention has been a national priority in Scotland over the past decade. Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland (2002-2012)\textsuperscript{87} provided a national focus for suicide prevention work in the immediate years following the Sandra Grant Report. It was succeeded by the Suicide Prevention Strategy 2013-2016\textsuperscript{88}. Preventing suicide is complex and understanding the impact of policies and interventions is problematic due to the issues of attribution. Choose Life has supported multi-level approaches to understanding and addressing suicide in Scotland. A key national achievement within suicide prevention work in Scotland has been the development of the Scottish Suicide Information Database (ScotSID), which first reported in 2012. ScotSID aims to provide a central repository for information on all probable suicide deaths in Scotland, in order to support epidemiology, policy-making and preventive activity.

As a general trend, population level suicide rates in Scotland have fallen slightly over the course of the last ten years, after reaching a peak of 16.1 deaths per 100,000 in 2007 and 2008, reduced to 14 deaths per 100,000 in 2013 (see Figure 7). The suicide rate for men remains consistently and significantly higher than for women, in line with international trends. The prevalence increases significantly among those who experience greater economic deprivation, in particular multiple derivation and loss.

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<th>Year</th>
<th>2003</th>
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<th>2011</th>
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<tr>
<td>Deaths by suicide per 100,000 population</td>
<td>15.6</td>
<td>16.3</td>
<td>14.8</td>
<td>14.7</td>
<td>16.1</td>
<td>16.1</td>
<td>14.0</td>
<td>14.7</td>
<td>14.4</td>
<td>14.2</td>
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</table>


\textsuperscript{87} http://www.gov.scot/Publications/2002/12/15873/14466

\textsuperscript{88} http://www.gov.scot/Publications/2013/12/7616/0
One of the major drives within suicide prevention work in Scotland has been training key frontline workers in suicide interventions, such as STORM and ASIST. A target of training 50% of frontline staff in suicide prevention was met in 2010. An evaluation of the use and impact of ASIST undertaken in 2008 reported a number of positive impacts, including reducing stigma and raising awareness of suicide within organisations and communities. However, there was also some evidence that the impact of ASIST had been limited in some local areas where, for a variety of reasons, it had been difficult to implement. Furthermore, there was a perception that there had been little take-up of ASIST among certain professional groups such as GPs and other primary care staff, NHS hospital staff, ambulance staff and addictions workers.

Many participants expressed concerns relating to self-harm in Scotland, especially among young people. Respondents who worked with young people highlighted what they perceived as increases in the referrals to CAMHS where self-harm and/or suicidal ideation or attempts were being presented.

Self-harm was viewed as a significant and increasing public health concern with associated implications for services, which is recognised in the distinct approach to self-harm described by the Scottish Government Suicide Prevention Strategy 2013-2015.

Stigma experienced by those who self-harm when seeking help from medical professionals was frequently discussed by review participants. Some improvement and good practice was reported within psychiatry liaison team systems which work to improve links between emergency departments and mental health services. However, the presence of a psychiatric liaison team in itself seems to be no guarantee against stigma and discrimination. Feedback from mental health service user participants suggests significant attitudinal and behavioural issues exist in A&E. Reported poor practice included: a lack of empathy; the liaison service not being used and people being sent home instead with a leaflet; those who had self-harmed being low priority; stitching without anaesthetic; refusal to stitch wounds; negative attitudes around it being the person’s own fault, their choice and due to selfishness; bringing the police in to deal with people who are highly anxious or distressed rather than attempting to understand the issues.

‘Lack of compassion among A&E staff has been identified as an issue by those who present after self-harm.’

- Staff, Panel Inquiry Area

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90 A psychiatric liaison team works in general hospitals, for example in the emergency department or in-patient wards. They provide psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital and provide a valuable interface between mental and physical health.
Innovative practice exists in the self-harm field in statutory services including NHS Greater Glasgow and Clyde Adolescent Self-Harm Service\(^9\) and the NHS Lothian Self-Harm Service based at the Royal Edinburgh Hospital. A range of voluntary sector providers have addressed this client group, with Penumbra’s long standing self-harm projects addressing need. Penumbra recently linked with Changing Faces to offer self-harm scar camouflage support in their project locations, a key aspect of enabling recovery from self-harm and the stigma relating to it.

The ongoing strategic focus on managing distress in the current mental health strategy and suicide prevention ties well with a holistic model of suicide prevention. In addition to pilot work on managing distress undertaken in Tayside, the Scottish Association for Mental Health has developed a Community Support Service to provide direct and family support to people who are experiencing suicidal feelings. These approaches are interesting emerging practices and could be carefully examined as potential models for future service delivery.

### 4.11 Advocacy

Independent advocacy is support and representation provided to someone by an individual or group who can act solely on that person’s behalf, independent from the person’s professional support and family. Since 2002, the Scottish Independent Advocacy Alliance has produced five Advocacy Maps looking at advocacy provision for people with learning disabilities and mental health conditions in Scotland. This work shows that over the last ten years there has been an increasing emphasis on the importance of access to independent advocacy, with a number of key changes relating to mental health including:

- A move away from hospital-based advocacy
- An increase in independent advocacy organisations and a wider recognition of the importance of advocacy in mental health
- A shift in priority of access to towards those patients detained under mental health or capacity legislation leading to challenges in access to advocacy for those patients not detained or requiring advocacy services in the community.
- An increase in people seeking support in relation to welfare reform.

The data in the most recent SIAA Advocacy Map 2013-2014\(^9\) suggests significant increases in referrals of people with mental health conditions to advocacy organisations. A range of reasons are cited for this, including welfare reform and the closure of services people have previously relied on. The number of paid staff employed by advocacy organisations has risen in recent years and stands at 508. An additional 1,000 volunteers are currently engaged in

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advocacy. Over 27,000 people accessed advocacy across the Scottish NHS Boards in 2013-2014. Although this data provides an overview, it does not include enough detail on the type and time of activities undertaken to extract accurate data on how many of the 27,000 contacts were with people with mental health conditions.

As well as people with mental health conditions as their primary issue, covered by the majority of advocacy agencies, advocacy is provided for people with learning difficulties, looked after young people, those on the child protection register, those who have experienced domestic abuse, addictions, people who are unable to safeguard their own wellbeing and unpaid carers. Both individual and collective advocacy is provided. Individual advocacy is one to one support and collective advocacy enables a peer group of people with shared interests to represent their views, preferences and experiences, providing a stronger voice than individual action and reducing isolation. Advocacy organisations reported to the SIAA that they now prioritise individuals facing compulsory measures under the Mental Health Act with this being written into 50% of SLAs. The SIAA report that many advocacy providers now find that they have to restrict access to advocacy to those who meet the criteria clearly defined by the Act. Although anyone with a mental health disorder has a statutory right to advocacy, the SIAA are concerned that as a result of the consequences of the requirement under the Act for access to advocacy to be prioritised for those who are facing compulsory measures, many, such as people with dementia, who are not subject to compulsory measures may not have advocacy available to them.

Nine out of 32 Local Authorities do not yet fund a collective advocacy service as part of their independent advocacy provision. Advocacy organisations report steadily increasing demand for their services; however, increased funding was reported by only 35% of agencies. This is placing pressure on staff in many organisations, leading to increased stress at work. Another downside of the increased demand and lack of capacity to respond well to the requirements identified in the SIAA report is that advocacy organisations are less able to raise awareness about the value of advocacy amongst potential service users, for fear of raising expectations. The SIAA Advocacy Map highlights a number of key gap areas around advocacy provision for people with mental health conditions including: young people using mental health services, carers, prisoners, older people, ethnic minorities, travellers and refugees and asylum seekers.

In terms of the feedback from participants in this review, there was a common view that staff and service users and carers now have a clearer understanding of the role of advocacy and that service users have become more confident and passionate about having their say and being heard. However, it was also felt by some that there was a need to further promote the value of advocacy more rigorously on a national basis and for more exchange of good practice between advocacy organisations. There was a call from some for the SIAA to create greater clarity about their role in supporting advocacy organisations on the ground. The Scottish Government is funding a Quality Assurance Pilot project until 2015, which will support the evaluation of advocacy organisations and provide opportunities for sharing learning.

Although participants mainly had positive experiences of using advocacy services, an area of concern expressed was the lack of follow-up after initial meetings. Service user respondents were particularly appreciative of advocacy services and they felt that they took
Advocacy services have adapted their communication styles to meet the needs of the different people they work with, such as texting. One advocacy group has found that texting is perceived to be more suitable for young people and that older people tend to prefer face to face. Some new systems seem to have been implemented which allow people to tell their stories, but they also seem to incur long waiting times. Advocacy worker attendance at hospitals, GPs and other meetings was perceived as particularly helpful, as was support with benefits forms.

“If you can get a good advocate fighting your corner they are worth their weight in gold.”

- Review Participant

Participants also reported that advocacy services are more accepted and can feel less confrontational than in the past. Advocacy organisations were praised for making efforts to build positive relationships with GPs and psychiatrists outwith specific client support matters. In one area, the Citizens Advice Bureau (CAB) holds monthly sessions in the local advocacy organisation’s offices, which enable people to access CAB with the support they need from advocates. Some participants felt that the intervention of advocacy groups has led to a drop in complaints about services in favour of an increase in conversation and dialogue with providers.

The lack of advocacy for carers in general, and specifically for those who care for people with mental health conditions, was raised as a significant issue by respondents. Another gap area identified by participants was advocacy support for parents around issues of child protection. Responses to this review also reflected the SIAA findings around a gap in advocacy support for people who have limited contact with mental health services, who rarely find themselves in crisis but have ongoing issues they require support with.

“The Mental Health Act actually says people should have collective advocacy. Let’s ensure it happens and let’s ensure it’s well funded so that people have an opportunity to come together, have their voices heard in a local area and have the wherewithal and knowledge base to actively engage in the processes to determine the type and quality of the services that are delivered in their own area…that’s what’s missing.”

- Review Participant

4.12 Funding, commissioning and service design

4.12.1 Mental health service funding

Exact figures for NHS mental health funding are difficult to define as NHS Boards receive generic funding from the Scottish Government and the proportion of this funding allocated to mental health is at the discretion of each NHS Board. Definitions of mental health and the services which fall under this remit vary across NHS Boards, making total spend across Scotland difficult to calculate.

Information Services Division’s (part of NHS Scotland) Adult Mental Health Benchmarking Project collects and publishes data on NHS Scotland spending and resources which can
provide an insight into spending on psychiatric services across NHS Boards. The most recent data from the ISD Adult Mental Health Benchmarking 2013/14 Project shows that expenditure on psychiatric services has remained fairly constant since 2008. ‘General psychiatric’ comprises spend on general psychiatry, older adult, forensic, child and adolescent specialities and is defined by ISD Mental Health Benchmarking Project as expenditure for inpatients, outpatients, day patients, community psychiatric team and resource transfers. Total expenditure by NHS Scotland for general psychiatric services in the 2012/13 time period was £899 million, representing 9.2% of total NHS spend. This is an increase from £877 million in 2011/12. Just over half of the general psychiatry expenditure is accounted for by inpatient services (54%) and a further 34% is accounted for by community spend. Community spend comprises total costs for day patients, community psychiatric team and resource transfers93.

General psychiatry spend across Scotland remained fairly constant over the 2008-2013 time period at around £170 per head (Figure 6). The greatest increases in funding were seen in NHS Shetland, NHS Orkney and NHS Tayside, but there was a marked decrease in spend for NHS Highland. Total expenditure per head on general psychiatry is highest in NHS Tayside (£220 per head) and NHS Greater Glasgow and Clyde (£199 per head), and the lowest spend on general psychiatry was seen in NHS Fife (£135 per head) and NHS Lanarkshire (£134 per head). Expenditure was very low in NHS Orkney (£66 per head) and NHS Shetland (£54 per head), however, medical facilities in Orkney and Shetland tend to be general and multi-purpose due to the very small populations of these places (Figure 5); dedicated psychiatric services are limited and this may explain the relatively low spend in these areas. It is not possible to make judgements about the parity between NHS Boards in terms of total expenditure per head, as these figures include significant capital expenditure, such as the new psychiatric facilities at Murray Royal Hospital and Stracathron Hospital in NHS Tayside.

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93 Costbook 300, ISD Scotland
Figure 8 – General psychiatry total expenditure (£ per head) NRAC adjusted population 2012/13 Data source: Costbook 300, ISD Scotland

NRAC (NHS Scotland Resource Allocation Committee) is a formula used by NHS Scotland to allocate funding to NHS Boards based on the size of population that NHS Board serves, adjusted for the age/sex profile of the NHS Board population, their additional needs based on morbidity and life circumstances (including deprivation) and the excess costs of providing services in different geographical areas.
Figure 9 - Trends in general psychiatric spend (£ per head) by NRAC adjusted population by NHS Board 2008-13. Data source: Costbook 300, ISD Scotland.

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95 See footnote 99
Community psychiatry services receive 34% of the expenditure on psychiatric services and this proportion has remained relatively stable since 2008 (see Figure 10). The total expenditure on community psychiatry services in 2012/13 was £307 million, an increase from £304 million in 2011/12. NHS Orkney and Shetland allocate the greatest percentage of their general psychiatry spend on community services. This may again be due to the limited availability of inpatient psychiatric services. This is followed by NHS Borders and NHS Lanarkshire, which each allocate 41% of their general psychiatric spend on community services. The lowest percentage of spending allocated to community services was seen in NHS Fife (22%) (see Figure 10).

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Community Spend (%)</th>
<th>Inpatient Spend (%)</th>
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</thead>
<tbody>
<tr>
<td>NHS Argyll &amp; Bute</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>59</td>
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<td>NHS Fife</td>
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<td>34</td>
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<td>SCOTLAND</td>
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Figure 10 – Community psychiatric spend as a percentage of total psychiatric spend by NHS Board. Data source: Costbook 300, ISD Scotland.
Figure 11 – Trends in community spend in £ per head NRAC adjusted population by NHS Board 2008-13. Data source: Costbook 300, ISD Scotland
The 2015/16 Scottish Government draft budget allocates £23.7 million to Mental Health Improvement and Service Delivery, an increase of 6.3% over the 2013/14 budget.

Experiences and perceptions of funding

Participants employed at various levels within the NHS including GPs, Primary Care Mental Health Teams and NHS Board Senior Managers reported experiencing cuts to funding for specific services. These cuts had resulted in the closure of some services, such as services for survivors of sexual abuse and counselling services within GP practices. Other services were operating with reduced funding, meaning cuts to staff and limitations to the number of people they could support. Tangible examples of cuts to services included reduced staff training and withdrawing taxi provision for people in distress, making the service less accessible.

