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Mental Health in Scotland - a 10-year vision: analysis of responses to the public engagement exercise

HEALTH AND SOCIAL CARE

social research

Mental Health in Scotland - a 10-year vision

Analysis of responses to the public engagement exercise

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Contents

Executive Summary **3**
Introduction **12**
Background 12
Profile of respondents 12
Analysis and reporting 14
Priorities **16**
General comments on the proposed Strategy 18
Themes and emphasis 22
Types of approach or service 26
Key agencies or sectors 28
Groups to be prioritised 28
The existing 8 Priorities 34
Other actions to improve mental health **38**
Priority 1 38
Priority 2 40
Priority 3 43
Priority 4 44
Priority 5 46
Priority 6 47
Priority 7 48
Priority 8 50
Future vision **52**
Reduced stigma and discrimination 52
Wellbeing and prevention 53
Tackling inequalities 53
Whole systems working 54
Integrated and equitable services 55
Self-management 56
Carers and families 56
Employment 56
Outcome-focused evaluation 57
Co-production and lived experience 57
Summary findings 58
Annex 1 ..... **60**
Annex 2 ..... **70**

Executive Summary

Introduction

This summary presents the key messages from the analysis of responses to the Scottish Government's engagement exercise about a new Mental Health Strategy for Scotland.

The new Mental Health Strategy is intended to cover a 10-year period. The framework on which respondents were asked to comment sets out the priorities that the Scottish Government thinks will deliver significant improvements to the mental health of the population of Scotland. It is organised around life stages: Start Well; Live Well; and Age Well. The framework sets out 8 Priorities that the Scottish Government has identified for the next Strategy. These are:

1. Focus on prevention and early intervention for pregnant women and new mothers.
2. Focus on prevention and early intervention for infants, children and young people.
3. Introduce new models of supporting mental health in primary care.
4. Support people to manage their own mental health.
5. Improve access to mental health services and make them more efficient, effective and safe – which is also part of early intervention.
6. Improve the physical health of people with severe and enduring mental health problems to address premature mortality.
7. Focus on **'All of Me'**: Ensure parity between mental health and physical health.
8. Realise the human rights of people with mental health problems.

A total of 598 responses were available to inform the analysis. The majority of responses, 61%, were submitted by individual members of the public. The remaining 39% of responses were submitted by groups or organisations, including health organisations, local authorities, multi-agency partnerships, third sector organisations and service user or carer groups.

Many of the submissions made were both lengthy and detailed, and this analysis focuses on the most frequently raised themes and issues.

The Priorities

The first question asked if the 8 Priorities are the most important for transforming mental health in Scotland over the next 10 years. 51% of those who answered the question thought that the 8 Priorities are the most important. Of the remaining respondents, 39% disagreed and 10% did not know. Group respondents were relatively evenly divided (with 50% agreeing, 45% disagreeing and 5% not

knowing), as were individual respondents (with 51% agreeing, 36% disagreeing and 13% saying they did not know).

General comments on the draft proposals

Although Question 1 focused on the 8 Priorities set out, a number of respondents raised more general or fundamental issues about the scope or focus of the current proposals. Many of these respondents offered support for the shift from a 3-year to a 10-year strategy, the life-stage focus of the strategy, and the overt focus on prevention and early intervention.

Some respondents raised issues or concerns about the overall focus of the current draft document. A primary concern for some respondents was that, while the 8 Priorities would help improve mental health services, they do not amount to transformation, and that the overall Strategy lacks ambition or vision. It was recommended that a vision and core set of values should be developed in partnership with those with lived experience.

In terms of elements to be taken into account and which should inform the Strategy, it was suggested that the Strategy needs to be aligned with other strategies, policy and legislation and the appropriate parallels and linkages made. It was also suggested that clear arrangements should be in place for monitoring and evaluation.

Themes and emphasis

In terms of the overall themes and emphasis running through the Strategy, it was suggested that there should be a much stronger focus on wellbeing. This would mean a shift in focus away from service provision to the emotional health and wellbeing of Scotland's communities, and would require a major revision of the current Strategy. It was also suggested that a whole system response, with a stronger emphasis on a collaborative, multi-agency approach, should be central.

Areas in which it was suggested that overall coverage is insufficient included the impact of socio-economic disadvantage, and the needs of the most marginalised and hardest to reach communities. Another area on which a number of respondents commented was the human rights-based approach. It was sometimes suggested that this needs to be more firmly embedded and should be 'threaded-through' the whole Strategy rather than be seen as one of the Priorities. On a connected point, a number of respondents commented on the extent to which the Strategy addresses equalities commitments. A clear statement recognising how experiencing inequality can contribute to, or cause, poor mental health was also proposed. Other areas which respondents suggested should be given greater focus included: addressing the needs of more vulnerable populations; the rural dimension; tackling stigma and discrimination; employment and employability; and the links with alcohol or substance misuse.

Other comments focused on key requirements for the successful delivery of the Strategy including the need for sufficient resources and funding. The need for a

sufficient level of funding to support appropriate staffing levels was highlighted in particular, as were issues around workforce development and training.

Many comments focused on the types of approach or service which should be given greater prominence within the Strategy. Suggestions included rehabilitation and recovery. It was suggested that recovery needs to be at the core of mental health policy and practice, not seen as an added extra that can be bolted on. Person-centred approaches and trauma-informed approaches were seen as important, as was delivering a family-inclusive model of care. It was also seen as important to have mental health services which respond to the needs of those who do not fit current service approaches, including those with complex or unusual needs.

It was suggested that the overall balance between specialist and general care needs to be reconsidered, and the important role that general care plays should be recognised. Acute and crisis services, and specialist mental health care, were also seen as needing further focus and investment.

Groups or approaches requiring additional focus or priority

Some respondents highlighted particular groups of people to whom they felt the draft document does not give sufficient focus. They included: families and carers; people with severe and enduring mental ill health; people with learning disabilities or autism; children and young people with mental health problems; people experiencing or at risk of homelessness; LGBTI people; and young LGBTI people in particular.

Respondents also identified a range of groups of people or types of issue or approach which they felt should be an additional priority within the Strategy. A number of the groups identified were focused on children and young people and included: care experienced children and young people; young people needing secure care; children or young people in the youth justice system; deaf children and young people; children and young people with learning disabilities; and older young people. Other groups suggested included: people going through transitions; people with sight loss; people with disfigurements; people with dementia; older people; people with eating disorders; prisoners and those in the criminal justice system; refugees and asylum seekers; and students.

The need to consider the role and contribution of various types of organisation was also highlighted, including that of: the third sector; Integration Authorities; Community Planning Partnerships; and non-mental health specialist statutory and public services.

Themes or types of service which respondents identified as possible priorities included: co-production and valuing lived experience; suicide prevention; addressing discrimination and inequality; developing inclusive, connected and resilient communities, which can support good mental health; preventing mental ill health through education; building and maintaining wellbeing; recovery-focused mental health services; the role of employment; access to greenspace; tackling

obesity; developing and expanding the provision of crisis care; and a review of the use of medications.

Specific comments on the priorities and actions

Priority 1: Focus on prevention and early intervention for pregnant women and new mothers.

Raising awareness of perinatal mental health and working closely with mothers was seen as a significant way of intervening early, reducing vulnerabilities and supporting the child protection agenda. The focus on the early recognition and treatment of perinatal mental health, particularly for those most vulnerable, was widely endorsed, although some respondents suggested that there could be a greater emphasis on the inclusion of work with fathers and other family members.

It was noted that the onus for perinatal mental health appeared to be placed on health services, but suggested that success will depend on the inclusion and integration of the work of a number of key agencies. Frequent reference was made to the third sector as continuing to have a key role to play.

Priority 2: Focus on prevention and early intervention for infants, children and young people.

There was strong support for evidence-based programmes to promote good mental health, and that these should again target vulnerable groups. It was noted that a range of issues which can affect a child or young person's mental health, such as being bullied, difficulties at school, or unmanaged grief or loss, need to be recognised. It was suggested that the Strategy needs to consider the unmet need which can result from these issues. However, there was also a frequently-expressed view that such programmes should also focus on wider physical and mental health determinants such as deprivation, employment, social connectedness, and environment.

When taking this work forward, it was suggested that community involvement will be imperative and that communities need to take responsibility for children and young people. It was noted that schools have a particularly important part to play in the promotion of good mental health and that the Strategy needs to recognise this.

Although a clear link was seen between mental and physical health, many of those commenting thought these principles should be extended to consider a whole person response to supporting wellbeing. Resilience, self-worth and optimism were seen to equip children and young people to be socially connected, confident and to decrease the impact of any inequalities, and it was thought these should be promoted. Co-production of services with children and young people and their communities was considered to be of value to the individuals involved, and was seen as having a positive role to play in challenging stigma.

Priority 3: Introduce new models of supporting mental health in primary care.

There was a frequent view that, in order to support mental health in the community, wider determinants of mental and physical wellbeing needed to be considered. This included the impact of factors such as poverty, employment and social inclusion on health outcomes and recovery.

In order to address these challenges, it was felt that service responses need to extend beyond primary care, other health services and other statutory services. The wide range of private, independent and third sector partners was noted, and it was highlighted that delivering primary care does not preclude collaboration with the third sector or with non-mental health focused statutory services. It was suggested that the independent, private and third sectors should also be supported to introduce new models of care.

This shifting of the balance of care was seen as key to accessing the extensive pool of resources embedded in the heart of communities and, by extension, to addressing inequalities effectively.

Priority 4: Support people to manage their own mental health.

The focus on self-management and self-help resources was welcomed, as was the emphasis on building emotional resilience, confidence and coping strategies rather than just psychological self-help. The ability to manage day-to-day living, retain employment and access social and leisure activities was considered important in reducing vulnerability, with the third sector seen as having a key role in achieving this. The value of diet, exercise and positive relationships was also noted, alongside the provision of a range of alternatives such as mindfulness, yoga and exercise.

A focus on employment was welcomed as having a role in improving aspiration and sustaining positive health. It was also suggested that the benefits of volunteering as a preventative measure should be highlighted. It was suggested that volunteering is evidenced to improve mental health and wellbeing, and employability. In particular, it was suggested that buddying and peer support models could be referenced, although these should not be promoted as a ‘quick fix’ for pressures on primary care. More generally, it was noted that self-management should not be seen as a way to reduce access to support or services, or used as a cost cutting exercise.

Priority 5: Improve access to mental health services and make them more efficient, effective and safe – which is also part of early intervention.

It was suggested that the focus of Priority 5 should be on providing an effective and safe service, and that it will be important to maintain quality and governance whilst improving the speed of access to services. It was noted that, without a focus on ensuring quality, there is a risk that whilst patients may be seen more quickly, the treatment provided may be less effective.

Many of those who commented felt that priority should be given to ensuring timely and accessible services throughout the wider health and social care system,

acknowledging the valuable role of them all. A number of respondents also commented that a true partnership approach which embraces social care, children's services and the third sector, could provide a more comprehensive range of support, would help prevent crisis and escalation, and would support positive outcomes.

The development of a mental health outcomes framework was welcomed as providing open and accessible public reporting of mental health outcomes data. It was seen as valuable for monitoring progress against clear targets and developing evidence-based interventions.

Priority 6: Improve the physical health of people with severe and enduring mental health problems to address premature mortality.

There was a view that physical health should be embedded throughout the Strategy. Many respondents commented on the interrelationship between the physical and mental health of individuals with severe and enduring mental health problems, including noting that to treat conditions in isolation presented a risk of an incomplete picture and conditions being ignored (or not explored adequately).

The remodelling of primary care was seen as an opportunity to integrate services and create more holistic approaches to the care of individuals with severe and enduring mental health problems, incorporating both physical and mental wellbeing. Partnership was seen as being of particular importance in relation to those with additional vulnerabilities such as older age, learning disability, autism or substance misuse.

Priority 7: Focus on 'All of Me': Ensure parity between mental health and physical health.

Priority 7 was described as 'critical and visionary' and it was suggested that it is essential that mental health is seen as being as significant and requiring of investment as physical health. Other points raised about Priority 7 included that the Strategy needs to more clearly set out that physical and mental health are not just issues that sit alongside each other, but are closely interconnected. It was also suggested that this Priority should include a clear preventative focus, with GPs encouraged to ensure early intervention takes place and health and wellbeing issues are addressed before they worsen.

A number of respondents identified actions or opportunities which would help realise the ambition of parity between mental health and physical health care, with inequalities reduced and mental health being seen as part of everyday life. They included that the integration of health and social care would provide an opportunity to establish better links between services through strategic commissioning, but that the contribution that other sectors - such as housing, leisure and employment - can make should also be recognised and exploited.

It was also suggested that increasing financial security through employment has the potential to promote inclusion, decrease stigma, increase self-worth and open up

opportunities. It was felt that employment and welfare programmes should be designed to take account of mental health conditions and offer people the greatest chance of success.

Priority 8: Realise the human rights of people with mental health problems.

There was a broad consensus that realising the human rights of people with mental health problems is essential to the delivery of quality mental health care. This Priority was seen as providing a clear focus on recovery, choice, uniqueness and dignity, and as key to improving the quality and experience of health and social care. Success was seen as not being about simple adherence to legislation, but as requiring a substantial shift in both organisational culture and workforce development.

It was suggested that joined-up thinking across Government departments and strategies would help maximise impact in this important area. In particular, the Strategy should explicitly align itself with the Scottish National Action Plan for Human Rights, and there should be explicit reference to the United Nations Convention on the Rights of the Child (UNCRC).