‘Everything is cut to the bone; everyone does everything….being forced into greater efficiencies over the years is starting to tell; increased waiting time, increased triage and increase in crisis.’

- Independent Advocacy, Panel Inquiry Area

The withdrawal of funding for hospital-based day services and drop in centres emerged as a particular area of concern for participants. It was recognised that this may be a result of the move towards community-based services but a number of participants expressed concern that services which were keeping people well were not being replaced and that service users were becoming unwell as a consequence. Voluntary sector participants described cuts to core funding and great uncertainty regarding the availability and security of future funding. However, representatives from some voluntary organisations described securing funding through joint commissioning processes.

4.12.2 Strategic commissioning and integration of health and social care

While Scotland retains a publicly-funded NHS which provides the vast majority of mental health services, some services such as independent advocacy, user involvement, service design and psychological service delivery are commissioned from outside parties, including voluntary sector organisations and private companies.

Strategic commissioning is often undertaken by two or more agencies working in cooperation, usually NHS Boards and local authorities. The process of strategic commissioning is outcomes based in that it involves identifying gaps in service provision, defining the outcomes which are to be met by this service and building in a review system whereby progress towards these values can be evaluated. Each individual NHS Board is responsible for writing its own Strategic Commissioning Framework which should set out its principles for outcomes-based strategic commissioning, aimed at meeting the needs of the people it

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serves. For groups of service users, for example older adults or children and young people, separate strategic commissioning plans should be provided which describe their specific needs and provide evidence as to how these needs are not currently being met. Procurement of services is a specific aspect of strategic commissioning by which opportunities to provide services in order to meet defined outcomes are advertised and organisations can then tender for these contracts. The National Steering Group for Joint Strategic Commissioning works to the following definition:

‘Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.’

- Joint Strategic Commissioning – A Definition, 2012

Conversations carried out in the panel inquiry visits and interviews revealed how joint commissioning structures work in practice. Instances in which joint commissioning was working well and providing a route for innovation from the third sector to improve service delivery were discussed. Voluntary organisations had been commissioned to redesign services to improve outcomes for service users.

‘We have won four contracts where we have effectively closed existing day centres and redeveloped them into a much more community-based, social inclusion type of service so that it’s a sort of day service without walls...So that’s been a big development for us and something we think we’ve done well and others think we’ve obviously done well as well because they’ve given us prizes for it.’

- Expert Interview

Some concerns were voiced during the expert interviews around joint and third sector commissioning, highlighting in particular the commissioning of service user and carer representation and the extent to which this representation can be independent and unbiased when reporting directly to the NHS Board or funding body concerned. However, many of the voluntary organisations involved in this work report to independent governance committees, maintaining a level of impartiality. There was some agreement among the review participants that there were many exciting and innovative projects and services and that joint strategic commissioning has the potential to bring some of this innovation into statutory services:

‘Most of the innovation in mental health over the last ten years has come from the voluntary sector and been shared with others but this is almost in spite of, and not because of, any encouragement.’

- Expert Interview

One expert interviewed felt that commissioning voluntary and third party organisations to redesign services is often an expensive and time consuming process and that NHS Boards may be prevented from engaging fully and successfully with the voluntary sector due to funding constraints:

‘When it comes to redesigning or retendering or rethinking services, I think we’re still stuck in the mode of more of the same for less.’
Integration of health and social care

The Public Bodies (Joint Working) (Scotland) Act 2014\(^7\) sets out plans for the integration of health and social care across Scotland with the intention of improving quality of services, providing seamless transitions through services, supporting service users in the community and meeting the needs of specific groups. Local strategic plans for health and social care integration are expected to be in place by April 2016. This review found evidence that each of the NHS Boards visited in the course of the case studies were moving towards integration from different starting points. Representatives from some NHS Boards reported working towards integration over the last ten years, while the integration model was a relatively new way of working for others. There were mixed experiences of integration, with some areas discussing how although not integrated at a ‘strategic’ level due to co-location, some specialist services had been working jointly for many years. However, in other areas, although health and social work shared a building, the services and staff were viewed as ‘quite separate’. This led to discussions suggesting that to enable integration to take place, consideration has to be given to good partnership working at all levels e.g. on the ground and at the strategic level. Among service users there was less understanding of how integration would bring benefit (or otherwise) to them or if it would impact upon their care and treatment at all.

‘I am not sure what the effect of the integration of health and social care has been for mental health \(^8\). In my opinion it has not benefitted mental health, but my understanding is that it was aimed largely at improving links/services for care of the elderly.’

- Service User Focus Group

Despite mixed experiences, there was a feeling of optimism reported at the potential for health and social care integration to bring about positive change in terms of clearer leadership and direction and greater involvement of service users and carers:

‘It is too early to say what will happen but it does feel on the up; more focus, more strategic approach, more involvement of services users, carers and focus groups on this and others like “service access” and so on. A strategic plan that gives a feeling that things are happening. More of a focus on where we are going, feels more like a joint journey.’

- Staff, Panel Inquiry Area

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\(^8\) As health and social care integration will not be fully completed until 2016, the full effect on mental health services is speculative
However, representatives of a small number of services which were visited during the course of the panel inquiry visits expressed concerns that health and social care integration would introduce an additional level of bureaucracy, resulting in more complicated systems that would bring little benefit to the public but instead lead to a need for ‘funding another layer of management.’

4.13 Mental Health Services Development and Delivery

4.13.1 Workforce and culture

Data on characteristics of the psychological services workforce is held by ISD Scotland. This data indicates a substantial increase in the whole time equivalent (WTE) number of clinical and other applied psychologists since 2005\(^99\). This increase is also seen in WTE of CAMHS staff since 2006\(^100\). Mental health nursing staff numbers have seen a more modest increase since 2013\(^101\).

In general, review participants reported positive experiences of interactions with mental health professionals. Representatives from service user and carer groups agreed that this finding was reflected amongst their membership. However, this review found that, while rare, experiences of poor care and harmful staff attitudes do appear to occur within mental health:

‘I would say that the majority of our members are happy with the services that they get but often think that they need more so I rarely meet people that say “I can’t stand my psychiatrist or my CPN” or whatever but I do meet some, and I do meet some people who would very clearly say they have had quite unhelpful attitudes from professionals.’

- Expert Interview

‘I’ve been in hospital about four of five times in the last ten years and my experience with most of the nurses has been really good. There have been some who have been abysmal…but others I was astonished how well they were able to look after me when I was unable to communicate.’

- Expert Interview


\(^{101}\) ISD Scotland (2015) Nursing and Midwifery Staff In Post Data Tables [available at http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp#859]
There was the perception among the review participants that a continuing squeeze on funding had had a negative effect on staff culture, as caseloads have become higher with less time available for staff to network and share the benefits of their experience:

‘Attitudes within services…I do think there’s a sense of retrenchment. I think people have withdrawn into their bunkers almost because of the way that finances are, because of cuts to services people are unable to perhaps network, communicate, debate, make connections, build new partnerships in the way that might have been possible previously and I think there’s been less money put into bringing people together.’

- Expert Interview

However, staff within individual services spoke of fostering an ethos of openness and communication through open door policies and socialising together.

The inclusion of the Mental Health (Care and Treatment) (Scotland) Act 2003 in the training of new mental health nurses was seen to have had a positive effect on nursing culture, as were the publication of Rights, Relationships and Recovery: the Report of the National Review of Mental Health Nursing in Scotland Review in 2006 and the introduction of the Scottish Recovery Indicator in 2007:

‘The review of nursing reinvigorated that workforce. They kind of re-found a bit more of their purpose, I think, and they used recovery as a way of doing it. So they changed the way that nurses were trained, for example, and the sort of information that they received on their training was very much revised. Things like the SRI were introduced and it’s very specifically to do with nurses.’

- Expert Interview

‘Family Based Treatment’ training for eating disorders, ‘ASIST’ suicide prevention training and online ‘Dignity and Respect’ training were mentioned by participants as specific courses that had been of benefit to services. However, concerns were expressed by participants that limited resources meant that it had become more difficult to release staff to attend training and that Health Care Assistants and other care staff members were not being given appropriate, mental health specific training. This review identified understaffing and staff recruitment as an area of concern among many of the participants:

103 Developed by Maudsley Hospital in London, family-based therapy for anorexia nervosa involves the families of patients in psychological therapy which explores the family relationship.
104 Applied Suicide Intervention Skills Training (ASIST) is a two-day training workshop which provides participants with the skills to recognise and intervene effectively to help people who are at risk of suicide.
105 Dignity and Respect training is aimed at those working in the health and social care sector to help them provide a more dignified care service and understand the legislation that affects human rights within the care sector.
‘An example would be the huge difficulty there is nowadays to recruit psychiatrists and the fact that, for at least a year, we’ve been really down on psychiatrists so that people are not getting appointments and are not getting assessed for a number of months.’

- Staff, Panel Inquiry Area

4.13.2 Acute mental health service experiences

Bed numbers

In 2014, there were 4,380 available psychiatric beds across Scotland. This figure has fallen substantially over the last ten years, from 6,556 available beds in 2005. Approximately half of the inpatient psychiatry beds currently available in Scotland were dedicated beds for people over the age of 65\(^{106}\). An average of 86.5 inpatient psychiatric beds was available per 100,000 population (Figure 12). The highest numbers of beds are found in NHS Fife (102.5 beds per 100,000 population) and NHS Greater Glasgow and Clyde (95 beds per 100,000 population). The lowest number of beds is found in NHS Highland (65.8 beds per 100,000 population). NHS Orkney and NHS Shetland are omitted from this figure as they do not have any specified inpatient psychiatry beds.

\[\text{Beds per 100,000 NRAC weighted population by health board 2012/13}\]

\(^{106}\) Adult Mental Health Benchmarking Project, ISD Scotland
Despite the decreasing number of available beds, occupancy rate has remained fairly constant around 80% occupancy over the last ten years. Average length of stay varies greatly across NHS Boards, with the shortest average stay of 29.9 days reported by NHS Dumfries and Galloway and the longest average stay of 138.5 days reported by NHS Forth Valley.

This data raises salient questions around the reduction seen in the number of inpatient psychiatric beds. It may be that there has been a concurrent increase in community-based services, allowing service users to receive support at home. In addition, a proportion of decrease may be explained by the development of new medium-secure facilities. However, overall, it is unclear from this data what the underlying reasons are for the variation in bed numbers and lengths of stay seen across NHS Boards, but it does raise an important area for further investigation.

\[^{107}\text{See footnote 99}\]

Figure 13 – Trends in inpatient psychiatry beds per 100,000 population by NHS Board 2008-2013. Data source: Adult Mental Health Benchmarking Project, ISD Scotland.
Experiences of accessing inpatient care

With the shift from hospital-based to community-based mental health care, there was a perception among service users that accessing hospital services has become more difficult but that there has not been a corresponding increase in community care capacity. Therefore, people are now more ill on admission to hospital:

‘It’s more and more hard for people to get into hospital, especially those who have personality disorders and it almost seems to be a national statement to say that all the evidence is that if you have a personality disorder, you shouldn’t go into hospital without providing any alternative.’

- Expert Interview

This view differed from some members of staff in some of the services visited. They recognised this perception amongst some of their longer terms service users who had lived through the movement towards more community-based mental health care. However, they felt that home treatment, crisis teams and community services represented progress in that they now allowed for people to be supported in their own homes for longer than previously possible:

‘We try to treat people at home unless it becomes unavoidable and they have to be admitted. They are then sent home to be supported and treated there.’

- Staff, Panel Inquiry Area

Inpatient environment

This review found a general feeling among participants that improvements had been made to the mental health inpatient environment over the last ten years. Numerous improvements have been made to existing wards and new inpatient facilities have been opened to replace older sites which were no longer fit for purpose. A number of inpatient wards were identified as exemplary, including Midpark Hospital and the community hospital provision in Cumnock. However, it was recognised that there are still a number of inpatient facilities which do not provide adequate provision for the people they are serving. It was suggested that hospital settings had improved less for those with longer term mental health conditions, and that patient experiences may be worsening among this group:

‘I’ve mentioned severe and enduring mental illness…You still have people stuck in some very old crumbling buildings…I consider it a national disgrace that the Royal Edinburgh Hospital still exists in the form that it’s in 2014. Some of the conditions within that hospital [are] just appalling. It’s not conducive to good patient care.’

- Expert Interview

Service user and carer involvement in care planning

This review found that, while some pockets of good practice exist, service users felt that their involvement in care and discharge planning was insufficient. Review participants reported feeling that they were not being listened to and that involvement processes were sometimes tokenistic, that their preferences were noted on a form
but that this did not always have an impact on their care. ‘We’re still seeing less emphasis on a personalised approach…with the person being considered an expert in their own experience.’

- Expert Interview

‘The doctors – you try to tell them what is wrong with you – they are listening but they are not listening and they cut you off your medication and do detox without you knowing.’

- Service User, Panel Inquiry Area

‘I never got told what was wrong with me’

- Service User, Panel Inquiry Visit

‘You get discharged when they decide you should be not when you decide.’

- Service User, Panel Inquiry Area

Ways in which review participants suggested that service user involvement in care planning could be improved were: clearer and more frequent communication between staff and service users; full consultation on decisions regarding medication and discharge; and involvement of carers in care planning. The Care Programme approach, a co-ordinated approach to care planning for those who experience severe mental health conditions, was highlighted as promising practice in improving service user involvement in making decisions which affect their care. The range of experiences of involvement in care planning from the very positive to the very negative was echoed in the comments of carers who participated in the review. One individual had received exemplary support in being involved in planning her son’s care, down to having her travel expenses paid. However, some participants also described having had no input at all into care decisions and being unwilling to challenge medical practitioners on their decisions due to fears that those for whom they cared would be labelled as ‘problem patients’ and receive poorer treatment as a result.

Findings from research carried out by the Carers Trust (2014)\(^{109}\) into experiences of 24 carers in admission and discharge planning support the findings of this review. The Carers Trust report found that the majority of carers who participated had been as involved as they wanted to be in planned admissions, with examples of good practice including good communication between ward staff and carers, and inclusion in important appointments and consultations. However, many found the extent to which they had been involved in discharge planning insufficient and unsatisfactory. The majority felt that discharge plans had not been communicated to them and that they were not offered support in preparing for supporting service users at home. Some carers felt that their involvement was a tick-box exercise and that their genuine concerns regarding discharge were not taken seriously and written off as ‘anxieties’. The Carers Trust report suggests a number of ways in which carers could be more engaged in care planning, including better communication with health care staff

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\(^{109}\) Carers Views on Admission/Discharge Procedures. 2014. Carers Trust Scotland.
regarding admission, discharge and what to expect, as well as involving carers and GPs in planning a seamless transition into community support. Issues with confidentiality were cited in the Carers Trust report as a reason often given to carers for their lack of involvement. This raises an important issue about the complexity of balancing the rights of service users and those that care for them, and is an important area of future research to identify effective approaches.

It should be noted that there are interesting pockets of promising practice emerging in relation to involving carers in Scotland, such as the use in NHS Greater Glasgow and Clyde of the National Mental Health Development Unit (NMHDU) Triangle of Care Approach\(^{110}\) developed in England. However, the evidence of this having improved experience has not filtered down into any of the evidence gathered within this report.

### 4.14 Specialist services

#### 4.14.1 Children and young people services

There are currently the following dedicated Child and Adolescent Mental Health Services (CAMHS) inpatient facilities for young people aged 12-18 in Scotland:

- Skye House, Glasgow (24 beds, includes 2 short stay beds)
- Young People's Unit, Edinburgh (12 beds)
- Dudhope Young People’s Inpatient Unit, Dundee (12 beds)

In addition to the above provision, 6 inpatient psychiatric beds are available for children under the age of 12 at Ward 4 in the new Royal Hospital for Children in Glasgow\(^{111}\). There are a further 22 beds for 11-18 year olds at Huntercombe Hospital, a private facility in Lothian.

Accessibility and availability of inpatient provision is impacted by the number of inpatient beds and the average length of stay on wards. This can be influenced by a number of factors, including the severity of issues affecting the young person and availability of suitable care and treatment in the community.

**Young people on adult wards**

While the number of young people admitted to adult wards has increased over time, this should be understood in the context of increasing young people’s admissions to inpatient provision overall. The proportion of young people admitted to adult wards as a percentage of


\(^{111}\) Ward 4 is the new name (and location) for Caledonia House that was located within Yorkhill Hospital. Relocation has seen new day service provision being developed.
all admissions has decreased from 75% to around 50%. Overall, admission of young people to inpatient wards increased between 2008 and 2013 from 28.3 admissions per 100,000 populations to 42.3 admissions per 100,000 populations. Young people’s admissions to dedicated CAMHS inpatient psychiatric beds increased over the time period from 7.1 per 100,000 population in 2008/09 to 21.2 per 100,000 population in 2012/13. Admission of young people to adult wards remained relatively constant across the time period (Figure 11).

The highest total numbers of young person inpatient admissions are seen in NHS Borders (64.2 admissions per 100,000 population) and NHS Lanarkshire (59.6 admissions per 100,000 population). The proportion of young people admitted to adult wards strongly reflects the availability of dedicated CAHMS inpatients services within each area. Those areas with the highest proportion of young people admitted to specialist CAMHS beds are those which have dedicated services within their area, namely NHS Lothian, NHS Greater Glasgow and Clyde and NHS Tayside. NHS Lothian had the lowest number of young person admissions to adult wards with only 2.5 admissions per 100,000 population in the 2012/13 time period (Figure 12).

Figure 14 – Trends in child and adolescent inpatient admissions per 100,000 under 18 population 2008-13. Data source: Child and Adolescent Mental Health Services (CAMHS) Balanced Benchmarking Scorecard: Publication Report, ISD Scotland
Figure 15 – Numbers of young people on adult wards per 100,000 under 18 population by NHS Board 2012/13. Data source: Child and Adolescent Mental Health Services (CAMHS) Balanced Benchmarking Scorecard: Publication Report, ISD Scotland
Agreements exist between NHS Boards whereby Boards with specialist CAMHS inpatient facilities provide inpatient capacity for those without. In 2013, the number of CAMHS beds met around half of the demand for inpatient services for children and young people, compared to meeting around a quarter in 2008. This issue raised concerns during the review panel inquiry visits among mental health practitioners and service users. Those working within NHS Boards found that CAMHS inpatient services were difficult to access, in some cases leading to young people being admitted to adult wards.

‘A main concern is the lack of inpatient beds. We cannot access Skye House when we need them. In the last three months we have had seven or eight people on an adult ward.’

- Staff, Panel Inquiry Area

The increase in demand for CAMHS inpatient services was viewed differently by staff within tier 4 services. One tier 4 team engaged in the review felt that there work needed to be done alongside community CAMHS so that there was a ‘shared understanding’ of what inpatient provision could and could not achieve. There was recognition that length of stay in units has an impact on availability and that some inpatient units have considerably longer lengths of stay than others. Staff commented on demand and appropriate referral patterns being regular issues on the agenda in meetings between inpatient and community teams. Some inappropriate referrals of young people to inpatient services were attributed to changes within the workforce, whereby very experienced staff had moved on, leaving newly recruited and less experienced staff in place who were more likely to refer to specialist inpatient care.

Service users who participated in the review reported feeling scared and isolated on adult wards which are not equipped to deliver appropriate services to young people.

‘I went to Crosshouse because there were no spaces for young people, so I was in adults, then transferred to Skye House for two months. I was waiting for a bed while I was in Crosshouse. I was there six months. By the time I left the work had then already been done.’

- Service User, Panel Inquiry Area

‘I felt isolated. I was kept away from other patients and on constant obs. The nurses were all lovely, the patients were dead nice but I wasn’t used to it. It was scary at first. I could still move around but I had someone with me, both clinical need and because I was under sixteen.’

- Service User, Panel Inquiry Area

However, another young person described their experience of care in an adult unit (not as an inpatient but receiving intensive day treatment) very positively.

‘I think the service is great…. I can phone when I want and every time I call I have been able to speak and they have booked me appointments when I asked for them. They give me a sense of hope and a feeling that things will get better…I’m quite comfortable here. I’m unsure what a dedicated young people’s service would be like.’

- Service User, Panel Inquiry Visit
When young people are admitted to inpatient beds in regional centres, this can necessitate travelling long distances to Glasgow, Lothian or Dundee, away from family, friends and school. In a very small number (4) of complex cases, usually involving young people looked after and accommodated in residential units prior to admission, this has included transfer to specialist units in England due to lack of suitable provision in Scotland\textsuperscript{112}.

Waiting times for community CAMHS

The original HEAT target for access to CAMH services required that young people should wait no longer than 26 weeks from referral to treatment. This was updated in the 2014-15 HEAT targets, specifying that this wait should be reduced to 18 weeks for 90% of patients from December 2014. Figures from ISD\textsuperscript{113} indicate that 85.2% of people seen by CAMH services started their treatment within 26 weeks and 78.9% were seen within 18 weeks of being referred for the quarter ending 31\textsuperscript{st} March 2015. Half started their treatment within 9 weeks. This is similar to the percentage of people seen within 26 weeks and 18 weeks in the previous quarter ending December 2014 (Figure 13).

![Percentage of patients who start treatment with CAMHS within 18 weeks Apr 14-Mar 15](http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/data-tables.asp?id=1399#1399)

Figure 16 – Waiting times for CAMHS services: 18 weeks ISD adjusted completed waits for people seen, Child and Adolescent Mental Health Services Waiting Times in Scotland 2015. http://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/data-tables.asp?id=1399#1399


In 2009, the Scottish Government committed central funding to expand the CAMHS workforce of NHS Scotland. This has resulted in a steady increase in the CAMHS workforce from 764.6 WTE (883 headcount) in 2009 to 980.6 WTE (1136 headcount) as of 31st March 2015. As of 31st March an additional 61.6 WTE posts were between recruitment and being filled and a further 22 WTE posts were approved but not yet advertised. The workforce supply reports by ISD identify a gap in workforce data, with current vacancies in teams due to absence, illness or internal movement not being known, meaning that in practice staff could feel limited or no immediate net gains to the workforce in terms of numbers.

![Advertised and unfilled CAMHS posts (WTE) Jun 2011-Jun 2015](chart.png)

Figure 17 – Advertised and unfilled CAMHS posts (WTE) per quarter Jun 2011-Jun 2015 (Data from ISD Scotland)

Within this review, participants highlighted their experience of significant problems in recruiting CAMHS staff, including specialist consultants, resulting in changing staff levels and more nurse led services:

‘Staffing levels have been ridiculous – we are short staffed and have unfilled posts.’
- CAMHS Service, Panel Inquiry Visit

‘Secondment, sickness, vacant posts mean we’re always running at a lower number.’
- CAMHS Service, Panel Inquiry Visit

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Review participants felt that pressure on staff teams due to unfilled posts could lead to problems with morale. However, other CAMHS staff talked about good team spirit with team members making conscious efforts to connect regularly with each other. There was recognition among participants that there has been enormous change within CAMHS over the past ten years. This includes how CAMHS are structured as well as a significant increase in demand.

Some CAMHS teams who participated in the review described difficulties in meeting the 18 week HEAT access target. Problems with unfilled posts were felt to be compounded with a rise in referral rates, with one team describing a 57% increase in referrals since 2009. One team felt that a potential reason for the rise in demand for CAMH services were the reduction in services elsewhere in the public sector, such as school psychology services. The increase in demand was raised in a number of ways, with some participants expressing that in their experience it was increasingly common for CAMHS to not accept referrals due to cases *not fitting criteria*. Among CAMHS staff, they highlighted that they were dealing with more complex cases and *crisis work*, including self-harm and suicide attempts. However, there was also a view that CAMHS were still expected by some to take on *tier 2 cases*¹¹⁵ that could be *dealt with better by primary care work*. It was felt that this situation was resulting in *patient referrals going round in circles* and *young people falling off the radar*.

A reoccurring theme that emerged from the review, raised by a range of participants including GPs, CAMHS staff teams and voluntary sector organisations, was the view that some of the demand on CAMH services was due to a gap in provision around crisis care and in prevention/early intervention. Despite this, one area highlighted good practice around training of teachers and those who work with young people to identify distress, in particular self-harm, and provide them with the skills to help young people manage this.

> *We are coming across more and more complex cases now, but we don't have the number [of cases] to sustain a crisis team.*

- Staff, Panel Inquiry Visit

Over the last ten years, a number of specialist CAMHS community services have developed, particularly teams supporting looked after and accommodated young people (LAAC) and young people who self-harm. These were viewed as positive changes by review participants. One CAMHS team in a NHS Board without a specialist LAAC service indicated that they spent around 50-60% of their time supporting this population group, which constituted a major resource issue in their opinion.

A significant development in recent years has been the creation of early intervention teams for psychosis for young people. However, the review found that access to such services remains limited, with services only located in major population areas and able to support relatively small numbers of individuals.

¹¹⁵ CAMH services are generally delivered through a tiered model.
Issues around transition were raised in relation to children and young people’s services. Overall, the transition between CAMHS and adult services were felt to be better now than in previous years and better than relationships between paediatric and CAMHS.

‘Better links between paediatrics and CAMHS are needed. There are totally different management structures and a more integrated approach would work better than simply transferring at age.’
- Staff, Panel Inquiry Visit

One young service user discussed how transition would always be difficult because of the bond developed with staff and the significantly different approach taken by CAMHS and adult services. In this case, this was despite the handover being felt to have gone ‘well’.

‘The cut off thing is not ideal…you form relationships and trust people.’
- Service User, Panel Inquiry Visit

Among the few young participants who took part in the review, the bond they felt with their therapist was frequently discussed.

‘They really, really helped me. I couldn’t have done it without them...they helped me through it when nobody else was there.’
- Service User, Panel Inquiry Visit

‘They are calm and relaxing people and very understanding.’
- Service User, Panel Inquiry Visit

As highlighted above, there was very little discussion among participants on mental health prevention initiatives with two areas making reference to work in schools. This is a reflection of the scope of the review process as direct work to explore experiences of tier 1 staff (teachers, youth workers, social workers etc.) were not within the agreed areas of inquiry. Another area where the review was not able to gather sufficient evidence was in perspectives and opinions on the impact of developments that have taken place within maternal and early years’ provision. It is important to note, however, that there has been promising work emerging on perinatal mental health pathways and specific initiatives to support young mothers. Parenting programmes including Mellow Parenting, Mellow Bumps and Triple P, have emerged over recent years, some of which have been within the remit of public health. This is an area that would require further investigation when many of these new services bed down, but capturing a baseline may be an important starting point.

4.14.2 Perinatal mental health services

Provision for mothers and babies was a specific concern raised during the passage of the Mental Health (Care and Treatment) (Scotland) Act 2003, and provision was developed
consisting of two dedicated NHS Mother and Baby Units (MBUs) that admit mothers with mental health conditions with their babies. The West of Scotland MBU is sited at Leverndale Hospital, Glasgow, and has 6 beds, serving the following NHS Boards: Greater Glasgow and Clyde, Ayrshire and Arran, Dumfries and Galloway, Lanarkshire and the Western Isles. The NHS Lothian MBU is at St. John’s Hospital, Livingston, and also has 6 beds. It admits from Lothian, Fife, Grampian, Highland, Tayside and Borders NHS Boards. In a recent study, there is evidence that patients in Forth Valley have accessed both of these units but no data to indicate that NHS Shetland or NHS Orkney patients had been admitted to either of the units during 2012 and 2013.

It was beyond the capacity of this review to audit perinatal mental health services in detail across Scotland, but two recent reports provide further more detailed mapping of these services. Everyone’s Business conducted a UK wide mapping of Perinatal Services in 2014, which showed that NHS Greater Glasgow and Clyde, NHS Lothian, and NHS Forth Valley provided dedicated perinatal community mental health teams. Their map showed limited community provision in Ayrshire, Lanarkshire, Borders, Grampian and Highland and no dedicated community provision in Dumfries and Galloway, Fife, Tayside, Western Isles, Orkney or Shetland.