Future vision

Respondents were also asked to outline their vision of what mental health services in Scotland should like in 10 years' time. Overall, the most frequently raised ideas reflected the central issues or concerns raised at earlier questions. They are summarised below under broad and frequently inter-connected themes.

Reduced stigma and discrimination: In 10 years' time, Scotland will be a country where mental health is seen as everybody's business. A focus on prevention will improve understanding of mental illness, support a reduction in stigma and address inequalities. People will instead be aware of the importance of good mental health and how they can manage it themselves. This message will be understood and promoted throughout communities, including through our schools. Positive mental health will be recognised but, where ill health does occur, then more enlightened public attitudes will ensure that the experience is free from stigma.

Wellbeing and prevention: In 10 years' time, Scotland's approach to mental health will focus on promoting wellbeing, prevention and early intervention. An early, responsive service will be seen as key and as offering the best chance of avoiding problems escalating, with potentially lifelong consequences. There will have been a substantial shift in the focus of services, along with the resources that go with them, and wider society will collectively experience a mental health gain.

Tackling inequalities: Understanding and addressing inequality will be a key part of creating a mentally healthier society in 10 years' time. Early disadvantage and damage can have lasting effects on life chances and stifle potential. There needs to be recognition that many of the barriers to wellbeing and recovery lie within society and not within the people who experience mental ill health. Both society as a whole

and services need to work to remove these barriers so that disadvantaged individuals or groups have access to the support they need.

Whole systems working: In 10 years' time, we will have a whole systems approach which will be intrinsically person-centred, flexible, effective at promoting recovery and will have moved away from overly-medicalised models of care towards person-centred and individualised support. The consideration of mental health in its widest context will mean that communities as a whole will be healthier, more cohesive and more supportive of each other. This more holistic approach to mental health, if founded on promoting wellbeing and otherwise taking an expansive and public health-focused approach to prevention, will mean that the need for more specialist services may have been reduced.

Integrated and equitable services: Partnerships between organisations will be seen as providing the framework within which a whole systems way of working can sit, with 'behind the scenes' structures and processes supporting a joined-up, community-focused approach which then feeds into a better patient, service user and carer experience. The services involved will extend well beyond health and specialist mental health services. A wide range of other services, agencies and groups - including education, social care, the third sector, housing and employment services - will also have a central role to play. There will be a tiered approach to care, with a range of prevention and early intervention initiatives, and access to the right service at the right time. In 10 years' time, where someone lives will not affect their easy access to this package of fit-for-purpose services.

Self-management: In 10 years' time, self-management will be seen as an integral component of a tiered approach to care and this will support people to better understand and manage their own mental illness. This will include equipping people with the tools that support them in increasing their own self-awareness, managing their mental health challenges and remaining connected to society. A proactive approach to the promotion of self-management will be in place which will include options such as guided self-help, online support and peer mentoring.

Carers and families: A Scotland in which the vital role played by carers and families is recognised, and they are supported accordingly, was a key part of many people's 10-year vision. Mental health services will work alongside service users and carers with 'no decision about me without me' being the norm. Carers and families will be seen as key partners, and equal contributors, and this in turn will strengthen the partnership approach.

The impact on families and carers will be better understood, allowing the right support to be made available in the right places. This will include recognising that becoming a carer of someone with a mental health issue can be a challenge and be both physically and emotionally demanding.

Employment: In 10 years' time, the importance of good quality employment opportunities being available will be recognised and there will be a focus on enabling people to both access and retain employment. Employability support will

be seen as an inherent part of the package of community-based provision, alongside access to information, social support and physical healthcare. The critical role employers have to play in providing support to employees will be understood, including in terms of promoting wellbeing and good mental health. There will be programmes to support and advise employers.

Outcome-focused evaluation: Considering what is working well and less well will be a central and ongoing process and will be focused on the outcomes being delivered. There will have been a clear move from measuring outputs such as service volume or hours of support delivered, to measuring outcomes which contribute towards achieving recovery.

Co-production and lived experience: The vital importance of involving and listening to those with lived experience has been a common theme running through many of the responses to this public engagement exercise. Although many respondents did set out their vision for what mental health services in Scotland should look like in 10 years' time, there was a common view that the important people, if not the most important people, to be involved in developing this vision are those with lived experience.

This focus on the importance of co-production extended to the Strategy itself, but also to the planning and delivery of services. The approach should be inclusive and ensure that everyone has the opportunity to have their voice heard, including children and young people. People will not only have a right to be involved but will have been made aware of that right.

In 10 years' time the idea of 'service user involvement' will have been replaced by the user-led participation model, with the involvement of the majority of people with lived experience. Services will reflect and act upon the views and experiences of both those using the service, as well as their families and carers. This will not only support informed service and resource decisions, but will also help in moving towards models of skilled user-led peer support. To reap the full benefits of this culture shift, outcome measures will focus on indicators of wellbeing and the development of these measures will be strongly informed and influenced by people with lived experience of mental ill health.

For many, co-production was seen as driving the person-centred approach where people feel empowered to choose and pursue paths to recovery which are right for them. This was at the heart of many respondents' vision of what mental health services in Scotland will look like in 10 years' time but was also seen as key to enhanced wellbeing across Scotland's communities.

Introduction

This report presents an analysis of responses to the Scottish Government's engagement exercise about a new Mental Health Strategy for Scotland.

Background

The new Mental Health Strategy is intended to cover a 10-year period and follows on from a 3-year strategy that ran from 2012 to 2015. During 2015 and 2016, the Scottish Government has reviewed evidence and engaged with a wide variety of stakeholders, internal and external, to inform the development of policy for the next strategy. People and organisations also gave written comments, and events were hosted by the Scottish Association for Mental Health, Voices of Experience, the Scottish Youth Parliament and Young Scot.

The Scottish Government has been carrying out an engagement exercise on the themes and aims that the next strategy will cover. That engagement exercise has included 6 public engagement events and a 7-week period during which groups and individuals have been invited to submit their views through the Scottish Government's online consultation hub (Citizen Space). Respondents were asked for their views on:

- The Scottish Government's priorities for transforming mental health in Scotland;
- The early actions the Scottish Government proposes to take to deliver this transformation; and
- How success should be measured over the 10-year period.

The Scottish Government's paper on the new Mental Health Strategy can be found at: https://consult.scotland.gov.uk/mental-health-unit/mental-health-in-scotland-a-10-year-vision/supporting_documents/mentalhealthstrategy.pdf.

This report presents an analysis of the written responses to the engagement exercise. The Scottish Government will consider this analysis alongside the feedback from the public engagement events that have been run across 2016 by organisations including NHS Health Scotland, the Scottish Youth Parliament and the Mental Health Alliance. These findings will be used to inform the development of the final Strategy ahead of publication later in 2016.

Profile of respondents

A total of 598 responses are available to inform the analysis[1]. The majority of these were received through the Scottish Government's online consultation hub.

[1] A small number of duplicate responses were removed. If more than one response was received from any individual or group, the content of the multiple responses will have been merged to form a single response.

A profile of respondents by type is set out in Table 1 below. Group respondents have been placed into one of ten respondent types by the analysis team. Please be aware that a number of respondents could have been placed in more than one group and a degree of judgement has been used.

Table 1: Respondents by type

Type of respondent	Number
Academic or research group	8
Health	40
Local authority	8
Multi-agency partnership (MAP)	21
Network, forum or membership organisation	31
Other	6
Professional body or college	16
Public agency	13
Third sector	80
User and/or carer group	11
(Total Groups)	*(234)*
Individuals	364
TOTAL	**598**

The majority of responses, 61%, were submitted by individual members of the public. The remaining 39% of responses were submitted by groups or organisations. Points to note about the respondent categories for the group respondents are:

- The academic or research groups span six Scottish universities and the specialisms of: looked after children; youth and criminal justice; child and adolescent health; health and social care; mental health and incapacity law, rights and policy; learning disabilities; and health sciences and sport.
- The health respondents include: health boards; directorates, divisions, committees or strategy groups from health boards; clinical groups; groups of primary or secondary care practitioners; and health promotion or education groups or bodies.
- The local authority group includes: local authorities; the educational psychology service of local authorities; and the Convention of Scottish Local Authorities (COSLA)
- The multi-agency partnerships (MAPs) group includes: Health and Social Care Partnerships (HSCPs); Alcohol and Drugs Partnerships (ADPs); Strategic and Planning Partnerships; and an Integrated Joint Board (IJB).
- The network, forum or membership organisation group includes organisations with a specific mental health focus but also a number of networks, forums or

organisations with another primary focus, such as younger or older people. It also includes a campaigning community which submitted a response containing the views of more than 10,000 of their members in Scotland.

- The "Other" group includes private sector organisations or bodies, a religious denomination and a political party.
- The professional body or college group is primarily made up of bodies or colleges representing those working in the health or social care sectors.
- The public agency group includes bodies working in the justice sector, the health and social care sectors and on human rights.
- The third sector group is the largest and includes a very wide range of organisations. They include organisations which work primarily in the field of mental health as well as those whose work focuses on other subject areas or other groups of people.
- The user or carer group includes organisations which work nation-wide as well as organisations representing people in a particular area of Scotland.

A list of the groups that submitted a response to the consultation is included as Annex 1 to this report, and copies of responses to be published[2] can be found on the Scottish Government's website at:

https://consult.scotland.gov.uk/mental-health-unit/mental-health-in-scotland-a-10-year-vision/consultation/published_select_respondent.

Analysis and reporting

The remainder of this report presents a question-by-question analysis of the three main questions set out in the consultation document. Question 1 included both a closed ('Yes/No') part and an open-ended opportunity to make a further comment. Questions 2 and 3 were both open questions.

The data at the closed ('Yes/No') part of Question 1 was analysed by respondent type. A number of respondents did not make their submission through Citizen Space, but submitted their comments in a statement-style format. When these responses contained a very clear answer at the 'Yes/No' element of Question 1, this has been recorded. The remaining content was analysed qualitatively under the most directly relevant consultation question.

An analytical framework was developed for each of the open-ended questions, with a separate code created to cover each of the main themes arising. These codes were then applied to each comment made.

Many of the submissions made were both lengthy and detailed, and this report can only present a summary analysis which focuses primarily on the most frequently

[2] Respondents were asked whether they wanted their response to be published. Amongst those who said yes, a very small number of responses have not been published, or have had some content redacted, because they contained personal information about a third party or defamatory comments.

raised themes and issues. However, as noted above, most of the responses can be found on the Scottish Government's website and all responses have been considered by the Scottish Government's Mental Health Unit.

Each of the three questions had a particular focus (priorities, actions, and vision of the future), but there was considerable variation as to how respondents addressed each question. This has meant that very similar comments may have been made against any of the questions and there is a degree of repetition running through the report. For example, an issue such as 'needing to do more to tackle stigma and discrimination' might have been made as a general comment about the whole Strategy, have been raised about one or more of the existing Priorities or suggested as an additional Priority. It could also have been raised in relation to existing actions or suggested as an additional action at Question 2, while a Scotland in which there is less stigma or discrimination may have been part of the future vision set out at Question 3.

As with any engagement or consultation exercise, it is important to note that the views expressed and, by extension, the themes and issues presented below, are those of the groups or individuals who chose to make a submission. These views cannot be assumed to be representative of the wider population.

Priorities

The framework described in the new Mental Health Strategy sets out the priorities that the Scottish Government thinks will deliver significant improvements in the mental health of the population of Scotland. It is organised around life stages:

- **Start Well** – ensuring that children and young people have good mental health, and that we act early when problems emerge;
- **Live Well** – supporting people to look after themselves to stay mentally and physically healthy, to get help quickly when they need it, and to reduce inequalities for people living with mental health problems;
- **Age Well** – ensuring that older people are able to access support for mental health problems to support them to live well for as long as possible at home.

The framework sets out 8 priorities the Scottish Government has identified for the next Strategy. These are:

1. Focus on prevention and early intervention for pregnant women and new mothers.
2. Focus on prevention and early intervention for infants, children and young people.
3. Introduce new models of supporting mental health in primary care.
4. Support people to manage their own mental health.
5. Improve access to mental health services and make them more efficient, effective and safe – which is also part of early intervention.
6. Improve the physical health of people with severe and enduring mental health problems to address premature mortality.
7. Focus on **'All of Me'**: Ensure parity between mental health and physical health.
8. Realise the human rights of people with mental health problems.

The first question asked respondents whether the 8 priorities (as set out within Annex A of the Mental Health in Scotland – a 10 year vision paper) are the most important.

Question 1: The table in Annex A sets out 8 priorities for a new Mental Health Strategy that we think will transform mental health in Scotland over 10 years. Are these the most important priorities?

If no, what priorities do you think will deliver this transformation?

Responses by respondent type are set out in Table 2 below. The analysis presented in Table 2 excludes those respondents who did not answer the question: the corresponding table including such respondents is attached to this report as Annex 2.

Table 2: Question 1 – Responses by type of respondent

Type of respondent	Yes		No		Don't know		TOTAL
	N	%	N	%	N	%	N
Academic or research group	3	43	4	57	-	-	7
Health	24	73	8	24	1	3	33
Local authority	3	50	3	50	-	-	6
Multi-agency partnerships (MAPs)	4	27	11	73	-	-	15
Network, forum or membership organisation	8	32	16	64	1	4	25
Other	2	50	2	50	-	-	4
Professional body or college	10	83	2	17	-	-	12
Public agency	5	63	2	25	1	13	8
Third sector	26	43	31	52	3	5	60
User and/or carer group	5	50	2	20	3	30	10
(Total Groups)	*(90)*	*(50%)*	*(81)*	*(45%)*	*(9)*	*(5%)*	*(180)*
Individuals	181	51%	127	36%	47	13%	355
TOTAL	**271**	**51%**	**208**	**39%**	**56**	**10%**	**535**

51% of those who answered the question thought that the 8 Priorities are the most important. Of the remaining respondents, 39% disagreed and 10% did not know. Group respondents were relatively evenly divided (with 50% agreeing, 45% disagreeing and 5% not knowing) as were individual respondents (with 51% agreeing, 36% disagreeing and 13% saying they did not know).