Galloway and Hogg (2015) produced a detailed map of perinatal provision Scotland for the NSPCC and Maternal Mental Health Scotland. Their report ‘Getting it Right For Mothers and Babies’ brings together substantial research across 14 boards about perinatal provision at every level. The following practice example from NHS Forth Valley is quoted from the report:

**PRACTICE EXAMPLE: NHS FORTH VALLEY**

NHS Forth Valley developed a multi-disciplinary nurse led perinatal team service supported by a Consultant Psychiatrist in 2013. The focus of the team is early intervention, prevention and minimisation of mental illness. The model of care is based on a virtual concept. The Advanced Nurse Practitioner is the only full time post, all other members of the team remain in their substantive posts with minimum weekly time dedicated to perinatal mental health. There is no maximum time limit this is dependent on the individual needs of the women and other non-direct clinical activity. Having members of the perinatal team with substantive posts from community mental health teams, liaison psychiatry, the intensive home treatment team

116 http://www.nhsggc.org.uk/your-health/health-services/mental-health-services/services/other-services/west-of-scotland-mother-baby-unit/
117 https://www.nspcc.org.uk/globalassets/documents/research-reports/getting-it-right.pdf
119 http://www.nspcc.org.uk/globalassets/documents/research-reports/getting-it-right.pdf
and inpatient setting allows the team to be flexible, tailoring the level of care to the women’s need while avoiding input from multiple teams. Adopting this approach has prevented a lack of human resources for what would be a very small team based on an average annual birth rate of 3133 covering a geographical area spanning 984 miles.

The team accepts referrals for preconception advice, women in the antenatal period, maternity liaison and the first six postnatal months. Referrals beyond this timeframe are discussed on an individual basis. The team can work with mothers until their infant is 1 year old.

Care is provided in the outpatient clinic and the home environment. Hospital admission is provided locally in a purpose built annex of the general psychiatric ward for women at any stage of pregnancy or mothers who are offered but decline admission to the regional mother and baby unit and are admitted without their baby.

When a mother is admitted to the regional mother and baby unit the team liaise with the regional unit and provide care on discharge. (Galloway and Hogg, 2015 p.35)

In the voluntary sector, Crossreach provides Post Natal Depression Counselling in Lothian and Glasgow, which include a range of preventative activities, parenting support and support for fathers experiencing post-natal depression.

4.14.3 Dementia services

The first specific dementia strategy for Scotland was published in 2010. The second strategy runs from 2013-16 and contains 17 commitments to improving care and support for people with dementia and their carers. These focus on diagnosis, post-diagnostic support, maintaining independence and quality of life, advance care planning, improving staff skills, supporting user and carer involvement, appropriate prescribing and supporting research. Review participants were very positive about the Scottish Government making dementia a significantly higher priority over the last ten years.

‘There’s been a huge commitment to dementia and I think in the last two or three years we’ve seen a big shift in terms of how dementia is funded.’

- Expert Interview

121 http://www.crossreach.org.uk/postnatal-depression-services-lothian-0
122 http://www.crossreach.org.uk/postnatal-depression-bluebell-services-glasgow-0
It was felt that this policy shift and increased focus on dementia had led to wider positive developments including more awareness of dementia, less stigma associated with it and people with dementia being involved in their care and treatment for longer. Specific initiatives in recent years were also viewed positively including Dementia Link Worker positions.

‘Compared to ten years before, stigma has changed absolutely, and people with dementia are more involved. There’s a lot more awareness of dementia…it’s now all in the open.’

- Staff, Panel Inquiry Visit

However, participants raised concerns about the care available for people with dementia. One recurrent issue was a lack of continuity of care, with examples of individuals no longer having a named social worker, reviews being completed by phone or teleconference and issues being dealt with by duty social workers. This was raised specifically in rural areas and was felt to be due to restructuring and cost saving approaches being implemented.

‘Continuity is the big, big thing for folks with dementia and for relatives.’

- Staff, Panel Inquiry Visit

Within the review, discussion about dementia care and available services was often set within a wider context of concern about cuts to budgets and the impact this has on service provision for older people overall. An issue raised by some participants was that, in their view, there has been a move from specialist and personal support to more generic and impersonal support, largely implemented through phone or teleconference provision. This is of particular importance for rural areas and was also framed within discussions about population change, increased numbers of older people and rising dementia cases. Specific issues raised in rural areas were increased feelings of isolation among older people and difficulties around transportation due to large geographic areas being covered. When numerous home visits were required, it impacted on staff time, often leading to a reliance on volunteers and community support.

‘There are very few volunteers in Oban to assist with getting folks to activities. They are supporting approximately 100 clients, none of whom are on SDS [self-directed support] budget.’

- Staff, Panel Inquiry Visit

When discussing service redesign in local areas, and specifically new hospital buildings, the extent to which good practice on dementia was felt to have been taken into account or implemented varied. In one panel inquiry area, the new hospital was discussed as being ‘dementia friendly’. However, in another area, dementia support services felt there had been a ‘missed opportunity’ with ‘no colours or way-finders’ around the hospital. In a third area, currently consulting on a new build hospital, it was felt that dementia services are actively involved in the consultation process and this would lead to good practice being built in.

Perhaps because of the dementia HEAT targets, there was a perception among some review participants that greater emphasis has been placed upon diagnosis and post-diagnosis support rather than that for people at more advanced stages of the illness.
'There’s very much a focus on early diagnosis and post-diagnosis support and you forget that there's people at the severe end of the dementia spectrum where there’s not really been a major policy focus.'

- Expert Interview

A related concern was a lack of support available for carers of people with dementia. It was also suggested that the focus on dementia may have taken attention away from other older peoples’ mental health conditions and many called for a renewed focus upon older adults’ mental health outwith dementia in national government strategy.

### 4.14.4 Older adults

Dedicated psychiatric inpatient facilities are available for older adults in all NHS Boards except Orkney and Shetland. These include:

- Specialist dementia wards
- Inpatient services treating older people with non-dementia related mental health conditions
- Mixed purpose wards treating older people with a range of dementia and non-dementia related mental health conditions

In addition, older people may be admitted to adult psychiatric wards where specialist beds are not available. The Royal College of Psychiatrists’ report on inpatient care for older people within mental health services recommended:

- The care of frail older adults with complex needs on wards for younger adults is usually inappropriate as it can place them at risk from robust, behaviourally disturbed younger adults and deprive them of the specialist nursing, medical and other care that they require.
- Having separate inpatient beds for those who have an ‘organic’ brain disorder such as dementia and older people with so-called ‘functional’ disorders has been consistently regarded as good practice and is recommended. If separate wards cannot be provided, then mixed wards should be provided with clear separate living spaces available on wards for those with dementia and those with functional mental health conditions.
- There is a clear need for specialist mental health services to develop challenging behaviour services for older people. Without significant investment in this area, it is likely that some individuals who are difficult to treat/place remain ‘long stay’ within services that are designed to provide short stay assessment and treatment, to the detriment of all patients in that environment.
• Shared care protocol between adult and older people’s mental health services for the care of ‘graduate’ patients.
• The suggested number of beds for acute care should be 1-2 per 1000 elderly persons in a community.  

Specialist Older Adult Community Mental Health Teams now exist in most NHS Board areas, but, as with CAMH services, recruitment to consultant posts within older adult services was felt by review participants to be problematic.

The subject of older adult inpatient facilities was not raised frequently by review participants, although it was suggested that there was currently ‘too much emphasis on keeping [older people] out of hospital’. Concerns were also raised that there is a lack of provision for ‘older adults with a functioning mental illness’. One carer also felt that there was a tendency to consider older people’s mental health in terms of dementia care:

‘Older people with a mental illness, they see them as dementia cases. This is not a good mix as you need people you feel comfortable with….who are similar.’

- Carer, Panel Inquiry Visit

Participants in one panel inquiry area presented a disjointed picture of older adult inpatient services, with specialists being based on a different site to the older peoples’ wards. Delayed discharge was not highlighted as a key issue by participants, even though it continues to be an issue that is raised as predominantly affecting older patients. Some older service users who participated in the review felt that age was not taken into consideration when designing and delivering services. In particular, they highlighted an increased reliance on technology to deliver services, apply for benefits and obtain information, which could be ‘confusing to older people’. It was also emphasised that internet access was often poor or non-existent in some rural areas. Several participants in community services felt that some community mental health services offered limited provision to people over 65 and that more needs to be done to ensure effective provision and transitions for older service users.

‘Voluntary organisations shouldn’t be plugging the gap….it is wrong to say to people: you are 65, we can’t admit you to counselling.’

- Focus Group Participant

‘They won’t close someone because they reach age 65 but they feel that there is some pressure to especially if support needs changing.’

- Focus Group Participant

A minority of participants also raised more general concerns about older people in care homes, with a sense that overall ‘trust in care’ has broken down over the years with families and older people.

“When you let people go into care you don’t know that they will be safe.’

- Focus Group Participant

### 4.14.5 Forensic

The following forensic mental health inpatient services are available across Scotland:

<table>
<thead>
<tr>
<th>Level of Security</th>
<th>Area Served</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Scotland</td>
<td>State Hospital, Carstairs</td>
</tr>
</tbody>
</table>
| Medium            | Regional    | North – Rohallion Clinic, Perth  
|                   |             | South East – Orchard Clinic, Edinburgh  
|                   |             | West – Rowanbank Clinic, Glasgow |
| Low               | Local       | Most NHS Boards have low secure services |

Figure 18 – Forensic mental health inpatient facilities across Scotland

Several participants in the review felt that capacity was currently stretched within medium secure units. It was suggested that there was a need for increased high and medium secure provision, particularly for women. In terms of support available within forensic inpatient settings, specialist carers’ support was seen as vital. It was felt that carers often avoid mainstream services for fear of having to disclose their story, and prefer the direct peer support of a forensic group. The Triangle of Care approach was also highlighted as beneficial.

### 4.14.6 Prisons

The review did not raise discussions about mental health care provision in prisons and among offenders. However, since 2004, there is a considerable body of evidence showing that mental health needs among prisoners and offenders in Scotland is high, and that mental health services for common mental health conditions need to be reviewed. The NHS took over responsibility for health in prisons from the Scottish Prison Service in 2011, and national reviews and local public health needs assessments highlight mental health as a
priority for male and especially female offenders. Linda de Caestecker highlights this challenge in her Director of Public Health report for Greater Glasgow and Clyde.

4.14.7 Specialist services

Specialist mental health services visited during this review included veteran services, trauma services and homelessness teams.

One of the advantages of specialist services was felt to be the opportunities for peer support and shared understanding between individuals with similar life experiences:

“It is completely different to conventional facilities – we know what we have gone through and can share it – we greet each other with “who did you serve with?”

- Service User, Veterans Service

Staff from specialist mental health services described the multiple and complex needs of many of their service users, and consequently emphasised the importance of reconnecting individuals with their communities, through housing, employment and welfare support. Good links between services were therefore viewed as vital. It was hoped that integration between health and social care could further assist this. However, participants raised the issue that they felt there is limited capacity within specialist services to address the extensive needs of very vulnerable people who often present with complex social, physical and mental health conditions.

Veterans services

Since the Sandra Grant Report, the UK has been engaged in several global military commitments which has seen an increase in demand for mental health services from soldiers on active service and those who have left the services. UK-wide, this is seen as a major challenge and initiatives to support veterans led by established veterans charities have been supported by additional funding, including, for instance, from the income collected by the Exchequer from fines relating to the LIBOR scandal.

In Scotland, Veterans First Point is a service model developed by NHS Lothian, implemented in Edinburgh and jointly funded by the Scottish Government. The service provides a full range of services to veterans, including peer support, access to specialist psychiatric and psychological support and a range of activities. Commitment 35 of the current mental health strategy involved an exploration with northern NHS Boards into the provision of the same service model to veterans in centres with high need, including

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128 http://www.veteransfirstpoint.org.uk/Pages/default.aspx
A REVIEW OF MENTAL HEALTH SERVICES IN SCOTLAND

Aberdeen, Inverness and Dundee. This has progressed, with a LIBOR bid ensuring that NHS Lothian is able to provide development support to these initiatives.

Other service provision is offered by the voluntary sector. Combat Stress runs treatment centres across the UK, including Hollybush House located in Ayrshire. The service provides short stay residential care and treatment for complex presentations of PTSD in a 24 bed residential unit. The facility includes some provision for accompanying family and carers. Gardening Leave is a horticultural therapy charity that supports veterans with mental health conditions. Gardening Leave helps veterans find peace, strength and recovery through horticulture, supporting them on their journey to good health and their transition to civilian life. The charity has gardens in Achincruive, Ayrshire, and at the Erskine Hospital in Erskine, Glasgow.

Defence Medical Welfare Services (DMWS) provides support and assistance for current serving military personnel, from combat zone to community rehabilitation. It operates in the field, at recognised rehabilitation centres in the UK and through an outreach team in Scotland. Scottish Veterans Residences operates in Scotland under the auspices of the Scottish Veterans Housing Association, providing safe supported housing to veterans and former service personnel who are homeless or at risk of homelessness. The charity has properties in Edinburgh, Dundee and now in the new Bellrock Close development in Glasgow, through which it provides veterans with transitional housing support.

It is important to note the more recent development of services created to support veterans. The fact that the review team were able to visit specialist services where people were being supported among others with similar needs is seen by many as a progressive move. It is too early to ascertain the impact that this may have over the longer term in preventing veterans from experiencing ongoing mental health conditions and the frequently associated social drift e.g. difficulty in getting and maintaining employment, and family breakdown. However, the development of these services do appear to highlight the importance placed by service providers and the Scottish Government in ensuring that this vulnerable group no longer fall through the service gap and go on to develop more complex needs.

**Trauma services**

In the past decade, there has been an increased understanding of the significant impact trauma has on mental health and ongoing life experience. Access to specialist trauma services for people who have experienced recent trauma or complex trauma arising from childhood sexual abuse remains an important consideration. The mapping identified two specialist trauma services in Scotland, both of which are members of the UK Psychological Trauma Society Directory. In addition to these, Commitment 18 of the current mental health

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129 http://www.combatstress.org.uk/veterans/contact-us_old/hollybush-house,-ayrshire/
130 http://www.gardeningleave.org/
131 https://www.dmws.org.uk/
132 http://www.svronline.org/
133 http://www.ukpts.co.uk/site/assets/UK-Trauma-Services-Jun-2014.pdf
health strategy outlines the Scottish Government’s commitment to improved identification and response to trauma within primary care.

In terms of specialist NHS services, The Rivers Centre for Traumatic Stress\(^\text{134}\) is located in the grounds of the Royal Edinburgh Hospital. It accepts referrals from general practitioners and other agencies, but not self-referrals. The waiting list is normally 6 weeks to assessment. The Centre offers treatment for the whole range of post traumatic disorders including evidence-based psychotherapies (CBT, EMDR, CPT), art therapy and physiotherapy. Treatment is offered to adults over 18 in both individual and group sessions, with support also offered to family members and friends through a supporters group and joint sessions where appropriate.

The NHS Greater Glasgow and Clyde Trauma Service is a specialist service which provides assessment and therapy to people with moderate to severe mental health conditions following complex trauma. It is not an emergency service and does not accept self-referrals. All teams are led by a Consultant Clinical Psychologist.

Currently there are three teams which work closely together:

- The Compass Team\(^\text{135}\). This team provides culturally sensitive mental health care to asylum seekers and refugees of all ages with a complex trauma history. Including individual, group and family therapy, Compass is a national resource for consultation and training and also provides training placements for a range of mental health staff.

- The Trauma and Homelessness Team\(^\text{136}\) This provides a service to people aged 16 and over who are homeless or at risk of homelessness, plus training and consultation to staff from the voluntary and statutory sectors. A key aim is to try and prevent re-victimisation in people with a history of trauma. Individual and group therapy is offered.

- The SAAS Team. This serves the North East of Glasgow and provides therapy for women and men aged 16 and over with a history childhood sexual abuse and/or a history of sexual assault as an adult.

There is a range of provision in the voluntary and independent sectors. Edinburgh based mental health charity Health in Mind runs the national service Trauma Counselling Line Scotland\(^\text{137}\), which is funded by Survivor Scotland and offers confidential telephone counselling to people aged 16 and over who experienced abuse as a child. This can include sexual, emotional, physical, psychological and spiritual abuse or neglect.

**Homelessness services**

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\(^\text{134}\) [http://www.nhslothian.scot.nhs.uk/Services/A-Z/RiversCentre/Pages/default.aspx](http://www.nhslothian.scot.nhs.uk/Services/A-Z/RiversCentre/Pages/default.aspx)

\(^\text{135}\) [http://www.nhsggc.org.uk/your-health/health-services/compass/](http://www.nhsggc.org.uk/your-health/health-services/compass/)


\(^\text{137}\) [http://health-in-mind.org.uk/assets/files/Trauma%20Counselling.pdf](http://health-in-mind.org.uk/assets/files/Trauma%20Counselling.pdf)
Within the limits of this review, it was not possible to carry out a more thorough examination of homelessness services. However, it has been evident that after a number of years where complex needs have not been addressed well that there is an emerging understanding of the importance of tackling this challenging area. While homelessness services have experienced an initial growth over the last two decades, this still remains a comparatively neglected area in relation to mental health. There are some examples of good practice, with NHS Greater Glasgow and Clyde having a dedicated Homeless Mental Health Team which provides emergency (same day) and urgent (48 hours) assessment access.

**Eating disorders services**

Inpatient facilities for adults with eating disorders are provided on a regional basis, with specialist units in NHS Grampian for the North of Scotland, NHS Lothian for the South East of Scotland and NHS Greater Glasgow and Clyde for the West of Scotland.

Inpatient facilities are also provided by the independent sector in Glasgow and West Lothian. Review participants highlighted that regional provision can mean that some patients are ‘having to move 250 miles away from all their friends and relatives’, suggesting that this could be a very isolating experience for those involved. There is also some limited voluntary sector support service provision, available through organisations such as Beat.

**4.14.8 Crisis services**

One of the major changes in mental health service provision over the last ten years has been the introduction of crisis provision across the country. In 2005, the Scottish Government identified the provision of crisis services as a priority and delivered additional funding to support this development\(^{138}\). In 2006, national standards for crisis services were set out by the Scottish Government. The function of crisis services is defined as:

> ‘The crisis function of any NHS, local authority (LA), voluntary sector or joint service is to address prevention, intervention and recovery through the management of individuals during periods of acute illness, relapse or mental distress.’\(^{139}\)

Crisis services are designed to provide support to individuals with or without prior diagnoses of mental health conditions in instances of acute distress as an alternative to hospitalisation, with the intended outcome of reducing unnecessary first time admissions or readmissions. Crisis support can be provided by a dedicated Crisis Resolution or Intensive Home Treatment Team, or as part of the remit of existing Community Mental Health Teams, at the discretion of individual NHS Boards. Delivering Health: National Standards for Crisis Services set out the requirement that all NHS Boards in Scotland meet these standards by December 2009. In 2010, the Scottish Crisis Resolution/Home Treatment Network carried


out a review of crisis service provision across NHS Boards, with the aim of mapping crisis provision, identifying plans to develop these services and establish whether any outcome data was collected. The 2010 review identified dedicated Crisis Resolution teams in six NHS Boards: Ayrshire and Arran, Borders, Dumfries and Galloway, Forth Valley, Greater Glasgow and Clyde and Lothian. Plans to develop crisis services were described by a further five NHS Boards (Highland, Lanarkshire, Shetland, Tayside and Western Isles), while NHS Fife and Grampian reported no plans to develop dedicated crisis provision as this service was integrated within Community Mental Health Services. Data collected by this review identified the following crisis service support:

- NHS Ayrshire and Arran, NHS Borders and NHS Greater Glasgow and Clyde continue to provide 24-hour access to crisis services.
- NHS Greater Glasgow and Clyde provides an out of hours nurse led service that works with day time services in Glasgow to provide a comprehensive and seamless approach to crisis provision.
- NHS Lothian Intensive Home Treatment Teams can be accessed 8am-12 midnight, with emergency provision filling the remaining hours.
- NHS Dumfries and Galloway reported ‘day and evening’ access to a Crisis Assessment Treatment Service.
- NHS Forth Valley’s Intensive Home Treatment Team operates 9am-9pm on weekdays and 10am-6pm on weekends.
- NHS Fife and NHS Grampian continue to provide crisis support through an integrated unscheduled care model.
- NHS Highland and NHS Lanarkshire report that they provide a Mental Health Assessment Team.
- NHS Tayside identified the provision of a Crisis Response and Home Treatment Service but did not specify the hours of access.
- NHS Orkney reported the extension of out of hours provision by staff from Community Mental Health Teams.
- No information regarding crisis services was returned from NHS Shetland or NHS Western Isles.

Overall, very few of the participants in the review made reference to their experiences of crisis services. Those that did spoke about issues with transitions between crisis and community mental health services and concerns about funding and continuity of support:

‘Crisis team will see people for a maximum of 6 weeks but they do not then allocate a CPN.’

- Service User, Panel Inquiry Visit

### 4.14.9 Psychological services

HEAT targets for 2014-15 are that 90% of patients should start psychological therapies treatments within 18 weeks of referral by March 2015. Data from ISD on Psychological
Services waiting times, published in March 2015, shows that approximately 80% of patients are consistently receiving treatment within 18 weeks of referral (see Figure 19).

![Figure 19 – Waiting times for psychological services ISD adjusted completed waits for people seen. Figures do not include NHS Shetland figures for March 2015. Source: ISD Psychological Therapies Waiting Times database.](image)

Some review participants working in the mental health sector expressed the view that pressure to reduce waiting times had contributed to difficulty in accessing services by narrowing the focus of services to specific diagnoses:

‘I think ten, fifteen years ago when there was a waiting list, there was a pressure on managers to say we’re only going to take people therefore from those waiting lists. We’re going to cut down and be more selective of who we’ll take. We’ll take people who are more chronic or more complex and everyone else we won’t see.’

- Staff, Panel Inquiry Visit

Although these developments were welcomed by many, there were also tensions between the competing priorities they raised. Service users and those working in the mental health sector felt that this narrowing focus within services has contributed to the prioritisation of a more reactive ‘firefighting’ approach towards treatment for those with severe mental health conditions, at the expense of the promotion and prevention agenda.

‘I think we’ve lost a lot of ground in terms of thinking about mental wellbeing and we’re back to thinking about the old mental illness thing.’

- Expert Interview
"I think so much of the money goes into reacting to crisis, dealing with crisis, responding to escalations in mental illness and we are actually seeing money move away from the prevention agenda despite the clear policy agenda."

- Expert Interview

Experiences of waiting times

This review found that the majority of NHS Boards were not meeting the current 18 week waiting time target for access to psychological services. In addition to this, the shortened waiting time has only gone part of the way in supporting those who still found the waiting time problematic in trying to access services. Review participants tended to agree that services were helpful once access could be gained but that waiting times were still too long:

‘The wait for psychological services is much too long. Often the needs of the service user have changed between referral and first appointment.’

- Staff, Panel Inquiry Visit

‘You have to book your illness in advance.’

- Service User, Panel Inquiry Visit

Participants spoke of the increased pressure placed on GPs and voluntary organisations to provide support in the interim between referral and access to services. Identified as particularly problematic was the combination of long waiting times and time-limited services, such as six or eight week CBT courses. Participants reported instances of service users reaching a critical point in their treatment towards the end of their course of therapy and being required to self-refer and re-join the waiting list in order to continue their treatment with the same practitioner.

Access routes

Across the review areas, there was little consistency of access routes to services. Referral pathways differed between services and NHS Boards, and included complex combinations of self-referrals and GP referrals. Single referral pathways had been designed with the help of service users and had been rolled out in a number of the panel inquiry areas. This approach seems promising in increasing ease of access to services, as review participants identified not knowing how to access help and having to tell their story numerous times as major barriers to seeking help. A number of review participants from voluntary organisations highlighted a lack of awareness among GPs about the range of services available.

4.15 Transitions and continuity of care

4.15.1 Integrated Care Pathways

Integrated Care Pathways (or ICPs) provide a person-centred, evidence-based framework for delivery of high quality mental health care. The ICPs for mental health standards have four main elements:
• Process standards: describe the key tasks which affect how well ICPs are developed in a local area.
• Generic care standards: describe the interactions and interventions that must be offered to all people who access mental health services.
• Condition-specific care standards: build on the generic care standards and describe the interactions and interventions that must be offered by mental health services to adults and older adults with a specific condition.
• Service improvement standards: measure how ICPs are implemented and how variations from planned care are recorded and acted on.

Delivering for Mental Health set out a commitment to producing standards for adult and older adult mental health ICPs for the following conditions by the end of 2007: Bipolar Disorder, Borderline Personality Disorder, Dementia, Depression and Schizophrenia. Following publication of standards for ICPs for child and adolescent mental health services in June 2011, the ICP programme now covers the whole age spectrum in mental health.

4.15.2 Transitions between services

‘Communication between services is not good. Individuals feel they are surviving like islands.’
- Panel Inquiry Visit

Transition between services was identified as an area of particular concern among the review participants. Participants had experienced gaps in care between leaving hospital and accessing treatment in the community. Some had periods when medication and support were not available to them. Transitions from age-limited services including CAMHS to adult, and adult to elderly services were cited as particularly problematic:

‘People can find that everything changes at that point…The support that was keeping them well can either change or be withdrawn completely when they enter older people’s services.’
- Panel Inquiry Visit

This finding raises questions around the separation of adult and older adult mental health services and whether service users would benefit from a more continuous approach to services across the life course, as is seen in England. However, a number of services which were visited throughout the course of the review were aware of this area of difficulty and had programmes in place to provide additional support to services users through these changes. Examples of this include adult psychiatry liaison for young people about to turn 18 and move

Continuity of care was one area of service delivery which was identified as particularly problematic by a number of review participants. This lack of continuity was expressed in terms of:

- Time-limited courses of psychological therapies, such as CBT and counselling, interspersed by long waiting periods
- Issues with the linking up of hospital and community care
- Unclear referral systems and no clear system for re-entering treatment after a period away
- Key members of staff moving jobs without replacement so that service users lost the support and services offered by that member of staff.

‘Each service was good but they didn’t work well together … pathway was more of a hop jump than a journey’

- Panel Inquiry Visit

‘I have several clients who have had regular CPN support, the CPN moves jobs and is not replaced, and they lose their support and are told they no longer need it.’

- Panel Inquiry Visit

Many of the review participants agreed that the key to improving this fragmented approach to care was better communication: communication within services, across services, throughout health and social care, and between services and service users. A number of medical practitioners and representatives involved in the review agreed that staff retention and recruitment was an ongoing issue.
5 Discussion

An important feature of this report was the broad support among participants for Scotland’s overall national strategic approach to mental health. A considerable amount of the report focuses upon how legislation, policy, services and health improvement programmes have had a substantial and positive impact. National mental health policy making has been responsive, enduring and engaged with wider public policies. However, there was recognition of the need for a wider public mental health framework to be applied that works across promotion, prevention, early intervention and recovery. Progress on more public mental health approaches was initially made through the National Programme for Improving Mental Health and Wellbeing\textsuperscript{141} in the early part of this review period, with some of the programmes such as the Scottish Recovery Network, See Me, and Choose Life seen as continuing to have an impact today.

At a regional level, the picture was felt to be more variable in scope and scale, with the need for a more coherent approach to be adopted consistently across all NHS Board areas. However, the reality of the geographic challenges was acknowledged. There is a need for this more systematic approach to extend to include preventative actions and interventions across the mental health system and beyond. This is informed by reflections upon high demand on services, budget restrictions and preventable inequalities, which were all recurring themes in this review. A focus on prevention and equality is in line with wider public policy reforms suggested in The Christie Report\textsuperscript{142}. There could be merit in ensuring that we have a very clear review and overview of the evidence for prevention in relation to mental health, particularly where it can enhance lives, reduce demand on limited services and have wider social and economic benefits. If prevention is to be central to a new approach, then we need to have systematic approach to prevention in the way that we design and fund health systems, services and public mental health. The Health Scotland framework ‘Good Mental Health for All’ makes a contribution to this process.

During the review process, it was clear that the Mental Health (Care and Treatment) (Scotland) Act 2003 has been successful in meeting some early expectations in advancing the rights of people who use mental health services. This legislation was also felt to have created an environment that has stimulated innovation and supported greater user involvement and representation. However, there are concerns about the poor uptake of advance statements. It was felt that more needs to be done to promote advance statements among service users and carers, as well as build staff understanding about their value.


\textsuperscript{142} Christie C (2011) \textit{Commission on the Future Delivery of Public Services}. APS Group Scotland (Crown copyright) [online] Available from: \url{www.publicservicescommission.org}
The last decade has seen increasing uptake of advocacy services in mental health, due to statutory duties in response to the Mental Health Act, along with increases in people seeking support in relation to welfare reform. Most experiences of using advocacy services were very positive and staff, service users and carers have a clearer understanding of advocacy’s role. Not all authorities fund collective advocacy and concerns exist about availability for young people’s mental health services; prisoners; older adults; ethnic minorities; asylum seekers and refugees; and traveller and gypsy communities. Lack of advocacy for carers and parents around issues of child protection were also highlighted.