Professional bodies or colleges, health respondents and public agencies were most likely to agree (83%, 73% and 63% respectively). Multi-agency partnerships, networks, forums or membership organisations and academics or research groups

and third sector respondents were least likely to agree (27%, 32%, 43% and 43% respectively). However, it should be noted that the number of respondents within some respondent type groups is small and these findings should be seen as indicative rather than robust. The content of many of the further comments made also suggests that the quantitative results should be viewed with a degree of caution.

Around 410 respondents went on to make a further comment at Question 1 and/or made general comments which have informed the analysis presented in this chapter of the report. Of those commenting, around 110 had answered 'Yes' at Question 1, around 200 respondents had answered 'No' and around 90 respondents had either answered 'Don't know' or had not answered the question. However, irrespective of how they had answered Question 1, many of the further comments included both positives and negatives and could most accurately be described as 'mixed'. In terms of how respondents giving mixed comments had answered Question 1, some appeared to have taken a *'Yes, but…'* approach, whilst others had taken a *'No, although...*'.

Although Question 1 focused on the 8 Priorities set out, a number of respondents raised more general or fundamental issues about the scope or focus of the current proposal. A number of respondents commented on one or more of the proposed Priorities and some respondents identified additional Priorities (either in terms of themes or in terms of client groups). Each of these areas is covered in turn below.

General comments on the proposed Strategy

The value of a long-term Strategy

Either in their opening comments or directly under Question 1, a number of respondents welcomed the intention to introduce a new Mental Health Strategy for Scotland. Some of these respondents noted their particular support for the decision to shift from a 3-year to a 10-year strategy. Reasons given for supporting this longer time-frame included that it will provide for a more realistic timescale to demonstrate outcomes, particularly in terms of prevention. However, notes of caution included that:

- The longer-term approach makes it even more essential that the right direction is taken and any current weaknesses in the system are not consolidated.
- The funding commitment only extends to 5 years. The lack of detail around how the planned investment will be allocated was also noted.

Strengths and weaknesses of a life stage approach

Another area of frequent comment was the life-stage focus of the Strategy, with those highlighting this approach generally offering their support. In particular, it was suggested that this approach helps to map out the journey through life and identify access points, referral thresholds and criteria to/for services. However, one respondent suggested that the changing demographics in Scotland, along with a

continuously evolving policy landscape, require continuous monitoring and responsiveness to changing needs and that the long-term nature of the Strategy may result in certain sections becoming obsolete or irrelevant.

Other comments included that some client groups, such as people with dementia or experiencing psychosis, would benefit from moving to ageless services and it was suggested that the overall message might be clearer if certain of the Priorities were not selectively applied to particular groups of people. For example, addressing physical health will be of benefit to people other than those with severe and enduring mental health problems. Equally, early interventions should be a priority across all age groups and circumstances and not just for mothers and children.

A further concern was that, while the Start Well stage is clearly set out, the Live Well and Age Well stages are conflated in the latter parts of the document. One respondent suggested there should be a fourth stage, Die Well. They suggested that the Strategy needs to ensure that people at the end of life, or living with a terminal illness, can access support for mental health problems to support them to die well.

There was also broad support for the overt focus on prevention and early intervention. However, there was a concern that the proposed approach is narrowly conceived and that the focus should be on the benefit of prevention and early intervention at any age and stage. It was suggested that the Strategy overall gives insufficient recognition to the prevention of mental ill health or to the need to respond to the worsening of an existing condition.

Scope for a more ambitious vision

Some respondents raised other issues or concerns about the overall focus or approach and/or the current draft document. A primary concern of some respondents was that, while the 8 Priorities would help improve mental health services, they do not amount to transformation, and that the overall Strategy lacks ambition or vision. It was suggested that to deliver transformation, that transformation needs to be defined and this of itself should be a Priority. It was also suggested that the Strategy should set out a clear vision or statement of ambition and a set of core values. It was recommended that these should be developed in partnership with those with lived experience and that when further developing and/or finalising the Strategy, the Scottish Government should take an inclusive approach, which includes meaningful consultation with people from across the protected characteristics groups.

A specific suggestion was that a Commission of Enquiry be established to lead and inform the transformation needed to significantly improve the mental health and wellbeing of Scotland’s population, and to reduce inequalities in mental health and wellbeing. It was proposed that this commission would bring together a range of people, including those with lived experience of mental health problems, to develop a longer-term vision and make recommendations for change, including legislative reforms.

Key components of a robust Strategy

In terms of what else should be set out within the Strategy document, suggestions included:

- The evidence base that has informed the Strategy.
- Further detail concerning the actions to be taken forward, along with the associated activities required. This should cover the 10-year Strategy period.
- A clear implementation/delivery plan. This should make clear which organisations will be delivering on the various actions contained in the Strategy.
- A reporting framework.
- Details of the budget and funding arrangements.
- Definitions of the terms used. It was noted that the national indicators and frameworks for mental health of adults, children and young people provide these definitions.

In terms of elements to be taken into account and which should inform the Strategy, the following issues were highlighted:

- The Mental Health Strategy needs to be aligned with other strategies, policy and legislation and the appropriate parallels and linkages made. Examples cited included the ongoing work to revise the Dementia Strategy, the Key to Life Strategy, the Criminal Justice Strategy, the National Clinical Strategy for Scotland, the soon-to-be-published Maternity Strategy, the Perinatal and Infant Mental Health Plan, Scotland's National Plan for Human Rights, and the National Outcomes for Health and Wellbeing. Reference was also made to the Self-directed Support and Health and Social Care legislation, the Children and Young People (Scotland) Act 2014, the Community Justice Act 2016, and the Child Poverty Bill. The need to demonstrate links with other transformation programmes was also highlighted. Suggestions included the Primary Care Transformation Fund, Urgent Care Transformation Fund, Mental Health Innovation Fund and Distress Brief Intervention Programme.
- The Strategy should recognise the good progress that has been made via the infrastructure created through the previous Strategy. It was recommended that the previous Strategy's 6 high-level priorities should remain and could be built on by introducing one or two more actions.
- There should be a clear outcomes-focused approach. Outcomes, like recovery, need to be a thread that runs throughout the Strategy and outcome-based measures need to be co-produced with people who use services. Restructuring the Priorities so that they focus on outcome first should be considered.
- The Strategy needs to take a needs-focused, evidence-led approach. Implementation science could be used to ensure interventions and approaches are implemented for maximum benefit.

- There is a lack of coherence and relationship between the early actions and the results and more work needs to be done to map out how outcomes will be delivered.

Delivering the Strategy

Other comments that focused on key requirements for the successful delivery of the Strategy included the need for:

- Sufficient resources and funding. Clarity was sought as to how the funding already committed over the next 5 years will be used to tackle a range of issues, including waiting times for accessing services and a lack of appropriate acute beds for mental health patients. The need for a sufficient level of funding to support appropriate staffing levels was highlighted. There was also a concern that the focus of investment will fail to contribute significantly to shifting the balance of care, and that the necessary funding should be available for third sector and independent provision.
- Workforce development and training and the availability of suitably skilled staff to deliver on the Strategy's commitments. For example, reference was made to current challenges in recruiting Mental Health Officers and to recruitment and retention issues in General Practice. In terms of the type of training required, it was suggested that early identification of mental health difficulties should be established as a core capacity of all health, social care and education professionals.

Monitoring and evaluation

Issues raised concerning the evaluation and/or monitoring of the Strategy included that:

- Learning from the implementation of the previous Strategy should be used to help inform the development and delivery of the new Strategy. An evaluation of the successes, or otherwise, of the previous Strategy is required.
- An independent oversight group, which includes representatives of people with lived experience and carers as well as other key third sector partner organisations, should be established. It was proposed that such a group should be given the authority to seek information and answers from those who fund, commission and manage services.
- Clear arrangements should be in place for monitoring and evaluating, including which models are the most effective and sustainable. This includes in relation to primary care models. The introduction of National Key Performance Indicators (KPIs) was one suggestion made. Older people from the LGBTI or black and minority ethnic groups should be included in any KPIs that are developed to measure strategy implementation.
- Measurement frameworks must capture health economic gains, making progress on addressing the social and economic determinants of mental health inequalities and, in particular, include effective measures of the impact of prevention activities.

- There may be opportunities to link with wider work to support measurement of progress towards outcomes in Local Outcome Improvement Plans.
- Elements which could lead to transformation should be measured rather than just those elements which lend themselves to being measured, such as waiting times.
- There is a need for caution in seeing measurement of outputs as denoting success. These are good as activity measures, but to be effective the outcomes should be captured on an individual, community and population basis.
- There should be an explicit commitment to greater data transparency and accountability. In particular, while many mental health statistics are published, basic information on aggregate levels of mental health spend are not readily available and improvements could also be made in reporting of rates of recovery and improvement.

Themes and emphasis

In terms of the overall themes and emphasis running through the Strategy, respondents raised a number of issues for consideration.

Co-production and valuing lived experience

A frequently-made suggestion was that the views of those with lived experience should be valued and a co-production approach taken - this was raised in relation to the development of the Strategy itself and regarding the development of services at a local level. It was noted that this level of influence was enshrined in The Public Bodies (Joint Working) Act (Scotland) 2014, and the Community Empowerment (Scotland) Act 2015.

It was suggested that an immediate priority should be the co-production of an ambitious and transformative vision for the future mental health of Scotland's people. This should be developed over the next few months with people who have lived experience, carers and other key third sector organisations.

Co-producing services with those with a lived experience of the mental health system was also considered essential to the human rights approach and as a commitment which should be threaded throughout the Strategy. It should include co-designing services and being part of governance and commissioning groups to ensure that services best meet the needs of people experiencing mental health problems. People with lived experience should also be involved in the evaluation process.

It was noted that this approach should be applied across all services and should be as inclusive as possible. This includes ensuring that children and young people are involved where appropriate. It was also suggested that the approach should be inclusive of carers, families and communities.

Human rights-based approach and tackling inequalities

Another area about which a number of respondents commented was the human rights-based approach. This needs to be more firmly embedded and should be 'threaded-through' the whole Strategy rather than being seen as one of the Priorities. It was noted that the Scottish Human Rights Commission and the Mental Welfare Commission recommended that the Strategy should be explicitly built around a rights-based approach and should utilise the human rights framework to shape its aims and mainstream human rights across its commitments.

Using the PANEL[3] principles was seen as allowing for a rights-based framework to shape the Strategy and for the Priorities already identified to be placed within this framework. It was also seen as allowing for any gaps in actions that would fully address the principles to be identified. However, it was suggested that it is difficult to see how the principles have been used to shape the proposed Priorities and that, in its current form, the Strategy does not embed a human rights approach.

One opportunity highlighted was around rethinking how international standards of human rights can be embedded and operationalised across mental health services. An approach to mental health and wellbeing where the person is at the core of decision-making because upholding of rights requires it was recommended.

On a connected point, a number of respondents commented on the extent to which the Strategy addresses equalities commitments. It was suggested that the PANEL approach be used to consider both the human rights impact of actions and to help ensure that the Strategy meets the diverse needs of Scotland's communities. It was also suggested that there should be an equality statement to ensure that no group, irrespective of equality characteristics, is disadvantaged in relation to accessing timely and appropriate support. A specific suggestion was that all aspects of the framework should have a strong gender focus. A clear statement recognising how experiencing inequality can contribute to, or cause, poor mental health was also proposed.

Areas in which it was suggested that overall coverage is insufficient included the impact of socio-economic disadvantage and the needs of the most marginalised and hardest to reach communities. Given that the incidence of mental illness is often greater in areas of deprivation, improving socio-economic inequalities needs to be given appropriate consideration. In particular, it was suggested that there should be a greater focus on inequalities and the impact of poverty and other socio-economic disadvantages on children and young people. The barrier created by digital exclusion, including in relation to accessing psychological therapies such as computerised Cognitive Behavioural Therapy (CBT) was also highlighted.

Other areas which respondents suggested should be given greater focus included:

[3] PANEL stands for **P**articipation, **A**ccountability, **N**on-Discrimination, **E**mpowerment and **L**egality.

- Addressing the needs of more vulnerable populations. It was suggested that while the Strategy should emphasise universal approaches where appropriate, it must also demonstrate awareness of the needs of particular groups. A number of these particular groups were suggested as being additional priorities for the Strategy and further analysis is included later in this chapter.
- The rural dimension and in particular the needs of those living in remote or isolated communities.
- Tackling stigma and discrimination. There could be more emphasis on addressing stigma attached to mental health. There should be a greater emphasis on addressing these issues within a range of settings including general health settings, job centres, schools, local community groups and the police. It was also highlighted that the stigma experienced by people with mental health problems can be further compounded if they have an addiction problem. Additionally, it was reported that stigma continues to be a problem for people living with HIV, and that this can directly impact on health outcomes.
- Isolation and loneliness. There should be a focus on addressing the crippling impact of chronic loneliness and isolation experienced by people who have no family networks. It was noted that a sense of belonging is important and some people who are unwell over many years feel increasingly isolated and abandoned by society.
- Improving the response of the justice system to people with mental health needs. It was reported that the police, the prosecution service, the prison service and the courts have all expressed a wish to respond better to people with mental health needs, be they offenders, victims or witnesses.
- The links with alcohol or substance misuse. It was suggested that this is one of the most vulnerable populations experiencing significant mental health problems in Scotland. It was highlighted that alcohol is not only relevant to the Strategy as a preventable physical health problem but as a contributory cause and compounding factor in mental ill health. It was also suggested that action to reduce alcohol consumption will help to prevent mental health problems arising and/or reduce their severity. There was a call for the Strategy to consider how people can be actively engaged in treatment for both these manifestations of their ill health and be actively and adequately supported with what can be long-term and chronic ill health. There was a specific concern that links to drug and alcohol use and specific vulnerability from dual diagnosis appears to be missing. In relation to suicide, it was suggested that the Strategy would be improved by a far stronger emphasis on the role of alcohol in suicidal behaviour.