Welfare reform and austerity are a real concern for service users, carers and practitioners. Uncertainty, delays and the assessment process can be demeaning and generate anxiety and stress. There was support for the Scottish Government’s ‘bedroom tax’ mitigation, the Welfare Fund, Citizen’s Advice services, and for NHS collaborations with money advice services. The issues raised around welfare may help to inform ongoing discussions about Scotland’s approach to welfare, benefits and devolved powers. At present, we do not know the impact of welfare reform and austerity on people’s mental health and subsequent use of services. Given the level of concern expressed throughout this review process, this is an area which could warrant further research.

A strong service user voice, including Voices of Experience (VoX), is a success of the last decade. It has advanced advocacy and influenced national policy. There is a mixed picture at regional level; although there are a number of examples of good practice, losses have also been recognised in local and regional collective advocacy capacity. Service users have consistently stated that they need to be systematically involved in co-producing all local service provision as full partners, from planning and model design, through to implementation and evaluation. An enhanced approach to service user involvement could include collective advocacy, peer support and creating genuine support to build real leadership capacity, while ensuring that the most hard to reach are fully engaged in the involvement processes.

One method by which these changes could be achieved was put forward at various points throughout the review process. There were numerous calls from service user participants to further develop outcome-based measures that are co-produced with people who use services. Tools such as the Individual Recovery Outcomes Counter (IROC) and Wellness Recovery Action Plan (WRAP) already exist but are not widely applied. In relation to wider service design, participants shared examples of where this had worked well, particularly in supporting new builds. However, the majority of strategic meetings at a local level still appear to be professionally focused, with little meaningful user or carer involvement. However, there are notable exceptions to this trend.

Scotland’s mental health carer movement has developed more slowly than the service user movement, with few formal routes for mental health carers to influence national policy. There is also a trend towards generalism, bringing all carers together, irrespective of the needs of those they care for. Carers feel that they need to be better engaged in elements of care where they have a strong role to play in offering support, such as discharge planning, and given greater opportunity to bring their specialist views about supporting someone with a mental health condition into the national policy arena.
Interactions with mental health professionals were broadly positive amongst service users, carers and representative groups. However, it was highlighted that the difference in quality of experience of care can all too often be dependent on which practitioner the service user or carer comes into contact with and/or the ethos, culture and environment of particular services. The inclusion of Mental Health Act training for new mental health nurses appears to have had a positive effect on improving this. The publication of Rights, Relationships and Recovery: the Report of the National Review of Mental Health Nursing in Scotland has also been important. There was the perception that a future squeeze on funding could have a negative effect on staff culture, with higher caseloads and less time spent with people.

The recovery movement has led to a common belief that most people can and do recover. The Scottish Recovery Network was felt to have successfully improved mental health services by raising aspirations of people with mental health conditions, engaging practitioners and promoting recovery-oriented practices. However, peer support does not yet appear to have achieved its potential as a transformative approach. There was a note of caution expressed during the review that, while the language of recovery is being widely adopted, it does not mean that all services have fully understood or embraced the ethos. Recovery as a concept remains open to debate, including the relationship between recovery, citizenship and human rights. There is a need for ongoing dialogue exploring what we mean by recovery and what the concept means to the full range of people who experience mental health conditions. The review found many good news stories about recovery. For recovery approaches to work, there is a need for professionals and commissioners to understand that this is an individual journey working towards personal outcomes and goals. Some participants did not feel that this was always the way recovery was interpreted and the impact of this on service design has, in some areas, led to the cutting back of the longer term support they need in favour of short term interventions.

Tackling stigma and discrimination continues to be a major priority for service users. The involvement of people with lived experience in See Me campaigns was reported as a reason for overall reductions in stigma in the last decade. But high levels of stigma and discrimination were reported in general health settings, job centres, schools, local community groups, police and mental health services. To meet this challenge, See Me was re-founded in 2013 into a programme to address discriminatory behaviour, self-stigma and human rights, based upon an independent review and wider international evidence. This co-production model links social marketing with community development and involves people with lived experience in the development and delivery stages. An issue that emerged was the different approach required to challenge stigma for those with specific illnesses, rather than mental health conditions in general. Evaluation of the re-found See Me programme is in its early stages but it would be useful to ensure that this explores what approaches work for specific groups and in which settings.

In the past ten years, mental health inequalities have emerged as a major public health challenge in Scotland, an issue that was echoed by participants in this review. Poor outcomes exist for vulnerable groups, especially asylum seekers and refugees; ethnic minorities; carers; low-income households; prisoners, including female offenders; people with long term physical health conditions; LGBT citizens; looked after children; and care leavers. People with enduring mental health conditions also experience socio-economic disadvantages and, despite ongoing initiatives, an enduring mortality and morbidity gap. This
is exacerbated for those experiencing multiple deprivation and our report highlights the importance of a mental health equalities focus. The implication is that reducing mental health inequalities should be at the centre of national mental health strategies, policies and goals. Equally, addressing mental health, and, in particular, working to prevent mental health conditions needs to be embedded in wider social and public policy. This is in line with current Scottish Government policies for a fairer Scotland and has implications for the targets we set on issues such as suicide, mortality and employment. It may also necessitate a clear focus on identifying what works in achieving outcomes and in creating datasets that enable us to measure progress. This may require formal cross-government working and commitments at both a national and regional level.

This report highlights the needs of vulnerable groups, or those that are exposed to high levels of adversity, who can as a result be at risk of experiencing mental health inequities, including challenges in accessing responsive services. However, the report goes beyond noting the importance of this, highlighting the value of specialist services and elements such as peer support. In the development of national and regional service developments, it may be more effective to ensure that the mental health needs of these vulnerable groups are not only specified in the mental health strategy but also in relevant wider social and public policy, through cross-government approaches. To give examples, regarding asylum seekers and refugees, mental health should be at the centre of the New Scots health planning, while, for prisoners and offenders, there is a need to jointly develop mental health improvements approaches with the Scottish Prison Service.

To meet some of these complex needs and to address mental health inequalities, it may now be important to shift from a national focus on policies and programmes that are aimed at improving mental health across the whole population to an approach more focused on mental health inequalities. For example, national aims to reduce population rates of suicide and the mortality gap experienced by people with mental health conditions, increase psychological therapy uptake and prevent discrimination could include explicit targets in relation to factors such as income and poverty, gender and sexuality.

Suicide prevention remains a national priority. Choose Life (2002-12) and the Suicide Prevention Strategy (2013-16) provided a national lever for change. These programmes adopted multi-level approaches to understanding and addressing suicide. Suicide rates in Scotland have fallen slightly over the last decade, but there are consistently higher rates among men and those from areas of multiple deprivation. There was broad support for taking a nuanced approach to suicide prevention, including the drive to train frontline workers in interventions that can be shown to achieve positive outcomes for these groups. However, there were concerns that the workers that could make best use of this training may not engage with it due to high caseloads and work pressures, particularly GPs, addictions workers and emergency care professionals.

Self-harm in Scotland was viewed as an increasing public health concern with associated implications for services, especially among young people. High levels of stigma, including blame, were reported for accident and emergency services. Liaison psychiatry teams were well received but not always seen as preventing stigma, while participants discussed promising initiatives that involved the third sector and the NHS working together.
The Public Bodies (Joint Working) (Scotland) Act 2014 sets out plans for the integration of health and social care across Scotland, with the intention of improving quality of services, transitions, community support and meeting needs of specific groups. Local strategic plans for health and social care integration are expected to be in place by April 2016. This report found mixed experiences of integration, with some areas discussing how, although not integrated at a ‘strategic’ level due to co-location, some specialist services had been working jointly for many years. However, in other areas, while health and social work shared a building, the services and staff were viewed as ‘separate’. Despite these mixed experiences, there was a feeling of optimism reported at the potential for health and social care integration to bring about positive change through clearer leadership and direction and greater involvement of service users and carers, provided it does not create another layer of bureaucracy.

The report outlines overall increases in national spending on mental health but with significant regional variation. However, several GPs, primary care mental health teams and NHS Board senior managers reported experiencing reductions in funding for specific services such as drop-in centres and counselling services, staffing and transport. Voluntary sector participants described uncertainty about the security of future funding but reported some positive experiences of securing funding through joint commissioning processes. Further exploration is needed to accurately understand this variance.

The Sandra Grant Report raised concerns that the quality and quantity of mental health services available to people varied geographically across Scotland. Improvements were identified in many aspects of provision, including buildings, accommodation and practice, but there are ongoing challenges such as the number of young people accommodated in out of area units and variation in out of hours provision and specialist services.

Over the past decade, there has been a reduction in inpatient bed numbers, while occupancy rates have remained stable at around 80%. There are significant variations across Scotland in bed numbers and average lengths of stay, which requires further analysis and consideration. There was broad agreement among participants that the overall conditions of inpatient facilities have been significantly improved and enhanced, with the exception of some of the longer stay facilities. Some service users felt that it was more difficult to access hospital services and questioned corresponding increases in community care capacity. Many practitioners recognised this perception amongst some service users who had lived through the movement towards more community based mental health care. However, they identified home treatment, crisis teams and community services as progress that enabled people to be supported in their own homes for longer than previously possible.

In some cases, participants reported increased isolation, particularly among those with severe and enduring mental health conditions. This was linked to the physical centralisation of some services combined with an increase in home-based support, which was felt to compound the risk of isolation of those with severe and enduring mental health conditions, particularly those living in remote and rural areas, and reduces the opportunity for people to form positive peer relationships. Some participants expressed concerns that a combination of funding restrictions and personalisation could reduce the availability of collective drop-ins and spaces to connect, and that this remains an important element of belonging, connection
and peer support. The unintended consequences of positive shifts towards more personalised approaches need to be considered and the impact of these monitored carefully.

Participants report major increases in demand for CAMHS in the past decade for complex reasons, that, alongside challenges in recruiting posts of all types, affects waiting times and service provision. Different professionals felt that demand was linked to gaps in crisis care and in prevention/early intervention. There have been improvements in the transitions between CAMHS and adult services, and positive developments include specialist teams supporting looked after and accommodated young people, young people who self-harm and early Intervention in Psychosis teams. However, access to such services remains limited, especially outside of major cities. There has been a considerable increase in admissions to dedicated CAMHS inpatient psychiatric care. Admission of young people to adult wards has not reduced but varies considerably by region. To reduce pressures, practitioners suggest stronger connections with community CAMHS to create more appropriate referral pathways. Service users reported mixed experiences on adult wards, some were positive, but others reported feeling scared and isolated on wards that were not equipped to deliver services appropriate for young people.

Review participants were very positive about Scottish Government policies, strategies and commitments in relation to dementia over the last ten years. It was felt that these have generated more awareness, reduced stigma and meant people are involved in their care and treatment for longer. Some participants felt that the major developments in diagnosis and immediate post-diagnosis support should also be applied to those at the more advanced stages. A related concern was a lack of support available for carers of people with dementia. The role of innovations such as telehealth which can be used for dementia care should be considered. It was also suggested that the focus on dementia may have taken attention away from other older adult mental health conditions and many called for a renewed focus upon older adults' non-dementia related mental health in national government strategy.

A range of specialist mental health services were visited during this review, including those for veterans, trauma services, homelessness and asylum seekers and refugees. Many positive examples were discussed and several common threads emerged, especially the multiple and complex needs of many people who fall between gaps in existing services. Common strengths identified within specialist services include the potential to create support structures built around shared experience, such as peer support. Overall, these services were seen to take a holistic view, working to reconnect individuals with their communities through housing, employment and welfare support, helping to reduce the social drift often experienced by those with multiple and complex needs. This way of working appeared to make intuitive sense, as no single service could meet every requirement. However, more general services may be able to replicate some of these innovative and holistic approaches to good effect.

Limited capacity remains a core constraint upon these services and integration between health and social care was seen as an opportunity to address this. The current refugee crisis makes the case for addressing the mental health needs of asylum seekers and refugees a priority. We argue that the needs of all groups who experience very poor mental health should be addressed across policy directorates. For example, the poor mental health and mortality of homeless citizens was highlighted a decade ago in the health section of the 2005
homelessness standards and new integrated boards offer the chance to identify and address the mental health needs of homeless people in their area.

A major advance in mental health service provision over the last ten years has been the introduction of crisis provision across the country. In 2006, national standards for crisis services were set out by the Scottish Government in partnership with the Mental Health Foundation and SAMH, which were designed to support individuals with or without prior diagnoses of mental health conditions in instances of acute distress as an alternative to hospitalisation. NHS Boards are implementing this using different models and approaches, which require more in-depth analysis. The need for crisis services was a major finding from the Sandra Grant Review but was not raised significantly within either site visits or focus groups within this review process. In part, that may be because where these services exist they are viewed as a part of the whole package of care and support, with no real differentiation applied. However, it is significant that lack of out of hours support was no longer viewed as a gap by those that participated.

The focus that had been placed upon access targets for psychological services received some support in this review but others felt waiting times remained too long to ensure adequate responses to need. Extended waiting times for time-limited services such as CBT were a particular concern, along with consistency of access routes. Some service users and staff felt that this reflected a narrowing of focus, with high levels of resource being directed to reactive service delivery at the expense of a prevention or mental wellbeing focus.

Participants from different backgrounds highlighted challenges in transitions between services, especially from hospital to community care. Problematic transitions were also highlighted between services across the life-course of paediatric, CAMHS, adult and elderly services. Integrated Care Pathway standards were produced for adults experiencing bipolar disorder, borderline personality disorder, dementia, depression and schizophrenia in 2007, as well as for child and adolescent mental health in 2011, and several positive examples of transitional support programmes were also outlined.

In preparing this report, the NHS National Benchmarking Project data has been particularly valuable in terms of describing inpatient service use. Although there is high-level resource allocation data in the National Benchmarking Project for community and inpatient services by NHS Board, there is no further breakdown of what types of services are being commissioned and delivered in the community. The data available is therefore limited to a descriptive picture and as such tells little about equality of access across Scotland, how well community services on the ground are meeting needs, the quality of services and levels of use. We attempted to retrieve this information directly from NHS Boards. Many were able to respond but for some this was more challenging, and, at the time of reporting, this data remains incomplete. Additionally, we found that the way in which services are categorised differs from NHS Board to NHS Board, adding a further layer of uncertainty when attempting to produce an accurate picture of allocation of resources to mental health. These challenges have limited our ability to draw firm conclusions using nationally available data.

In Scotland, we are still some way from having readily available standardised data that can indicate the extent to which key marginalised groups are represented in terms of access to mental health services and the extent to which specialist services are provided in the community. We also found that little national outcome data for mental health is available in
Scotland, something that was an aspiration of the Mental Health Information Improvement Project referred to in the Sandra Grant Report.