In addition to the suggestion that the Strategy should have a stronger focus on tackling inequality and discrimination, this was also proposed as an additional Priority. It was suggested that part of the current Priority 8 (“people with mental health problems experience less discrimination and fewer health inequalities, improved access to mental health services and improved employment”), would be

better relocated under a separate Priority focused specifically on addressing discrimination and inequality. A suggested title for this Priority was “Ensure that equality for people with mental health problems is achieved and protected across all the protected characteristics and their intersections”.

Suicide prevention

It was noted that there is a separate strategy for suicide prevention. Nevertheless, it was felt that suicide should be referenced within the Mental Health Strategy and, overall, must remain a key priority. It was noted that while suicide is not solely an issue of mental health, it is one the many different factors which can interact in complex ways to result in someone taking their own life. The commitment to a new and distinct Suicide Prevention Strategy was welcomed but it was suggested that there is merit in including a commitment to suicide prevention and actions to support a continuing reduction in suicide within the Mental Health Strategy. Issues raised about suicide prevention included:

- Evidence from elsewhere suggests that people with autism may be a particular ‘at risk’ group and this needs to be explored.
- The duty to share information to protect life should be articulated by Government to the leadership of all agencies involved in policing, health and social care. A mechanism should be developed which allows police, health and social care services to record information in relation to personal suicide risk and for this information to be capable of search by front-line staff.

Other areas to be emphasised or reviewed

Other areas suggested as warranting review included:

- There should be a much stronger focus on wellbeing. This would mean a shift in focus away from service provision to the emotional health and wellbeing of Scotland’s communities and would require a major revision of the current Strategy.
- Overall, the Strategy appears to be very health-focused, and in particular NHS-focused, based on medical models, and uses medical-based language. There is much less emphasis on social models.
- Shifting the balance of healthcare priorities should be central but the language used in the Strategy might be described as oversimplifying this. For example, the use of the term ‘primary care’ belies the complexity of multi-agency input and may erroneously be interpreted as referring only to healthcare systems.
- To be successful, a whole system response will be required and a whole government health improvement approach would be part of this. The ambition of an all-of-government approach is missing from the vision statement.
- There should be a stronger emphasis on a collaborative, multi-agency approach. In particular, there is no specific mention of health and social care integration, which is surprising given the scale and importance of the reforms being introduced and the changes still to come. There is also insufficient

recognition of the role of public health services, particularly with regards to prevention.

- The distinction needs to be made between mental illness (that requires specialist support services), mental distress (that can be addressed in general practice) and mental health (that is, fundamentally a community/societal issue).
- Many of the Strategy's broader aspirations overlap with the fields of public health, health improvement and primary care, suggesting unnecessary duplication and inefficiency.

Types of approach or service

Many comments focused on the types of approach or service which should be given greater prominence within the Strategy. Suggestions included:

- Rehabilitation and recovery. It was suggested that recovery needs to be at the core of mental health policy and practice not seen as an added extra that can be bolted on. This was seen as requiring there to be changes to the way mental health services are designed, commissioned and delivered. It was suggested that recovery can mean different outcomes for different people so what it means and how it will be measured needs to be defined. It was suggested that the role of recovery within child and adolescent mental health should be considered further. Also, the lack of focus on people who are 'stuck in services' was raised and it was suggested that the Strategy should look to addressing the needs of this group.
- Person-centred approaches. The increasing emphasis across the whole of health and social care on a personalisation approach was noted, and it was recommended that the Strategy should support further movement away from institutional care towards more person-centred and integrated community services. Particular reference was made to enabling people to access psychological therapies.
- Trauma-informed approaches. It was suggested that public services need to become trauma-informed and that this should include seeking to understand and nurture those with self-harming behaviours including substance misuse and dangerous risk-taking.
- Delivering a family inclusive model of care. It was suggested that the Strategy be reviewed to ensure its suitability for supporting families as a whole, rather than individuals within the household. It was felt this would recognise the family dynamics and interplay between family members, with consequences for mental wellbeing for all. It was also reported that preventative and early intervention strategies for young people are most effective when the family or primary carers are included at all stages. It was suggested that initiatives which support family and primary carers early, before requiring specialist CAMHS, will be essential to the successful delivery of the Strategy.
- Mental health services which respond to the needs of those who do not fit current service approaches. For example, people with complex or unusual

needs, including people with acquired brain injury, a personality disorder, or women and young people needing secure care. Developing an adequate response to these small but highly vulnerable populations often needs to be at a regional or national level, and requires a greater degree of co-ordination and strategic direction than often appears to be available at the moment.

- Generalist or primary care and the provision of services through GP surgeries in particular. It was suggested that the overall balance between specialist and generalist care needs to be reconsidered and the important role generalist care plays recognised. It was suggested that the current imbalance also extends to the funding regime for generalist services.
- Acute and crisis services. Reference was made to strengthening emergency out-of-hours psychiatric care and to the need for new approaches to support children and young people in crisis, as opposed to simply expanding CAMHS. It was also suggested there should be a focus on developing local partnerships to improve the response to and reduce the number of critical incidents involving people in metal health crisis.
- Specialist mental health care, including that within integrated health and social care services and the investment required to support this role.
- Community engagement and capacity building. Specific reference was made to the development of confidence, social skills and resilience to enable people to fulfil their potential and engage actively in their communities.
- Awareness raising and public education. Particular reference was made to educating children and young people about mental health issues. It was suggested that there is scope to share information about the body of work that is already under way.
- Advocacy. It was noted that people affected by mental health problems experience obstacles to their full, meaningful and effective participation in decisions that affect them. It was further noted that this extends not just to their own care, treatment and support, but more widely into decision-making around the design, delivery and financing of health services and support. It was suggested that supported decision-making should be incorporated into the Strategy and that advocacy for people with mental health problems is an area that could be better supported and resourced.
- Promotion of physical activity. It was suggested that the Strategy should stress the importance of physical activity for maintaining and improving mental health. It was also suggested that the value of physical activity as an opportunity for preventative spending should be highlighted.
- Employment and employability. It was felt that the Strategy could do more to recognise stresses and other conditions in the workplace which can precipitate or exacerbate mental health issues. It was also felt there should be more coverage around getting people back to work and the positive role that work plays for maintaining people's mental health. It was suggested that the Strategy should also place an onus on Government to provide employers with the tools to support colleagues with mental health conditions.

Other areas suggested as warranting further priority included preventing mental ill health through education, access to greenspace and tackling obesity.

Key agencies or sectors

The need to consider the role and contribution of various types of organisation was also highlighted, including that of:

- The third sector. Examples cited included specialist mental health services, substance misuse services, and employability organisations. It was suggested that third sector organisations have a particularly key role to play in the field of prevention and that this work needs to be acknowledged, harnessed, supported and developed. It was also suggested that there should be greater emphasis on the role that community-led health organisations have to play.
- Integration Authorities. In was noted that, with the advent of health and social care integration, mental health services are increasingly coming under the auspices of Integration Authorities and that this presents significant opportunities for developing a more joined-up approach. However, it was suggested that much of the Strategy fails to take account of the role of the Integrated Joint Boards (IJBs) in setting local priorities.
- Community Planning Partnerships. Specific reference was made to their ongoing role in improving early-years services.
- Non-mental health specialist statutory and public services. In particular, it was suggested that local authorities have a major role to play in preventing mental ill health and improving mental health, through their provision of a wide range of services which influence the determinants of mental health. Examples cited included Social Work Services, Criminal Justice Services, housing, education, community safety and employability services.

Groups to be prioritised

This section sets out some of the groups or types of people which respondents suggested should be given a higher priority or which are not but should be included within the Strategy.

Families and carers, including kinship carers

It was suggested that the identification, involvement and support for carers and young carers of people with mental health problems should be given much greater coverage. The difficulties carers and young carers face when trying to be seen as equal partners in mental health care was also highlighted.

It was suggested that the Strategy should be developed and considered in the context of the Carers (Scotland) Act 2016. There was a call for any carer who is caring for someone being treated under the Mental Health Act to have a specific right to independent advocacy. It was also noted that the Strategy currently contains no mention of specialist support to carers and young carers to help them manage their own mental health.

People with learning disabilities or autism

It was proposed that the Strategy should be informed by the specific experiences of mental health and mental healthcare inequalities experienced by people with learning disabilities and people with autism.

The particular needs and requirements of children and young people with learning disabilities or autism were also highlighted. It was noted that children with learning disabilities have a much higher risk of mental distress than those without, and that those from disadvantaged backgrounds can be particularly affected. There can be particular problems around inappropriate care settings or no suitable provision being available in Scotland. The Strategy should recognise these challenges.

People with severe and enduring mental ill health

It was noted that people with severe and enduring mental health issues have complex needs which include multi-morbidity issues. It was also noted that previous strategies have included numerous measures to improve the lives of people affected by severe and enduring mental health issues and that there is still much work to be done and this needs to be reflected across all areas of the Strategy.

LGBTI people, and young LGBTI people in particular

There should be a focus on reducing discrimination and inequality and improving practioners' awareness of their impact on the LGBTI community. It was also noted that trans people in particular can have very difficult life circumstances and need trans friendly mental health services. It was also noted that older LGBTI people can have specific mental health needs.

Care experienced children and young people

This particular group of young people was identified as having complex needs and often marginalised status. It was reported that looked after and care experienced young people have much poorer mental health outcomes than other young people. and that they have often faced trauma and neglect which will have a lasting impact on their mental health and wellbeing. It was suggested that looked after children's emotional and mental health needs cannot be understood and responded to without reference to the developmental impact of attachment and trauma.

It was suggested that a recognition of the duties and responsibilities held as corporate parents, as enshrined in the Children and Young People (Scotland) Act 2014, would strengthen the Strategy.

In terms of the support required, it was suggested that greater and more consistent attention should be given to the mental health of children and young people throughout their care journey. However, it was also noted that a 'one size fits all' intervention, based simply on the experience of being looked after, is unlikely to be of benefit and that it will be important to listen to what care experienced young people say about mental health services.

A specific concern was for looked after children who may have serious mental health needs that remain unmet due to a change in their place of residence resulting in discontinuation of a service, or increased waiting times to start receiving a service.

Young people needing secure care

This group of young people was also identified as being a Priority, including because children and young people within care or secure settings are often unable to access CAMHS. It was also noted that currently young people are unable to access inpatient NHS facilities in Scotland and young people in secure care are transferred to England for forensic mental health inpatient care.

It was suggested that for many of the young people on the borderline between the mental health and secure care services, having their mental health needs addressed is the point at which the balance between the NHS mental health threshold for admission and secure care's admission criteria comes into play. The importance of the referral pathway being supported by appropriate mental health assessments was highlighted and seen as ensuring the young person is placed in the most appropriate placement. The need to develop and measure outcomes in order to support efficient and effective service provision and redesign of services was also highlighted.

Children or young people in the youth justice system

Research highlighting that young people involved in violent offending are significantly more likely to be victims of crime and adult harassment, have self-harming and para-suicidal behaviour, problematic health risk behaviours and weak bonds with both parent carer and the school was referenced. It was suggested that working with these young people will require long-term intensive support.

Deaf children and young people

Research highlighting the importance of being aware of young deaf people's vulnerability to mental health issues was referenced. It was reported that while deafness itself does not cause mental health problems, the communication barriers and language delays that deaf children and young people may experience increases how likely they are to be affected by mental ill health. It was noted that there is currently no specialist mental health service for deaf children in Scotland, despite such services being available and well established in other parts of the UK.

Older young people

It was recommended that there should be a focus on the transition from CAMHS to adult services to ensure that vulnerable young people have a seamless transition from one to the other, along the same principles as a through-care model.

More generally, it was noted that there is no focus on older young people but the life stage from 18 to 25 is vital in setting up life skills, making new social connections and learning about becoming an adult. A specific concern was that in

some deprived areas, including more remote rural areas, these young people can easily ‘fall-out’ of the system, particularly if they leave school at 16.

It was also noted that in the current economic climate, many young people experience a prolonged transition into adulthood, with many not leaving the parental home until well beyond the minimum adult age of 16. It was also highlighted that those experiencing disadvantages, such as being care experienced or having caring responsibilities, can take longer to reach a settled, independent adulthood than others. For these reasons it was suggested that the definition of ‘young person’ in any initiatives funded under the Strategy be extended to 25 years as a minimum.

People experiencing or at risk of homelessness

It was noted that people experiencing or at risk of homelessness or living in unsuitable housing circumstances experience high levels of mental ill health. It was also reported that there is a high rate of both attempted and completed suicide and serious self-harming behaviour in the homeless population and that homelessness is both a cause and consequence of mental ill health.

People going through transitions

There was concern that people undergoing transitions in their lives, including moving from one priority group to another, could be missed. Particular transitions identified included becoming a parent or retirement.

It was also noted that other populations can be hidden by their transitory nature. Groups referred to (and who are sometimes referenced further above or below) included prison populations, looked after young people, gypsy travellers, refugees and people with first episode psychosis.

People with sight loss

It was reported that people in the UK with sight loss are more likely to experience mental ill health than the general population. It was suggested that people with sight loss need access to emotional support and/or counselling and that being offered information, advice and the appropriate support at the point of diagnosis and being given dedicated time and ongoing support to help gain confidence and achieve a sense of wellbeing is key.

The question was posed as to how accessible the consultation was for a hard to reach population, such as those with sight loss.

People with disfigurements

It was reported that people with disfigurement are more likely to develop mental health problems because of their visible difference and suggested that the NHS needs to provide people with the psychosocial care they need to reduce these health inequalities.

People with dementia

It was reported that one study of older people found depression nearly doubled the risk of developing dementia and suggested that the links between mental health and dementia should be addressed in the Strategy.

The broader issue of where policy development for dementia sits was also highlighted. It was noted that dementia has its own national strategy and that the interim publication of the new Dementia Strategy gives primary care a greater role in diagnosis and support for people with dementia. It was suggested that new thinking around where the focus should be within health services for the delivery of support for people with dementia would be welcome.

Older people

Although the document states that it is organised around three stages of Start Well, Live Well and Age Well, it was suggested there is little in the Priorities or the proposed actions which specifically addresses the needs of older people.

It was felt important to recognise the spectrum of mental health conditions that an older person may be living with, and that this extends beyond dementia. It was suggested that social isolation due to a lack of physical mobility, and sometimes the consequent inability to access the necessary support services, will disproportionately affect those in the older age groups. It was also suggested that the fact that people are living longer does not diminish the range of conditions they may be living with, nor the requirement for tailored, effective support to be available to those over 65.

Some of the particular challenges highlighted included the way in which both formal and informal support is available to individuals when they start receiving social care services, particularly within a care home setting. It was also noted that there are challenges around effectively supporting older people with enduring mental health conditions and it is important to recognise the particular factors relating to older people and social care which may prompt or exacerbate mental health conditions.

People with eating disorders

People with eating disorders were reported as having a high mortality rate, including being much more likely to commit suicide than people without an eating disorder. It was also reported that the duration of untreated eating disorder is critical and that early access to high quality, evidence-based treatment options is vital.

An ongoing need for innovative models of care and research into effective treatments was highlighted. There was a call for better provision of specialist services for young people with eating disorders, with most young people to be treated within the community. However, it was also noted that care needs to be provided across the full age range and not just for children and young people. Provision of effective support and information at a primary care level was seen as essential to facilitating this. The need for enhanced support to parents and carers was also highlighted.

Prisoners and those in the criminal justice system

It was noted that people who enter the criminal justice system disproportionately come from disadvantaged communities and have high levels of poor health, particularly alcohol, drug and mental health problems. It was also reported that there is a high proportion of people in prisons and community justice service with a learning disability. It was suggested that ensuring access to mental health services in police custody, courts, prison and through-care into the community is key to improving health.

With particular reference to the HEAT standard for the delivery of psychological therapies with 18 weeks of referral, it was noted that this does not apply to those within the prison population and it was suggested that there is insufficient resource allocated to the delivery of psychological interventions within prisons. It was also suggested that patients who are treated within forensic outpatient services are a vulnerable group and require greater consideration for improved outcomes.

People who use drugs

Other suggestions included that consideration needs to be given to dual diagnosis between mental health and addictions regarding emerging drug trends, including new psychoactive substances.

Refugees and asylum seekers

It was reported that studies have highlighted mental health as one of the biggest health issues for asylum seekers and refugees in Scotland. It was suggested that the Scottish Government should recognise and respond to the rights and experiences of refugees and asylum seekers in all mental health policy areas and strategy.

Students

The particular pressures which students can come under and the potential for this to affect their mental health was highlighted. It was suggested that accessible mental health support which is responsive to the needs of the often mobile student population should be available across Scotland.

The existing 8 Priorities

The analysis presented below summarises comments made on each of the 8 Priorities set out in the draft proposals, including why each is important and/or any suggested changes to how the Priority is focused or defined. Comments about how these Priorities should be taken forward are then covered under Question 2.

Priority 1: Focus on prevention and early intervention for pregnant women and new mothers.

Points raised about Priority 1 included:

- There is a need for clarity over who would be responsible for ensuring consistent prevention and early intervention. It was suggested that Managed Clinical Networks (MCNs) are not seen as being answerable to a specific body and thus are subject to variable quality. An MCN may not be needed: rather, the development of an agreed national pathway may offer consistency and may help develop a tiered model of intervention.
- The way the Strategy is worded, the focus seems to be on “routine” perinatal health service contact and there is limited mention of the work being done by Social Work Services or third or voluntary sector organisations.
- This Priority needs to consider those who have a long-term mental illness and become pregnant.
- This Priority should be rephrased to be more inclusive of the diverse gender identities of those who give birth in Scotland. The specific suggestion was ‘Focus on prevention and early intervention during and soon after pregnancy’.

Finally, it was suggested that consideration be given to viewing Priorities 1 and 2 as a continuum. It was felt that this approach could support an increased focus on the subsequent outcomes for children, and help ensure the best support is available to the most vulnerable families.

Priority 2: Focus on prevention and early intervention for infants, children and young people.

Points raised about Priority 2 included:

- There should be an explicit reference to the United Nations Convention on the Rights of the Child (UNCRC). In particular, reference should be made to Article 12 - the right for young people to express their views on matters affecting them.
- This Priority could include and begin with the promotion of good mental health. There is a need to work with children and young people on awareness of their own mental health. This can help in developing coping skills and in building their own emotional resilience.

- The partnership approach between CAMHS and partners needs to be expanded to detail the types of partnership working that will take place.
- There should be more of a focus on early intervention and prevention for older children and adolescents. It was suggested that schools should be a route in for teenagers and that there should be school-based counselling programmes.
- There is a pressing need for additional specialist services for children and young people, including for those with severe mental health problems. There should be a commitment to a 2-week treatment target for young people with first episode psychosis.
- There may be a link between mental health issues and increased susceptibility to radicalisation, particularly in young people. This should be given consideration.
- Scrutiny and improvement bodies would be able to contribute to an evidence-base about which early intervention programmes are leading to positive outcomes.
- The use of the term ‘bad behaviours’ in regard to 3- to 4-year olds is not helpful.
- The Strategy should specifically address the steps that need to be taken to cover the transition from CAMHS to adult services.

Priority 3: Introduce new models of supporting mental health in primary care.

Points raised about Priority 3 included:

- This Priority should be widened to be focused on all forms of community-based support for mental health and wellbeing and not just the statutory primary care sector. This should include the development of new models.
- This Priority is not clear enough either in intent or in deliverables. Given much research into new models has already taken place, some of these should be described in the Strategy.
- New models should form part of a tiered model of support whereby an individual can access the required levels of support and intervention depending on their mental health and wellbeing.
- This Priority also needs to incorporate a preventative focus and any new models should build in the routine recognition of the needs of people who are at high risk of mental health problems.

Priority 4: Support people to manage their own mental health.

Points raised about Priority 4 included:

- There should be a proactive approach to promotion of self-management.

- It should be clarified that the Strategy does not mean to imply that self-management online will be substituted for access to mental health services, where a mental health issue exists.
- An assessment should be made as to whether more accessible resources are being developed or if existing resources should be better advertised or visible.
- There needs to be much more support to third sector organisations working on self-management of conditions. There is insufficient focus given to non-clinical services and Asset Based Community Development approaches.

Priority 5: Improve access to mental health services and make them more efficient, effective and safe – which is also part of early intervention.

Points raised about Priority 5 included:

- The focus should be given to providing an effective and safe service. Listing efficiency first places too much emphasis on reducing spending on mental health.
- It will be important to maintain quality and governance whilst improving the speed of access to services. Without a focus on ensuring quality, there is a risk that whilst patients may be seen quicker, the treatment provided may be less effective.
- People seek support from a range of places, and a variety of organisations and sectors deliver relevant services. Understanding how and when people seek help could help realise this Priority. In particular, there is a need to address the gap between people identifying themselves as having an issue and actually seeking help.
- It is difficult for children and young people to access specialist support when they need it. The Strategy needs to consider how the increasing need for these specialist services can be met.

Priority 6: Improve the physical health of people with severe and enduring mental health problems to address premature mortality.

Points raised about Priority 6 included:

- There is a need for increased and equitable access to psychological treatments for this group.
- People with psychiatric disability in the community will often need long-term care packages tailored to their need. The Strategy needs to acknowledge this, including a need for adequate skilling and resourcing of social care and third sector services to allow people to be cared for in the community.

Priority 7: Focus on 'All of Me': Ensure parity between mental health and physical health.

Priority 7 was described as 'critical and visionary' and it was suggested that it is essential that mental health is seen as being as significant and requiring of investment as physical health. However, an alternative perspective was that this Priority is not sufficiently ambitious and that the Government should aim to end the mortality and morbidity gaps experienced by people with long-term mental health conditions.

Other points raised about Priority 7 included:

- The Strategy needs to more clearly set out that physical and mental health are not just issues that sit alongside each other, but are closely interconnected. Mental ill health and physical ill health are inexorably linked. Groups for whom there is a particularly strong link included people with learning disabilities.
- The Scottish Government should work with people with serious mental illness to develop a Strategy centred on taking a rights-based approach to physical health.
- This Priority should include a clear preventative focus, with GPs encouraged to ensure early intervention takes place and health and wellbeing issues are addressed before they worsen. More generally, there needs to be a focus on making every opportunity count.
- Success will be dependent on parity of funding.

Priority 8: Realise the human rights of people with mental health problems.

Points raised about Priority 8 included:

- This Priority should be reframed as 'Enact the human rights of people with mental health problems.'
- Joined-up thinking across Government departments and strategies would help maximise impact in this important area. In particular, the Strategy should explicitly align itself with the Scottish National Action Plan for Human Rights.
- There should be explicit reference to the UNCRC. An important right for children and young people is Article 12, the right of a child or young person to have (their) views heard in decisions affecting them.
- Some of the language used in the Strategy is not helpful from a human rights perspective, for example 'conduct disorder'.
- It would be helpful for the Scottish Government to set out timescales for the review of the legislation and to provide detail on the scope and approach of the review, as early as possible.

Other actions to improve mental health

The table in Annex A of the public engagement document set out a number of Early Actions, supporting the Priorities that seek to support improvement for mental health in Scotland over the life of the Strategy.

Question 2: Are there any other actions that you think we need to take to improve mental health in Scotland?

Almost all respondents (around 560 out of 598 respondents) commented on other actions needed to improve mental health in Scotland. These comments tended to be structured around the 8 Priorities and the analysis presented below deals with each Priority in turn.

Priority 1: Focus on prevention and early intervention for pregnant women and new mothers.

Early Action:

Perinatal mental health - improve the recognition and treatment of mental health problems in the perinatal period. This will initially be done through the introduction of a network of specialised staff working together, which is formally known as a Managed Clinical Network.

Perinatal mental health – focus interventions on the most vulnerable mothers who are at the highest risk.

Raising awareness of perinatal mental health and working closely with mothers was seen as a significant way of intervening early, reducing vulnerabilities and supporting the child protection agenda. The focus on the early recognition and treatment of perinatal mental health, particularly for those most vulnerable was widely endorsed, although some respondents suggested that there could be a greater emphasis on the inclusion of work with fathers and other family members. One suggestion was that the Priority could be reworded to refer to new parents and it was also suggested that there must be a whole family approach, recognising the impact of perinatal mental illnesses on babies and other family members.

Other suggestions focused on how vulnerability could be defined to ensure resources were prioritised most effectively and included highlighting:

- Individuals who may experience poverty, adversity or maltreatment in their own childhoods.
- New parents with a perinatal mental illness.
- Mothers who themselves were care leavers or looked after children.
- Those with addiction issues or poor physical health.

It was also suggested that, in order to support early identification and treatment, the provision of care and support needs to take into account the whole spectrum of wellbeing such as lifestyle, physical and mental health, employment, and socio-economic circumstances. This more holistic focus was considered better placed to mitigate future risks by identifying where early intervention would be most beneficial. One respondent suggested the screening of expectant mothers for early identification of mental health vulnerability and that this could be achieved through existing primary care systems. It was also suggested that staff should be trained in the early identification of domestic abuse and that this would allow trauma-informed perinatal interventions which can link effectively to agencies that can protect women at risk.

It was noted that the onus for perinatal health appeared to be placed on health services, but suggested that success will depend on the inclusion of and integration of the work of a number of key agencies. Frequent reference was made to the third sector as continuing to have a key role to play. The existing expertise of many third sector organisations, and in particular their position within and experience and knowledge of particular communities, was seen as a key asset. The role of other services, including education services and social care was also noted.

The establishment of a Managed Clinical Network (MCN) was frequently welcomed as providing a vehicle for local and national coordination and as helping to ensure services are consistent and of a high quality. MCNs were seen as offering a number of advantages including:

- Supporting evidence-based practice.
- Supporting the establishment of client pathways with rapid access to services when needed.
- Providing leadership.
- Fostering multi-agency collaboration.

Specific suggestions included a commitment to establishing a national MCN for perinatal mental health to ensure consistent implementation of the national clinical guideline, SIGN 127. It was also suggested that any MCN for Perinatal Care should be expanded to include Infant Mental Health.

Priority 2: Focus on prevention and early intervention for infants, children and young people.

Early Action:

In 2016-17, develop a range of evidence-based programmes targeted to promote good mental health, support key vulnerable populations of infants, and children and young people. These programmes will be delivered by children's services during 2017-20.