However, the main gap in nationally available data about mental health is from the perspective of those who need and/or use mental health services and those who care for/about them. This report goes some way to gaining that perspective, but is limited in its comprehensiveness. The development of a systematic and representative national survey of mental health service users and carers about the quality of services, whether they feel their needs have been met and what gaps remain may be one way to gain a robust picture of how well mental health services are working. In addition, there may be value in the Scottish Government’s Mental Health and Protection of Rights Division investing in completing the mapping of inpatient and community-based mental health services across Scotland to create a full and up to date national picture of what services are available for who and where, providing a strategic overview that currently does not exist.

Overall, the findings in this report present a sense that the general direction of mental health services over the last ten years has been positive, with an appreciation that progress has been made and that there has been change for the better. There continue to be challenges but respondents provided an extensive range of examples of where they felt progress had been made and change has occurred, both generally and in terms of specific service areas. These include: advocacy services, dementia diagnosis, crisis services, early intervention for psychosis, specialist trauma services, support for veterans, support for early years including mother and baby units, access to psychological therapies, access to peer support, stigma and discrimination, suicide prevention, Involvement and engagement with those who use services and who care for them, embedding of the recovery model into service delivery, and more focus in policy and practice on the mental health inequalities.
6 Appendices

6.1 Appendix 1: Specialist reviewer biographies

Hugh Hill: Hugh is currently Director of Services at the Simon Community Scotland, a national charity working to combat the causes and effects of homelessness. Hugh is a registered mental health nurse spending much of his career in England working with Primary Care Services as well as developing integrated multiagency intensive care management services. Hugh was one of the early Thorn Nurses trained in PSI, is a qualified CPN, has a Diploma in Counselling and is psychotherapy trained. On returning to Scotland he worked in planning and commissioning at NHS Ayrshire and Arran, before joining the SAMH as their Director of Services and later a low secure hospital.

Gordon Johnston: Gordon has lived experience of mental health. He is a Director of Voices of Experience (VOX) and of Bipolar Scotland. He has worked in the public and voluntary sectors, including managing a community development organisation, co-ordinating national Lottery and European funding and working in urban regeneration initiatives. He is also a freelance consultant in mental health specialising in peer research and service user involvement.

Carolyn Little: Carolyn Little is a project manager and carer. She has been Chairperson of Support in Mind for over 15 years and also a Project Manager for ‘User and Carer Involvement’ - a Scottish charity operating across the Dumfries and Galloway Health Board area which ensures that people who have mental illness, dementia and learning disabilities and their carers, have a voice. Carolyn was a member of the 2009 McManus Review of the Mental Health (Care and Treatment) (Scotland) 2003 Act. She is a carer representative on the Scottish Patient Safety Programme and has been part of several local and national groups including the Mental Health Legislation Reference Group and the West of Scotland Forensic Advisory Group. Carolyn has contributed to several conferences, facilitating workshops and giving presentations.

Graham Morgan: Graham Morgan is a special advisor to HUG (action for mental health) and carried out this piece of work on secondment from HUG. He used to manage HUG and People First Highland via SPIRIT Advocacy and prior to that worked for CAPS in Lothian. He served on the Millan Committee, was part of the McManus review and a part of Sandra Grants research around the implementation of the Mental Health Act. He brings his own personal experience of mental illness to this work and is committed to finding out the broad range of opinion and experience of people with personal experience of mental ill health.

Rob Wrate: Robert Wrate has worked as a Consultant Psychiatrist in Scotland since 1978, after completing clinical & research training in the University of Newcastle upon Tyne, UK, McMaster University, Ontario, Canada, and the Scottish Institute of Human Relations, UK. His clinical work has largely involved child and adolescent mental health, drawing upon additional training in psychoanalytic psychotherapy and family therapy (a founding member
of Scotland's main family therapy training program). Rob has had a strong interest in health-service research (including inpatient psychiatry, unmet health needs of the single young homeless, first-episode psychosis, depression, eating disorders, and also the mental health and wellbeing of health care professionals themselves), during most of which the voice of service-users and carers were given prominence. This varied work experience has led to working as a Mental Health Tribunal member and to co-authoring a book, several book chapters, and many peer-reviewed publications, and over the last twelve years (since retiring from the Royal Edinburgh Hospital) a commitment to supporting the clinical work of MH teams involved in the service challenges that remote-and-rural populations face, for example over ten years in Shetland (2005-2015).

6.2 Appendix 2: Methods

Stage 1: Documentary review

A rapid documentary review was undertaken to gather and identify the most influential mental health policies and important service developments spanning the ten years since the Sandra Grant Report was published in 2003. Two main areas of interest were evaluations of mental health services in operation between 2004 and 2014 and policy and national programme drivers that supported service improvements.

Literature databases were searched for peer-reviewed evidence published from 2003 to 2014 pertaining to Scottish mental health services. This was supplemented by searches of known, publicly available websites to retrieve the following document types:

- Scottish Government mental health policy documents, and documents in related policy areas
- Scottish mental health legislation
- Mental Welfare Commission documents
- Scottish Government-commissioned mental health programme evaluations, reviews and needs assessments
- NHS Health Scotland-commissioned mental health evaluations, reviews and needs assessments
- UK Government mental health guidance
- Significant documents from voluntary sector mental health organisations in Scotland
- Literature on user and carer perspectives of services over the last ten years

The retrieved documentary evidence was screened and relevant papers were coded by publication date and theme, then analysed to create chronological and thematic narratives.

Stage 2: Mapping

A mapping exercise was undertaken with all NHS Board areas to develop a picture of mental health services available across Scotland. This process covered: different service sectors (mainly statutory and voluntary services); services spanning the life course (child and
adolescent, adult and older adult services); and a range of different settings (community and inpatient services). Information was sought in relation to:

- **Demographics:** population, gender, age, ethnicity, morbidity and mortality rates
- **Resource allocation:** spending on inpatient and community mental health services
- **Governance:** including commissioning structures, needs assessment data, mental health improvement strategies, mechanisms for involving stakeholder groups in the planning, commissioning and delivery processes
- **Workforce:** specialist and non-specialist mental health roles, mental health improvement roles, and those working on mental health in non-mental health agencies
- **Service overview:** including national programmes, local mental health services and health improvement activities. Specialist regional services were collated alongside and in the same format as local services
- **Outcomes:** including national benchmarking data and targets, as well as locally derived outcome measures, focusing on how local service outcomes are measured.

For each NHS Board, a spreadsheet was produced and populated by the Mental Health Foundation research team using publicly available service data obtained from local service directories, NHS Board, local authority and voluntary sector websites. The draft map was circulated to the main stakeholders identified within each Board area for comment, ensuring each map accurately reflected the structures and systems in place at a local level. Where gaps in the completeness of the mapping data were identified, there was a concerted effort by the research team to achieve as much completeness as possible within the timeframe.

**Stage 3: Local site visits**

A local panel inquiry process was led by the recruited team of expert reviewers. A selective sampling approach was adopted in recognition of the scale of the task of visiting the wide range of services operating across Scotland and the limited timeframe allocated for the review. Five NHS Board areas were selected to gain an understanding of local service provision: Ayrshire & Arran, Forth Valley, Greater Glasgow & Clyde, Highland and Lothian. These Boards were selected to cover different geographic settings (rural, urban and mixed), varying levels of deprivation, specific populations (e.g. BME communities) and different degrees and phases of service redesign. The expert reviewers spent two days visiting each of the NHS Board areas and invited representatives from main stakeholder groups to provide their views and opinions and to share their stories and experiences about the local provision, focusing on the following themes:

- **Strengths of the local mental health system**
- **Weaknesses of the local mental health system,** including gaps, capacity issues, organisational cultures
- **Extent to which people who use services and their carers are able to plan their own care and influence service design**
- **Changes to the local service system over the ten year period,** including the most influential developments
• How mental health services should look to people in the next decade

Stakeholder groups that were invited to give evidence to the panel inquiry included: senior strategic managers, commissioners, service managers, frontline staff, voluntary sector representatives, service users and carers. 66 meetings were held across the five panel inquiry areas, involving approximately 325 individuals, of whom approximately 175 were people with lived experience of using mental health services. The findings of the panel inquiry were coded thematically, where possible, aligned to recommendations from the Sandra Grant Report while allowing enough flexibility for new areas and issues to emerge.

Stage 4: Expert interviews

In efforts to be as complete as was feasible within the timeframe, the expert reviewers and Mental Health Foundation researchers also interviewed 15 individuals from across Scotland with specific expertise that was not possible to capture fully within the five NHS Board inquiry areas. This also allowed for a wider overview and for important insights from specialist organisations like the Mental Welfare Commission to be included in the review. These interviews had representation from national policy makers and programme leads, subject specialists, academics and representatives from national voluntary, user and carer organisations. The expert interviews focused on the following themes:

• Where there has been significant progress in mental health since 2003
• Areas where gaps and issues still remain
• The extent to which service users and carers have been able to influence changes
• How well the current mental health system addresses the needs of service users, carers and equality groups
• How mental health services should look in future.

The findings of the expert interviews were also coded thematically and aligned to the Sandra Grant Report but again care was taken to allow for new themes and issues to emerge.

Stage 5: Focus groups with service users and carers

Service user and carer input were crucial to the development of this review. In order to represent as wide a range of voices as possible, additional meetings were organised through Voices of Experience (VoX) member groups in four locations: Glasgow, Galashiels, Dumfries and Aberdeen. In total, 44 people attended and contributed to these focus groups. The topic guide from the panel inquiry visits was modified and the same analytical frame employed.
6.3 Appendix 3: National mental health strategies’ commitments
<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Source</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion, inequalities and rights</td>
<td>DFMH</td>
<td></td>
<td>Commitment 1: We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights.</td>
</tr>
<tr>
<td></td>
<td>TAMFS</td>
<td></td>
<td>Commitment 18: The Scottish Government will work with NHS Boards to implement the Equally Well recommendations that work to address depression, stress and anxiety in targeted deprived communities, building on the action already being taken forward under the Keep Well programme and the Living Better programme</td>
</tr>
<tr>
<td></td>
<td>MHSS</td>
<td></td>
<td>Commitment 5: We will work with the Scottish Human Rights Commission and MWC to develop and increase the focus on rights as a key component of mental health care in Scotland.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Commitment 29: We will promote the evidence base for what works in employability for those with mental health conditions by publishing a guidance document which sets out the evidence base, identifies practice that is already in place and working, and develops data and monitoring systems.</td>
</tr>
<tr>
<td></td>
<td>MHSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>Forums</td>
<td>DFMH</td>
<td>Commitment 9: We will establish acute inpatient forums across all NHS Board areas, comprising service providers, service users and carers as well as other stakeholders such as local authority colleagues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MHSS</td>
<td>Commitment 35: We will work with COSLA to establish a local government mental health forum to focus on those areas of work where local government has a key role, including employability, community assets and support and services for older people, and make effective linkages with the work to integrate health and social care.</td>
</tr>
<tr>
<td></td>
<td>Service users and carers</td>
<td>TAMFS</td>
<td>Commitment 20: The Scottish Government will put in place a programme of support for local areas to implement With Inclusion in Mind.</td>
</tr>
<tr>
<td>Children and young people</td>
<td>Schools and universities</td>
<td>DFMH</td>
<td>Commitment 10(1): A named mental health link person is available to every school, fulfilling the functions outlined in the Framework.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TAMFS</td>
<td>Commitment 4: NHS Health Scotland will work with key stakeholders to develop a set of national indicators for children and young people's mental wellbeing, mental health problems and related contextual factors by 2011.</td>
</tr>
<tr>
<td></td>
<td>Looked after and accommodated children</td>
<td>DFMH</td>
<td>Commitment 10(2): Basic mental health training should be offered to all those working with or caring for looked after and accommodated children and young people.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MHSS</td>
<td>Commitment 9: We will work with a range of stakeholders to develop the current specialist CAMHS balanced scorecard to pick up all specialist mental health consultation and referral activity relating to looked after children.</td>
</tr>
<tr>
<td>Children and young peoples’ mental health</td>
<td>TAMFS</td>
<td>Commitment 1: The Scottish Government will work with partners and existing networks to develop by 2010 a web portal on mental health improvement for those working with infants, children and young people.</td>
<td></td>
</tr>
<tr>
<td>Infant mental health</td>
<td>TAMFS</td>
<td>Commitment 2: Promoting Well-being and Meeting the Mental Health Needs of Children and Young People: A Development Framework for Communities, Agencies and Specialists involved in Supporting Children, Young People and their Families outlines the competencies needed for mental health improvement work with children and young people. We will build on this work and focus on infant mental health improvement. NHS Health Scotland will work with partners to improve the skills and knowledge of front line staff with a particular focus on inequalities.</td>
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<tr>
<td></td>
<td>MHSS</td>
<td>Commitment 11: We will reduce the number of admissions of children and young people to adult beds by 50% by 2009.</td>
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<tr>
<td></td>
<td>TAMFS</td>
<td>Commitment 12: In addition to tracking variance and shorter lengths of stay, we will focus on reducing admissions of under 18s to adult wards, with a new commitment to reduce figures across Scotland to a figure linked to current performance in the South of Scotland area.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TAMFS</td>
<td>Commitment 3: NHS Health Scotland will initiate a programme in 2009 to disseminate the evidence base for mental health improvement and support its use through practitioner briefings and narratives to present the case to decision makers and planners.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TAMFS</td>
<td>Commitment 9: The Scottish Government is implementing Good Places, Better Health which will look at the relationship between the physical environment and children's health. It will concentrate on four child health priorities including mental health improvement, with the evidence being used to support policies and decision-making at national and local level. The work will be ongoing to March 2011.</td>
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<tr>
<td></td>
<td>MHSS</td>
<td>Commitment 7: In 2012, we will begin the process of a national roll out of Triple P and Incredible Years Parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MHSS</td>
<td>Commitment 8: We shall make basic infant mental health training more widely available to professionals in the children’s services workforce. We shall also improve access to child psychotherapy by investing in a new cohort of trainees to start in 2013.</td>
<td></td>
</tr>
</tbody>
</table>
### National mental health indicators CYP

**Commitment 4:** NHS Health Scotland will work with key stakeholders to develop a set of national indicators for children and young people’s mental wellbeing, mental health problems and related contextual factors by 2011.

### Improving dementia access, services and resources

**Commitment 14:** We will work with the Dementia Services Development Centre at Stirling University and NHS Forth Valley to undertake a pilot programme in improving dementia services. The pilot will be educated in 2008.