By 2018-19, support the work above by better assessing which early intervention programmes are proven to work for different vulnerable populations.

By 2019-20 have completed the national roll-out of targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder.

Psychosis – by 2017-18, have improved the recognition and treatment of first episode psychosis through early intervention services.

Develop further actions to support health and wellbeing of children and young people, recognising the link between mental and physical health through our Children and Young People's Health and Wellbeing strategy.

Utilise our universal services such as the new health visiting pathways to support good mental health, prevention and early intervention.

There was strong support for evidence-based programmes to promote good mental health and that these should again target vulnerable groups. It was noted that a range of issues which can affect a child or young person's mental health, such as being bullied, difficulties at school or unmanaged grief or loss need to be recognised. It was suggested that the Strategy should consider the unmet need which can result from these issues and, in particular, the prevalence of early-stage, undiagnosed depression.

However, there was also a frequently-expressed view that such programmes should also focus on wider physical and mental health determinants such as deprivation, employment, social connectedness, and environment. Taking such an approach was seen as having the potential to reach and support a broader range of vulnerable families, and as having the potential to prevent issues from occurring in the first place.

In terms of particular groups who may be vulnerable and which services should target the following were amongst those suggested:

- Looked after or accommodated children. It was suggested that it is vital that a person-centred approach is taken when the needs of care experienced young people are being considered. It was noted that the Strategy contains no specific recognition of the duties and responsibilities held as corporate parents, as enshrined in the Children and Young People (Scotland) Act 2014.
- Parents of children with learning disabilities or autism. It was noted that amongst infants, children and young people, the highest rates of mental ill health occur in those with learning disabilities and those with autism. It was

suggested that rather than generic programmes, specifically designed interventions are required.

- Young carers. There should be specific reference to advocacy and support for carers, aligned to the Carers' Act, when a family member requires mental health support. In particular, adult mental health services should be in a place to identify how adult patients' disorders are impacting on their ability to parent. Also, the impact on children of a parent or carer being in prison should be taken into account.
- LGBTI children and young people. It was suggested that there should be work to ensure that CAMHS practitioners understand LGBTI young peoples' experiences of inequality and are equipped to address these experiences where relevant in treatment.
- Those undergoing periods of transition and particularly the teenage years. It was suggested that not enough attention has been given to adolescence, despite this being an important stage of the life course and it was noted that many long-term mental health problems emerge during the adolescent years.

When taking this work forward, it was suggested that community involvement will be imperative and that communities need to take responsibility for children and young people. It was noted that schools have a particularly important part to play in the promotion of good mental health and that the Strategy needs to recognise this.

In terms of defining and designing the services required, comments included that:

- An assets and solutions based approach should be favoured. Such an approach helps develop life skills and fosters self-confidence.
- Taking the views of children and young people into account when developing interventions should be the norm rather than the exception.
- There should be a review of the counselling and other support that is available in schools and there is also much existing good practice which could be drawn on.
- Whilst early intervention programmes should be supported, the focus on the provision of quality, effective and accessible mental health services should not be lost. Unmet need remains a huge issue and capacity building in specialist services needs to continue while also building capacity in the wider CAMHS systems. Refining models of service delivery to make sure that urgent access is available when required should be supported more widely.
- The fundamental importance of attachment should be recognised. The Strategy must be underpinned by robust scientific evidence about the importance of attachment relationships for long-term mental wellbeing. In particular, the mental health of babies should be prioritised by expanding access to community-based perinatal mental health support that helps mothers form a secure attachment with their babies.
- There should be a focus on trauma-informed approaches and working with people, including young people, who have experienced trauma or

bereavement should be central. In particular, there should be a focus on Adverse Childhood Experiences.

The roll out of a national parenting programme for parents and children of 3- and 4-year olds with conduct disorder was welcomed, although some respondents expressed significant concern about the terminology being used. In particular, it was suggested that the term 'conduct disorder' could be perceived as out of step with the accepted child development model and that the use of the term 'behavioural issues' or 'attachment issues' would be more accurate. A small number of respondents questioned the ability to diagnose this condition in children under 4 years.

Improved recognition and treatment of first episode psychosis was also seen as positive and a number of suggestions were made as to how this could be achieved. They included:

- The establishment of a specific Integrated Care Pathway.
- Clear adherence to SIGN guidelines.
- More generally it was felt that quick and effective diagnosis and treatment should also continue as a clear priority.

Although a clear link was seen between mental and physical health, many of those commenting thought the principles should be extended to consider a whole-person response to supporting wellbeing. The promotion of resilience, self-worth and optimism was seen to equip children and young people to be socially connected, confident and to decrease the impact of any inequalities. Co-production with children and young people and their communities was considered to be of value to the individuals involved and as having a positive role to play in challenging stigma.

Universal services, particularly education, were seen as ideally placed to support good mental health, prevention and early intervention. It was suggested that alignment should be made with the Getting It Right For Every Child (GIRFEC) agenda and SHANARRI[4] indicators already embedded in the Curriculum for Excellence. Schools were seen to have a unique relationship with parents and an ability to empower young people and to strengthen the links to attainment. Suggested actions included:

- The provision of schools-based counselling.
- Training teachers in child development or mental health.
- Improving information and pathways been the child, the school, the parents and professionals.

[4] The acronym SHANARRI is formed from the eight indicators of wellbeing: **S**afe; **H**ealthy; **A**chieving; **N**urtured; **A**ctive; **R**espected; **R**esponsible; and **I**ncluded.

Priority 3: Introduce new models of supporting mental health in primary care.

Early Action:

By 2018-19 have tested and evaluated the most effective and sustainable models of supporting mental health in primary care. These models will be rolled out in 2019-20.

By 2019-20 we will have completed an evaluation of the Distress Brief Intervention and be in a position to recommend next steps.

There was a frequent view that to support mental health in the community, wider determinants of mental and physical wellbeing needed to be considered. This included the impact of factors such as poverty, employment and social inclusion on health outcomes and recovery. In order to address these challenges, it was felt that service responses need to extend beyond primary care, other health services and other statutory services. The wide range of private, independent and third sector partners was noted, and it was highlighted that delivering primary care does not preclude collaboration with the third sector or with non-mental health focused statutory services. It was suggested that the independent, private and third sectors should also be supported to introduce new models of care.

This shifting of the balance of care was seen as key to accessing the extensive pool of resources embedded in the heart of communities and, by extension, to addressing inequalities effectively. A small number of respondents offered examples of where a multi-agency single point of access to services had been established and had proved successful. The need for compatible, safe and effective information exchange to support collaborative working was also recognised.

Regarding primary care teams themselves, it was suggested these should be extended to include link workers but also psychological services, community psychiatric nurses and allied health professionals. Primary care services in turn would require rapid access to specialist assessment when indicated, particularly where early interventions have not worked. The need for effective pathways was noted specifically in relation to CAMHS and in relation to memory clinics or teams for those with dementia or cognitive issues. The creation of multi-disciplinary primary care teams was also seen as beneficial in increasing the capacity of general practice.

It was expected that within the Strategy reference would be made to Health and Social Care legislation and the autonomous role of the Integrated Joint Boards (IJBs). It was noted that IJBs are responsible for setting out a local framework, to lead service redesign, and to support Community Planning Partners (CPPs) to improve mental health. It was felt that CPPs were well placed to take local action on the broad socio-economic determinants of mental health.

Other approaches or models that were highlighted by respondents as positive included:

- A person-centred approach, with services shaped by individual needs rather than clients having to 'fit in' to pre-determined structures. Person-centeredness was seen to support a human rights-based approach to mental health care where individuals can achieve the outcomes that matters to them.
- The use of social prescribing as a means of actively promoting overall physical and mental wellbeing and accessing wider support services available within the community. A small number of respondents suggested an impact assessment on both the benefits and the cost-effectiveness of what they considered a valuable approach.

In terms of particular issues to be taken into account when developing services, the following were amongst the issues highlighted:

- For children and young people, primary care workers have a crucial role to play as they will often be the first point of contact that a child will have in relation to their mental health. It is crucial that they are trained in responding to the specific needs of children and young people.
- Adults with learning disabilities have the highest rates of mental ill health of any group in the population. However, they also experience significant barriers to accessing good quality health and other care across all tiers of the system. This point is particularly important for primary care, given that this is where the majority of health care takes place.
- The importance of primary care within custodial settings should be recognised.

The evaluation of Distress Brief Intervention (DBI), providing assistance with difficult emotions and situations and subsequently developing a 'distress plan', was supported. It was seen as important to acknowledge that DBI was a limited contact only and, if implemented, should be considered a single component of a wider tiered approach to care. If the evaluation of the pilots was successful, it was suggested that roll out be prompt and that the 'place' of DBI intervention in the wider care system be made clear.

Priority 4: Support people to manage their own mental health.

Early Action:

By 2017-18, develop more accessible psychological self-help resources.

By 2018-19 have increased the number of link workers and peer support workers in primary care providing information to support self-management and to support people with mental health challenges to access and stay in employment.

The focus on self-management and self-help resources was welcomed, as was the emphasis on building emotional resilience, confidence and coping strategies rather than just psychological self-help. The ability to manage day-to-day living, retain employment and access social and leisure activities was considered important in reducing vulnerability, with the third sector seen as having a key role in achieving

this. The value of diet, exercise and positive relationships was also noted, alongside the provision of a range of alternatives such as mindfulness, yoga and exercise.

A focus on employment was welcomed as having a role in improving aspiration and sustaining positive health. It was also suggested that the benefits of volunteering as a preventative measure should be highlighted. It was suggested that volunteering is evidenced to improve mental health and wellbeing, and employability. In particular, it was suggested that buddying and peer support models could be referenced, although these should not be promoted as a 'quick fix' for pressures on primary care. More generally, it was noted that self-management should not be seen as a way to reduce access to support or services, or used as a cost cutting exercise.

A number of respondents highlighted issues that would need to be considered if the activity around supporting people to manage their own health is to be successful. These included:

- A recognition that services need to consider how they can enable and support individuals to take action independently rather than being seen as the care recipient.
- Self-Directed Support Legislation (SDS) offers genuine self-management with individual control, support and choice. Steps should be taken to improve access to SDS for those with a mental health condition.
- Peer support workers and link workers could be seen as a valuable extension of primary care, providing support to engage with community resources and tackle social exclusion and promote self-management. However, a number of respondents, particularly those with lived experience, queried the relationship with carers who themselves required both recognition and support.
- The Strategy must make the distinction between the generalist link workers and specialist Dementia Link Workers who support people with a diagnosis of dementia in line with the Post Diagnostic Support guarantee and HEAT Target.
- The Strategy does not fully appreciate the complex capacity issues that prevent people from managing their own mental health now. Self-management would not always be appropriate and support must be realistic and based on ability; people experiencing substance misuse or people with a learning disability were two groups identified as possibly requiring additional support. Also, it should be made clear that children and young people can benefit from support to manage their mental health.

Priority 5: Improve access to mental health services and make them more efficient, effective and safe - which is also part of early intervention.

Early Action:

By 2017 publish a new mental health outcomes framework.

Continue to support the Scottish Patient Safety Programme in Mental Health.

By 2019-20 have delivered a programme of work on improving access to mental health services to increase capacity and address waiting times issues in CAMHS and psychological therapies.

By 2017-18 have improved access to psychological therapies by rolling out computerised Cognitive Behavioural Therapy nationally.

The development of a Mental Health Outcomes Framework was welcomed as providing open and accessible public reporting of mental health outcomes data. It was seen as valuable for monitoring progress against clear targets and developing evidence-based interventions. One suggestion was that the framework may also benefit from alignment to the National Care Standards (designed to apply across health and social care) as well as other relevant national targets and indicators. It was also noted that there is no mention of training and awareness raising.

The continued support of the Scottish Patient Safety Programme in Mental Health was widely endorsed.

Many of those who commented felt that priority should be placed on timely and accessible services throughout the wider health and social care system, acknowledging the valuable role of them all. A number of respondents also commented that a true partnership approach which embraces social care, children's services and the third sector could provide a more comprehensive range of support, would help prevent crisis and escalation and would support positive outcomes. It was also suggested that some value could be found in developing a partnership workforce model, based on wider population need and weighted for deprivation.

The role of psychological therapies was seen to be of value at all levels of care from self-management to clinical intervention. Other points raised about psychological therapies included:

- From area to area, there is inconsistent provision of clinical psychology services for some specific groups. These groups included people with severe and enduring mental illness and individuals with a learning disability.
- Current waiting times can be long. Suggested solutions included additional staffing, the strengthening of multi-agency collaboration and lower level interventions.
- People reaching the age of 65 with mental health problems appear to become ineligible for therapeutic interventions from a mental health budget. This is not

in the best interests of the person, or in the long-term care and cost implications for the NHS.

With reference to the capacity within CAMHS, suggested solutions included extending partnership working with other services, a greater emphasis on prevention, reviewing access criteria and working with schools and communities to raise levels of awareness.

The roll out of computerised Cognitive Behavioural Therapy (CBT) was supported as an option alongside a range of additional face-to-face supports such as guided self-help or self-management resources or Dialectical Behavioural Therapy. The evidence base for computerised CBT was widely accepted but it was suggested that barriers may exist for older people unfamiliar with technology, those with learning disabilities or in rural areas with poor internet access.

Priority 6: Improve the physical health of people with severe and enduring mental health problems to address premature mortality.

Early Actions:

By 2019, have evaluated the effectiveness of the Scottish Association for Mental Health's programme to increase the physical activity levels of people living with mental and/or physical health issues.

Ensure that prevention programmes - e.g. smoking cessation, alcohol, screening for preventable conditions - are accessible to people with mental health problems. This will ensure that our public health strategy delivers health improvements for people living with mental health problems.

By 2018-19, have improved responses to, and monitoring of, physical health issues associated with the psychiatric medications clozapine and lithium.

There was a view that physical health should be embedded throughout the Strategy. Many respondents commented on the interrelationship between the physical and mental health of individuals with severe and enduring mental health problems, including noting that to treat unitary conditions in isolation presented a risk of an incomplete picture and conditions being ignored or not explored adequately. The remodelling of primary care was seen as an opportunity to integrate services and create more holistic approaches to the care of individuals with severe and enduring mental health problems, incorporating both physical and mental wellbeing. Partnership was seen as being of particular importance in relation to those with additional vulnerabilities such as older age, learning disability, autism or substance misuse.

It was also noted that individuals with complex needs often presented with multiple health conditions and were at higher risk of poorer social, educational, health and employment outcomes. An integrated approach was seen to proactively mitigate these risks. In particular it was suggested this is crucially important for people with learning disabilities who die 20-25 years earlier than the general population and often from avoidable causes. It was suggested that different approaches will be

required as the pattern of physical health problems and causes of death in people with learning disabilities and people with autism differs from the general population.

Social isolation, poor access to support and living within deprived areas were considered key determinants of health behaviours such as smoking, excessive alcohol consumption and lack of exercise. A number of interventions were proposed including:

- The application of health psychology models in relation to positive behaviour change.
- Regular monitoring by key workers of those at most risk to prevent relapse and assist recovery. One respondent noted that those with the highest risk of health problems are likely be those with the most significant mental health issues and this relationship needs to be understood.

The commitment to ensuring that prevention programmes are accessible to people with mental health problems, including the screening for preventable conditions, was broadly welcomed. This was also the case for the evaluation of the Scottish Association of Mental Health's physical activity programme, appreciating the learning that could be taken from it.

In line with the stated preference for a more holistic approach, it was suggested that it may be beneficial to broaden the monitoring of physical health issues in relation to clozapine and lithium to include all antipsychotic drugs, given the known risks associated with them.

Priority 7: Focus on 'All of me': Ensure parity between mental health and physical health

Early Action:

We will develop mentally and physically healthy work places linked to the 'See Me' programme to eliminate stigma and discrimination.

We will ensure that our employment and welfare programmes are designed to take account of mental health conditions.

We will develop more effective alignment with wider population health improvement e.g. alcohol, diet, activity.

We will increase our focus on improving access to our mental health services for people living with other long-term conditions.

We will continue to improve the focus on recovery through supporting the work of the Scottish Recovery Network.

There was broad agreement that parity should exist between mental health and physical health care, with inequalities reduced and mental health being seen as part of everyday life. A number of respondents identified actions or opportunities which would help realise that ambition. They included that:

- The integration of health and social care would provide an opportunity to establish better links between services through strategic commissioning, but that the contribution of other sectors - such as housing, leisure and employment - should also be recognised and exploited.
- Increasing financial security through employment has the potential to promote inclusion, decrease stigma, increase self-worth and open up opportunities. A number of respondents queried whether employability should have an even greater focus in the Strategy given its essential role in wellbeing and the ability to reduce involvement in the health care system.
- Employment and welfare programmes should be designed to take account of mental health conditions and offer people the greatest chance of success. The capacity to make reasonable adjustments based on individual circumstances and the specific nature of mental health issues should be built in. Mental health services and primary care should embed models to support employment into their practice, supporting early employment with the provision of training and support on the job.
- Potential employers should be supported to undertake mental health awareness training and understand the nature of recovery. Collaboration across the mental health and employability fields would help achieve this.
- Improved joint working with the welfare system would help address problems such as the effect of hospital admissions on benefits and the effects of welfare sanctions on recovery.
- Parity should extend to ensuring the Curriculum for Excellence and what is taught around mental health and wellbeing has the same emphasis as physical wellbeing.

Other comments focused specifically on the people with multiple or complex needs and included:

- Specific action will be needed to address the challenges faced by individuals with severe and enduring mental health problems, learning disabilities or autism. They are more likely to experience stigma, discrimination and subsequent inequalities and services will need to take this into account.
- Given that multi-morbidity increases with age, efforts should be made to ensure that parity of mental and physical health is emphasised across the lifespan to include older people.
- Improving access to mental health services for people living with other long-term conditions will also be important. In particular, ensuring that people living with long-term conditions, such as dementia, are not compartmentalised is to be welcomed.
- Where complex or multiple issues exist, it was suggested an explicit pathway be put in place and clear standards of care articulated. It was noted that people often required long-term, holistic packages of care in the community and that, to support this approach, service integration, workforce training and the management of transitions should be prioritised.

Continued support for the Scottish Recovery Network was welcomed. The organisation was noted as having achieved a great deal and that it had provided valuable tools (such as the Wellness Recovery Action Plan) to help support an individual's strengths and assets and right to recovery.

Priority 8: Realise the human rights of people with mental health problems.

Early Action:

By April 2017 we will begin a review of learning disability, autism and dementia in the definition of "mental disorder" in the mental health legislation.

By April 2017 we will have started a review of how deaths of patients in hospital for mental health care and treatment are investigated.

In 2016-18 we will be conducting a review of the incapacity legislation.

There was a broad consensus that realising the human rights of people with mental health problems is essential to the delivery of quality mental health care. This Priority was seen as providing a clear focus on recovery, choice, uniqueness and dignity and as key to improving the quality and experience of health and social care. Success was seen as not being about simple adherence to legislation but as requiring a substantial shift in both organisational culture and workforce development.

Other changes or actions which respondents identified as being needed to realise the human rights aspirations of the new Mental Health Strategy included:

- Policy and legislation will need to recognise the specific barriers to accessing good quality health and other care which some people face. These groups include people with learning disabilities or autism.
- The increased use and consistency of advance statements, detailing individual preferences in the event that they cannot make their own decisions.
- The provision of advocacy and its role in assisting individuals to understand their rights in relation to legislation. To aid them in making healthcare decisions, people should be provided with enough information and support in an accessible format. More widely, more needs to be done around educating people about their rights.
- Recognition of the role and rights of the carer in terms of information and involvement.
- Mental Health Officers using their role as both a supporter and safe guarder of individuals' human rights.

There was support for the proposed review of learning disability, autism and dementia in the definition of mental disorder in legislation. Comments included that the review should help provide greater clarity for policy development, supporting equality and improving how a number of services work together to best effect.

The review of deaths of patients in hospital was also seen as offering essential learning. However, a number of those who commented suggested the review should not limit itself to deaths in hospital. It was suggested that the remit should be expanded to include deaths and serious incidents in all settings. It was felt that this expansion would inform practice, and ensure uniform and transparent approaches to investigation across the entire health and social care system. A number of respondents suggested it would be beneficial to clarify how the review of patient deaths in hospital will contribute to the outcomes outlined in Priority 8.

Similarly, a review of the Adults with Incapacity (Scotland) Act 2000 legislation was welcomed, with the assessment of capacity viewed as a fundamental component of mental health care. It was suggested that outcome measures be established to support this assessment.

It was also suggested that the review of incapacity legislation was necessary and should be set within the context of wider legislation and strategy. Examples of the legislation to be taken into account included the Mental Health (Care and Treatment) (Scotland) Act 2003, and the Children and Young People (Scotland) Act 2014.

Future vision

The third question asked respondents to consider their vision for the future.

Question 3: What do you want mental health services in Scotland to look like in 10 years' time?

Around 560 respondents commented at Question 3 and set out their vision for mental health services in Scotland in 10 years' time.

Overall, the most-frequently raised ideas reflected the central issues or concerns raised at earlier questions. They are summarised below under broad and frequently inter-connected themes.

Reduced stigma and discrimination

In 10 years' time Scotland will be a country where mental health is seen as everybody's business, and where it truly has parity with physical health in terms of how it is supported, delivered, and communicated about.

A focus on prevention will improve understanding of mental illness, support a reduction in stigma and address inequalities. A medical model will be a thing of the past and people will instead be aware of the importance of good mental health and how they can manage it themselves. This message will be understood and promoted throughout communities, including through our schools. Services will break down stigma at all levels, with practitioners examining their own practice to ensure people are encouraged to take part in their own care and there will be an emphasis on what people can do for themselves. People will feel empowered to choose and pursue paths to recovery that they feel are right for them. People and communities will be healthier and will help sustain each other.

Positive mental health will be recognised but where ill health does occur then more enlightened public attitudes will ensure that the experience is free from stigma. Accessing services will not come with a 'label' attached. Where an individual's mental health sits alongside other issues such as addiction this will be acknowledged and addressed. Services will be fully inclusive and affirming of all, but will be aware of the impact of multiple discrimination and intersectionality and will take this into account. Everyone will receive the same level of service, although services will be aware of the particular challenges some communities, such as the LGBTI community or older people, may face.

In 10 years' time, Scotland will not aim for less discrimination and fewer health inequalities, but will strive for no discrimination and no health inequalities.

Wellbeing and prevention

A common vision was that in 10 years' time, Scotland will have heeded the messages from the Christie Commission and the approach to mental health will focus on promoting wellbeing, prevention and early intervention. We will recognise the human cost of mental ill health, as well as the long-term social and economic consequences. Early intervention will be recognised as key to doing the best for individuals and communities, but also as cost-effective.

An early, responsive service will be seen as key and as offering the best chance of avoiding problems escalating, with potentially lifelong consequences. A public health-focused approach would help improve population mental health by building resilience within individuals and communities, and by helping ensure the support is there to allow people and places to fulfil their potential. There was a clear view that investment in the protection and promotion of mental wellbeing will improve quality of life, life expectancy, educational achievement, productivity and economic outcomes, and reduce violence, antisocial behaviour and crime.

Within 10 years' time there could have been a substantial shift in the focus of services, along with the resources that go with them, and the benefits could already be being realised. Critically, this shift could mean that wider society will collectively experience a mental health gain. Respondents felt there is considerable scope to develop more innovative approaches to good population-wide mental health including swift service access, new technologies, community asset building, social prescribing and peer support.

However, it was noted that while there are many reasons to support 'the earlier the better' approach, its full potential will only be realised if there is follow through and continuity of services for those who need it. The prevention focus will need to be a key theme running through all service development and work with individuals and should not be confined to initial intervention.

Tackling inequalities

Tackling the underlying root causes of inequalities was seen as key to delivering on the vision of a Scotland in which peoples' wellbeing is at the heart of policy-making and delivery. It was felt that progress will be seriously compromised if the problems which make people and communities more vulnerable to mental ill health are not addressed. Therefore, understanding and addressing inequality will be a key part of creating a mentally healthier society in 10 years' time.

The association between low socio-economic status and mental health disorder was seen to be well evidenced and should be a central consideration, particularly when considering the needs of children and young people. Early disadvantage and damage can have lasting effects on life chances and stifle potential. There will be both a human and economic cost of failing to act, and lack of progress here will not only undermine the realisation of the 10-year vision but will have repercussions for decades to come.

As a society we need to acknowledge the link between deprivation and the incidence of poor mental health. To address these challenges, there needs to be recognition that many of the barriers to wellbeing and recovery lie within society and not within the people who experience mental ill health. Both society as a whole and services need to work to remove these barriers so that disadvantaged individuals or groups have access to the support they need.

To take this vision forward, the Strategy needs to make tackling inequalities a clear priority. In so doing, it will provide the framework within which local partnerships can take this work forward. As part of this work, there will need to be a focus on ensuring that services are accessible to all, including those with complex needs. It was also hoped that in 10 years' time, person-centred services will be the norm. This will include recognising that some people, for example people from the LGBTI community, older people, people with a learning disability or people living in rural communities, may not have been well-served by a 'one size fits all' approach.

Whole systems working

The development of a whole systems or holistic approach to mental health, acknowledging and incorporating social factors, employment, environment and physical wellbeing was considered essential. Action focused on addressing the underlying determinants of poor population mental health is required. This includes addressing the effects of poverty and disadvantage, social isolation, lack of employment and skills and financial exclusion. However, to be truly successful, it will be important for policy, and the actions which stem from this policy, to recognise that many of these challenges are inter-connected.

It was felt that a more holistic approach to mental health, if founded on promoting wellbeing and otherwise taking an expansive and public health-focused approach to prevention, should help reduce the need for more specialist services. The whole systems approach will be intrinsically person-centred, flexible, effective at promoting recovery and will have moved away from overly-medicalised models of care towards person-centred and individualised support. The consideration of mental health in its widest context will mean that communities as a whole will be healthier, more cohesive and more supportive of each other.

To achieve this whole systems approach, respondents felt that there was a requirement to:

- Articulate what it will look like and map out the services and information that will be required for this vision to be achieved.
- Consider how a broad range of services can work together, with each playing their own distinct role and making their own contribution towards promoting wellbeing.
- Improve on the ways in which services work across organisational and geographical boundaries, with the clear aim of improving outcomes for those using the services.

- Ensure that support is both easily accessible and readily available and that accessing that support is seen as part of the everyday.

It was suggested that one of the specific benefits of this approach will be a more cohesive and comprehensive package of services being available to people with severe mental health conditions who are also experiencing other significant challenges. It was also seen as the right approach to ensuring the necessary supports are available to families and carers.

Integrated and equitable services

Partnerships between organisations were seen as providing the framework within which the whole systems way of working can sit, with 'behind the scenes' structures and processes supporting a joined-up, community-focused approach which then feeds into a better patient, service user and carer experience. To be truly effective, the services involved will extend well beyond health and specialist mental health services. A wide range of other services, agencies and groups - including education, social care, the third sector, housing and employment services – will also have a central role to play.