**Commitment 7:** Working with See Me, the Scottish Government will pilot and evaluate awareness-raising approaches on dementia with a focus on encouraging people to seek early diagnosis. The pilot will take place in the first part of 2009 in Dundee and the outcomes will be reported to the National Dementia Forum.

**Commitment 8:** NHS Health Scotland will publish and disseminate new dementia resources Worried about your Memory? and Facing Dementia: how to live well with your diagnosis.

### Dementia and older adults

**Commitment 6:** The Scottish Government will address mental health improvement in later life through the creation of a national group (hosted by NHS Health Scotland) which will produce an action plan in response to All Our Futures and the UK Inquiry by 2010.

**Commitment 20:** We will take forward the recommendations of the psychological therapies for older people report by NHS Boards and their statutory and voluntary sector partners and in the context of the integration agenda. Access to psychological therapies by older people will be tracked as part of the monitoring of the general psychological therapies access target, which applies to older people in the same way that it applies to the adult population.

**Commitment 21:** We will identify particular challenges and opportunities linked to the mental health of older people and will develop outcome measures related to older people’s mental health as part of the work to take forward the integration process.

### Older people's mental health

**Commitment 22:** The Scottish Recovery Indicator will be available from end April 2009 and should be in use by the majority of mental health services by 2012. The Scottish Government will monitor its use.

### Care options

**Commitment 6:** NHS QIS will develop the standards for ICPs for schizophrenia, bipolar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.

### Recovery

**Commitment 22:** The Scottish Recovery Indicator will be available from end April 2009 and should be in use by the majority of mental health services by 2012. The Scottish Government will monitor its use.
<table>
<thead>
<tr>
<th>Physical health</th>
<th>Specific needs</th>
<th>Peer support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer support</strong></td>
<td><strong>Physical health improvement</strong></td>
<td><strong>Forensic mental health care</strong></td>
</tr>
<tr>
<td><strong>DFMH</strong> Commitment 2: We will have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas later that year.</td>
<td><strong>MHSS</strong> Commitment 3: We will commission a short review of work to date in Scotland on peer support as a basis for learning lessons and extending the use of the model more widely.</td>
<td></td>
</tr>
<tr>
<td><strong>DFMH</strong> Commitment 5: We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months.</td>
<td><strong>TAMFS</strong> Commitment 21: NHS Health Scotland will review evidence-based approaches and develop health improvement information on smoking cessation, weight management and physical activity designed for people with mental health problems, and will work with NHS Education for Scotland to build knowledge and skills in the workforce</td>
<td><strong>DFMH</strong> Commitment 12: We will implement the new Care Programme Approach for all restricted patients by 2008.</td>
</tr>
<tr>
<td><strong>DFMH</strong> Commitment 3: We will work with GPs to ensure that new patients presenting with depression will have a formal assessment using a standardised tool and a matched therapy appropriate to the level of need. We will also develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes who are identified under the new QOF arrangements</td>
<td><strong>MHSS</strong> Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental health condition.</td>
<td><strong>MHSS</strong> Commitment 30: We will build on the work underway at HMP Cornton Vale testing the effectiveness of training prison staff in a ‘mentalisation’ approach to working with women with borderline personality disorder and women who have experienced trauma. The pilot will be extended in that prison and also introduced in HMP Edinburgh.</td>
</tr>
<tr>
<td><strong>MHSS</strong> Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness, and we will work with the Royal College of Psychiatrists in Scotland and other partners to develop a national standard for monitoring the physical health of people being treated with clozapine.</td>
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</tr>
<tr>
<td>Services: Access and improvement</td>
<td>MHSS</td>
<td>Commitment 31: We will also work with NHS Lothian to test an approach to working with women with borderline personality disorder in the community by extending the Willow Project in Edinburgh. We will use the learning from the test to inform service development more widely across Scotland.</td>
</tr>
<tr>
<td>Joined up approach to alcohol &amp; substance misuse</td>
<td>DFMH</td>
<td>Commitment 13: We will translate the principles of Mind the Gaps and a Fuller Life into practical measures and advice on what action needs to be taken to move the joint agenda forward and support joined-up local delivery by the end of 2007.</td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 32: We will promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health condition in appropriate cases.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 17: We will work with NHS Boards and partners to more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 10: We will work with clinicians in Scotland to identify good models of Learning Disability CAMH service delivery in use in different areas of Scotland or other parts of the UK which could become or lead to prototypes for future testing and evaluation.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 33: We will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings. As part of this work we will review the need for specialist inpatient services within Scotland.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 34: We will continue to fund the Veterans First Point service and explore roll out of a hub and spoke model on a regional basis, recognising that other services are already in place in some areas. We will collaborate with the NHS and Veterans Scotland in taking this work forward and will also explore with Veterans Scotland how we can encourage more support groups and peer to peer activity for veterans with mental health problems.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 27: Healthcare Improvement Scotland will work with NHS Boards to deliver the Scottish Patient Safety Programme – Mental Health.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 4: We will increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.</td>
<td></td>
</tr>
<tr>
<td>TAMFS</td>
<td>Commitment 17: During 2009, the Scottish Government will take forward work to develop referral criteria and information systems that would support the creation of access targets for psychological therapies.</td>
<td></td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 13: We will continue our work to deliver faster access to psychological therapies. By December 2014, the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.</td>
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</tr>
</tbody>
</table>
## New technology and alternative treatments

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
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<tbody>
<tr>
<td>6</td>
<td>During the period of the Mental Health Strategy we will develop a Scotland-wide approach to improving mental health through new technology in collaboration with NHS 24.</td>
</tr>
<tr>
<td>15</td>
<td>We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.</td>
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</table>

## Trauma

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
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<tbody>
<tr>
<td>18</td>
<td>We will develop an approach to support the better identification and response to trauma in primary care settings and support the creation of a national learning network.</td>
</tr>
</tbody>
</table>

## Distress

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>19</td>
<td>We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners, social work, the police and others, to develop an approach to test in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.</td>
</tr>
</tbody>
</table>

## Early intervention

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>16</td>
<td>NHS Health Scotland will work with the NHS, local authorities and the voluntary sector to ensure staff are confident to use Steps for Stress as an early intervention approach to address common mental health problems.</td>
</tr>
<tr>
<td>24</td>
<td>We will identify the key components that need to be in place within every mental health service to enable early intervention services to respond to first episode psychosis and encourage adoption of first episode psychosis teams where that is a sensible option.</td>
</tr>
</tbody>
</table>

## Crisis standards

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
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<tbody>
<tr>
<td>8</td>
<td>Ensure that people are managed and cared for more effectively in the community and avoid inappropriate admissions by ensuring that the crisis standards are achieved by 2009.</td>
</tr>
<tr>
<td>23</td>
<td>We will identify a core data set that will allow effective comparison of the effectiveness of different models of crisis resolution/home treatment services across NHS Scotland. We will use this work to identify the key components of crisis prevention approaches and as a basis for a review of the standards for crisis services.</td>
</tr>
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</table>

## Suicide and self-harm

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes. 50% of target staff will be trained by 2010.</td>
</tr>
<tr>
<td>14</td>
<td>The Scottish Government will take forward a further review of Choose Life in conjunction...</td>
</tr>
</tbody>
</table>
with key delivery partners, including NHS Health Scotland who have a lead responsibility for national implementation, and local government, who have a lead responsibility for local action. The review will be overseen by a National Suicide Prevention Reference Group with the work being completed by 2010. The work will be informed by an independent review of the second phase of implementation (2006-2008).

<table>
<thead>
<tr>
<th>TAMFS</th>
<th>Commitment 15: Working with partners, NHS Health Scotland will develop a secure, confidential suicide register for Scotland by December 2009.</th>
</tr>
</thead>
</table>

Commitment 16: The Scottish Government will work with partners to improve the knowledge and understanding of self-harm and an appropriate response. In taking forward this work we will:
- Agree a definition of self-harm and develop a non-stigmatising language and description of self-harm
- Increase awareness of self-harm and its determinants
- Map and assess existing training provision and projects across Scotland
- Increase our understanding of effective methods of prevention and offer guidance to those delivering both general and specific services
- Develop local and national information

<table>
<thead>
<tr>
<th>TAMFS</th>
<th>Mental health improvement: arts and culture Commitment 10: The Scottish Government is collaborating with local government and other Community Planning and stakeholder interests in developing a toolkit to help Community Planning Partnerships to work with culture and creativity in delivering priority outcomes; this will include action in support of mental health improvement.</th>
</tr>
</thead>
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<thead>
<tr>
<th>TAMFS</th>
<th>Mental health improvement: workplaces Commitment 11: The Scottish Centre for Healthy Working Lives will work with partners to develop a comprehensive programme of work to promote mentally healthy workplaces, with a specific focus on public sector workplaces and small to medium-sized enterprises</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th>TAMFS</th>
<th>Commitment 12: The Ministerial Task Force on Health Inequalities said in Equally Well that we need to do more to address the factors that lead to people losing work or remaining out of work as a result of poor health. The Scottish Government will undertake a review of the current Healthy Working Lives policy early in 2009 with increased emphasis on mental health improvement.</th>
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<tr>
<th>TAMFS</th>
<th>Commitment 13: The Scottish Government will take forward work to develop consensus on what it would mean to be an exemplar employer and agree standards and consider an implementation plan for public health bodies to achieve the standards</th>
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<tbody>
<tr>
<td>Monitoring and reviewing</td>
<td>TAMFS</td>
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<tr>
<td>MHSS</td>
<td>Commitment 4: We will work with the management group for See Me, the Scottish Association for Mental Health, who host See Me, and other partners to develop the strategic direction for see me for the period from 2013 onwards.</td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 1: The Scottish Government will commission a 10 year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland in 2013. The review report will be published in 2014</td>
</tr>
<tr>
<td>MHSS</td>
<td>Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, we will develop an indicator or indicators of quality in community services.</td>
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<tr>
<td>MHSS</td>
<td>Commitment 26: We will undertake an audit of who is in hospital on a given day and for what reason to give a better understanding of how the inpatient estate is being used and the degree to which that differs across Scotland.</td>
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<tr>
<td>MHSS</td>
<td>Commitment 36: To support progress on this agenda the Scottish Government will put in place arrangements to coordinate, monitor and performance manage progress on the national commitments outlined in this strategy. In doing this, we will build on the successful experience of managing the implementation of the Dementia Strategy.</td>
</tr>
<tr>
<td>Monitoring</td>
<td>TAMFS</td>
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</tbody>
</table>
### 6.4 Appendix 4: NHS Board strategies and priorities

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>Mental Health and Wellbeing Strategy 2014</td>
</tr>
<tr>
<td></td>
<td>South Ayrshire Adult Mental Health Strategy 2013-16</td>
</tr>
<tr>
<td>Fife</td>
<td>What matters to you? A joint mental health strategy for the people of Fife 2013-20</td>
</tr>
<tr>
<td>Grampian</td>
<td>Aberdeenshire Joint Commissioning Framework Mental Health 2013</td>
</tr>
<tr>
<td></td>
<td>Aberdeen Health and Community Care Strategic Partnership Strategy 2009-14</td>
</tr>
<tr>
<td>Highland</td>
<td>Strategic Framework for Mental Wellbeing in Argyll and Bute 2012-14</td>
</tr>
<tr>
<td></td>
<td>Highland Council Joint Community Care Plan 2010-13</td>
</tr>
<tr>
<td>Tayside</td>
<td>Perth and Kinross Joint Mental Health and Wellbeing Strategy 2012-15</td>
</tr>
<tr>
<td>Shetland</td>
<td>Shetland Mental Health 2015-16 Service Plan</td>
</tr>
<tr>
<td>Lothian</td>
<td>A sense of belonging: joint strategy for improving mental health and wellbeing of Lothian's population 2011-16</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>A range of mental health strategies spanning from 1999 including recent Modernising Mental Health Strategy and the Anti-Stigma Partnership- Mental Health and Wellbeing Guide.</td>
</tr>
</tbody>
</table>

### 6.5 Appendix 5: Commitment One area reviews: Practitioners’ discussion guide

We want to find out about your experience of working in mental health services in your area over the last 10 years.

1. **What service do you work in?**
   - What is your role in that service?
   - How long have you worked there?

2. **What do you think your service does well that is most helpful to people with mental health problems and their carers?**
   - Is there anything you feel has changed for the better? (over the last 10 years or time you have worked in this service)
     - How were you able to achieve this change?
     - What made it possible? / What, if anything had to be overcome?
     - Were service users / carers involved? If so, how?
   - Do you have any examples to share?
- Any practice that you feel has been exemplary / particularly good?

3. What aspects of your service do you think are less helpful?
- Is there anything you feel has changed for the worse? (over the last ten years or time you have worked in this service, whichever is longer)
  - If yes, can you give an example of where you feel practice / services have gotten worse?
- Can you share any practice within your service that you feel has been poor or less helpful?

4. What do you feel still needs to change in services?
- What needs to change and why?
  - In your own service
  - In other services? (acute, crisis services, primary care, CMHT’s, Voluntary Sector)
- Do you have any ideas how this could be changed for the better?
- Do you have any ideas how practice could be improved?
- Do you think stigma and discrimination exists in services and can you share examples?

5. What are your views on individuals’ journeys through services?
- Can you give examples of other services you work with where:
  - The relationship works well or has improved in last ten years
  - The relationship is challenging or has worsened in last ten years
- Do services share information appropriately?
- Have you experienced unacceptable delays in supporting people to access other services?
  - What do you feel the blocks are and how can they be overcome?
- Do people in your service have a discharge plan? (if appropriate)
- Do you have views on access to other services, for better / for worse?

6. Does your service involve individuals in planning their own care?
7. Have you been involved in strategic planning, development and monitoring in your area?
   - Have you been involved at a level you would like?
   - Can you give examples of your involvement?
   - Do you feel that your views made a difference?
     - If not, why not?
     - If so in what way?

8. Have you supported people with a lived experience of mental health problems or their carers to engage in planning, development and monitoring of mental health services / strategy or wider public / community services / strategy in your area?
   - Do you think people are involved at every level and at a level they would like?
     - Can you give examples of this involvement?
   - Do you feel that their views made a difference?
     - If not, why not?
     - If so in what way?
   - More generally, how do you feel involvement works in your area/service?
- Do you have suggestions for how involvement in planning, development and monitoring of services and strategy could be improved?

Mental Health Services – the next ten years

9. How would you like mental health services to look for future people using them in 10-years time?
   - One thing you would like to see?
   - One thing you would hope people with a mental health problem or their carers wouldn’t experience?