Easy and timely access to services remains a priority – a flexible, needs-led package of services should be available and there should be no discrimination of access. There will be a tiered approach to care, with a range of prevention and early intervention initiatives, and access to the right service at the right time. A particular emphasis was placed on rapid access for both medical and non-medical treatments for common mental health issues. The resources will be available to enable such access.

In 10 years' time it was hoped that where someone lives will not affect their easy access to this package of fit-for-purpose services. Current regional variations will be reduced, including in relation to services for people with complex needs and/or severe mental health problems. The system will be more equitable, both in terms of what is available and the outcomes achieved.

The ongoing work around integration of services, although recognised as being at a relatively early stage at present, should help ensure that someone who needs support will have a smooth journey through the system. In particular, the assessment, referral and transition stages will be as seamless as possible. There will need to be coordinated and clear pathways between hospital, primary or community-based services, particularly where a client is transitioning between one service and another. However, these moves will not be service-driven and according to a linear, predetermined process but will be based on each individual's needs. This approach will be applied consistently and will not be prejudiced by the type or complexity of someone's needs, their personal characteristics or their personal circumstances. Health and Social Care Partnerships will have a key role in ensuring the consistent application of these principles across Scotland.

Self-management

In 10 years' time, self-management will be seen as an integral component of a tiered approach to care and this will support people to better understand and manage their own mental illness. This will include equipping people with the tools that support them in increasing their own self-awareness, managing their mental health challenges and remaining connected to society. A proactive approach to the promotion of self-management will be in place which will include options such as guided self-help, online support and peer mentoring.

The self-management approach will make clear the link between physical and mental health and will recognise the impact on mental health of having long-term or multiple health conditions. It will also not sit in isolation and will be delivered in the knowledge that there is a risk of individuals becoming disengaged or isolated. The provision of self-management via self-directed care may be a means of mitigating this risk.

The promotion of self-management as part of the wider health and social care system will be evidence of a continued commitment to the Recovery Model and will send a clear message that supporting people to manage their own mental health has system-wide backing.

Carers and families

A Scotland in which the vital role played by carers and families is recognised, and they are supported accordingly, was a key part of many people's 10-year vision. Mental health services will work alongside service users and carers with 'no decision about me without me' being the norm. Carers and families will be seen as key partners, and equal contributors, and this in turn will strengthen the partnership approach.

The impact on families and carers will be better understood, allowing the right support to be made available in the right places. This will include recognising that becoming a carer of someone with a mental health issue can be a challenge and be both physically and emotionally demanding. Aligned to the Strategy commitment, there will be an expectation that the human rights of carers, as with service users, are fully met at every point in the mental health and social care pathway. These rights should include support to maintain resilience and wellbeing throughout the entire caring process. This in turn will feed into achieving better outcomes for all.

Meaningful carer and family involvement and support will be enabled by additional resources and investment. Carers and families will have access to appropriate information and will be in regular communication with mental health professionals.

Employment

The importance of accessing and staying in employment was highlighted. Employment was seen to offer a means of financial security, self-confidence and as

key to addressing some of the inequalities associated with a higher likelihood of having mental health problems.

In 10 years' time, the importance of good quality employment opportunities being available will be recognised and there will be a focus on enabling people to both access and retain employment. Employability support will be seen as an inherent part of the package of community-based provision, alongside access to information, social support and physical healthcare.

There will be initiatives for individuals to learn skills to enable them to gain and retain employment and people will be able to take on part time work without being penalised through the benefits-regime. The critical role employers have to play in providing support to employees will be understood, including in terms of promoting wellbeing and good mental health. There will be programmes to support and advise employers.

The approach will also recognise that many people with mental health problems are not able to work and many are in retirement, and the value of alternative meaningful activities will be recognised and promoted. For example, the role that volunteering can play in empowering individuals will be promoted.

Outcome-focused evaluation

Considering what is working well and less well will be a central and ongoing process and will be focused on the outcomes being delivered. There will have been a clear move from measuring outputs such as service volume or hours of support delivered, to measuring outcomes which contribute towards achieving recovery.

This will be particularly important given the shift to a whole system but person-centred approach. Outcome-focused performance reporting will be seen as the norm, and this will include improved monitoring and evaluation of personal outcomes. There will be systematic gathering of qualitative data from service users and carers and the views of those using services will be central to the process. This will include children and young people, families and carers and the wider community. The information generated will be used to inform ongoing and evidence-based review of practice. Services will be developed and improved based on this evidence-based assessment.

Co-production and lived experience

The vital importance of involving and listening to those with lived experience has been a common theme running through many of the responses to this public engagement exercise. Although many respondents did set out their vision for what mental health services in Scotland should look like in 10 years' time, there was a common view that the important people, if not the most important people, to be involved in developing this vision are those with lived experience.

This focus on the importance of co-production extended to the Strategy itself but also to the planning and delivery of services. The approach should be inclusive and

ensure that everyone has the opportunity to have their voice heard, including children and young people. People will not only have a right to be involved but they will also have been made aware of that right.

In 10 years' time the idea of 'service user involvement' will have been replaced by the user-led participation model, with the involvement of the majority of people with lived experience. Services will reflect and act upon the views and experiences of both those using the service, as well as their families and carers. This will not only support informed service and resource decisions but will also help in moving towards models of skilled user-led peer support. To reap the full benefits of this culture-shift, outcome measures will focus on indicators of wellbeing and the development of these measures will be strongly informed and influenced by people with lived experience of mental ill health.

For many, co-production was seen as driving the person-centred approach where people feel empowered to choose and pursue paths to recovery which are right for them. This was at the heart of many respondents' vision of what mental health services in Scotland will look like in 10 years' time but was also seen as key to enhanced wellbeing across Scotland's communities.

Summary findings

This engagement exercise generated a considerable level of interest, with responses received from many individual members of the public and a diverse range of groups and organisations. A number of key themes emerged from the analysis of the responses. They included aspects of the proposed approach which were particularly supported, as well as a range of areas which respondents felt required further consideration. A number of additional priorities were also proposed.

Elements of the proposed Strategy which received particular support included the shift from a 3-year to a 10-year strategy, the life-stage focus of the strategy, and the overt focus on prevention and early intervention. However, there were other areas which respondents felt should be being given a greater focus and which respondents felt could help transform mental health in Scotland over the next 10 years. These included taking a co-production approach to both strategy and service development and genuinely valuing the views and input of those with lived experience.

Other areas identified as requiring greater focus included:

- Developing a truly transformational approach, with an ambitious strategic vision supported by a clear plan of action and a robust, outcomes-focused monitoring and evaluation framework.
- Strengthening the links between the Mental Health Strategy, and other relevant strategies, policy and legislation.

- The impact of social and economic disadvantage and how tackling this can contribute to better mental health and wellbeing. The Strategy should also place greater emphasis on overall wellbeing.

- The development of a whole systems approach to care, with an emphasis on integration and multi-agency working and placing even greater focus and expectations on approaches to prevention and early intervention.

Many respondents identified groups of people who they felt should receive greater consideration. A focus was often placed on those individuals and groups whose needs are complex or distinct, and who thus are at risk of discrimination or inequity. Examples included: individuals with severe and enduring mental ill health; children and young people with mental health issues and particularly those in contact with the care system; people from the LGBTI community; older people with multiple issues; and those with learning disabilities or autism. There were also significant calls for the Strategy to include a much greater emphasis on the needs of families and carers.

The vision of many respondents for the future centred around a Scotland in which mental health is everybody's business and where the focus on prevention and wellbeing will improve understanding and support a reduction in stigma. Addressing inequalities will be key, releasing potential and improving life chances. Co-production with those with lived experience, their carers and families will be at the centre of decision making. A whole systems approach to care will be underpinned by integrated approaches, while services will be person-centred, and accessible and will support self-management. There will be clear and tangible evidence that individual and collective outcomes have improved and that the allocation of resources is evidenced based.

Annex 1

Group Respondents
38 Degrees
Aberdeen City - Integrated Children's Healthy and Active Group
Aberdeen City Alcohol & Drugs Partnership
Aberdeen City Health and Social Care Partnership
Aberdeen City Health and Social Care Partnership - Public Health Team
Aberdeen Mental Health & Wellbeing Network
Aberdeenshire ADP
Aberdeenshire Council Health & Social Care Partnership, Aberdeenshire Mental Health Strategic Outcomes Group and Aberdeenshire GIRFEC Mental Health & Wellbeing Group
Aberlour Child Care Trust
Action for Sick Children Scotland
Action in Mind
Action on Depression
ACUMEN
Addaction Scotland
Age in Mind
Age Scotland
Alcohol Focus Scotland
Alzheimer Scotland
Angus Health and Social Care Partnership
Argyll and Bute Council - Educational Psychology Service
Art in Healthcare
ASH Scotland

Group Respondents
Association of British Insurers
Association of Scottish Principal Educational Psychologists (ASPEP)
Autism in Scotland
Autism Network Scotland
Autistica
Barnardo's Scotland
Befriending Networks
Bipolar Scotland
Bliss Scotland
BMA Scotland
Boots & Beards
British Association for Counselling and Psychotherapy
British Medical Association
British Psychological Society
British Transport Police - D Division
CAMHS Lead Clinicians
CAPS Independent Advocacy
Care Farming Scotland
Care Inspectorate
Carers Trust Scotland
Carr Gomm
CELCIS
Centre for Youth and Criminal Justice
Changing Faces

Group Respondents
Chest Heart & Stroke Scotland
Child and Adolescent Health Research Unit (CAHRU), University of St Andrews
Children 1st
Children and Young People's Commissioner Scotland
Children in Scotland
Church of Scotland
College of Occupational Therapists
College of Occupational Therapists Specialist Section in Mental Health Scotland
Community Health Exchange (CHEX)
Community Justice Authorities
Community Mental Health Occupational Therapists - Secondary Care
Community Pharmacy Scotland
COSCA (Counselling & Psychotherapy in Scotland)
COSLA (Convention of Scottish Local Authorities)
Down's Syndrome Scotland
Dr L Taylor and Partners, Edinburgh - GP Practice
Dumfries & Galloway Health & Social Care Partnership
Dumfries & Galloway Strategic Partnership
Dundee Health and Social Care Partnership
Dundee SUN Mental Health
Earth for Life CIC
East Dunbartonshire Health and Social Care Partnership (including 3rd sector partners)
East Lothian Educational Psychology Service
East Lothian Health and Social Care Partnership - Adult Wellbeing

Group Respondents
Edinburgh Napier University - Centre for Mental Health and Incapacity Law, Rights and Policy
Employment Support Scotland
Equality Network & Scottish Transgender Alliance
Esteem GGC
Everyday Mindfulness Scotland
Falkirk Council
Families Outside
Federation of City Farms and Community Gardens
Flourish House
Glasgow Association for Mental Health
Glasgow City Health and Social Care Partnership
Granton Youth Centre
Health and Social Care Alliance Scotland (the ALLIANCE)
Healthcare Improvement Scotland
Highland Council
HIV Scotland
Homeless Action Scotland
HUG (Action for Mental Health)
Human Development Scotland
Includem
Intraining
ISD Scotland, NHS National Services Scotland
Keep Scotland Beautiful
Kindred Advocacy

Group Respondents
Lanarkshire Links
Lanarkshire Planning Partnerships North & South
LD CAMHS Scotland Network
LGBT Health and Wellbeing
LGBT Youth Scotland
LGBTQ+ Mental Health Empowerment Space
Lloyds TSB Foundation for Scotland
Marie Curie
Maternal Mental Health Scotland
Mental Health Aberdeen
Mental Health Network (Greater Glasgow)
Mental Health Pharmacy Strategy Group
Mental Health Service User Involvement
Mental Health Team, School of Health and Social Care, Edinburgh Napier University.
Mental Welfare Commission for Scotland
MHScot Workplace Wellbeing CIC
Mindroom
Mindspace Limited
Moray ADP
National AHP Mental Health Leads strategy group
National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care
National Deaf Children's Society
NEEDS Aberdeen

Group Respondents
NHS 24
NHS Education for Scotland
NHS Forth Valley
NHS Forth Valley - Health Promotion Service
NHS Forth Valley and Partners
NHS Greater Glasgow and Clyde
NHS Greater Glasgow and Clyde - Area Psychology Committee
NHS Greater Glasgow and Clyde - Clinical Psychologists from South Psychology
NHS Greater Glasgow and Clyde - Older People's Psychology Service
NHS Greater Glasgow and Clyde - Professional Leadership Group, Clinical Psychology
NHS Greater Glasgow and Clyde - Specialist Children’s Services
NHS Greater Glasgow and Clyde Board - Lead Occupational Therapists in Mental Health
NHS Heads of Neuropsychology Scotland (HONS)
NHS Highland
NHS Highland - Argyll and Bute
NHS Highland - Argyll and Bute Public Health
NHS Highland - Inverness, Inner Moray Firth and New Craigs
NHS Highland (re children, young people and transitions)
NHS Lanarkshire - Stop Smoking Service
NHS Lothian - Headroom, Edinburgh Health & Social Care Partnership
NHS Lothian - Interpersonal Psychotherapy Acute Crisis Multidisciplinary Team
NHS Lothian Allied Health Professions Mental Health Strategic Leads Group
NHS Lothian Health Promotion Service
NHS Lothian on behalf of Joint MH and WB Programme Board

Group Respondents
NHS Lothian's Lothian Area Medical Committee; Lothian Area Allied Health Professions Physiotherapists & Lothian Area Psychology Committee
NHS Shetland
NHS Tayside Directorate of Public Health
North Ayrshire Health & Social Care Partnership
NSPCC Scotland
NUS Scotland
Obesity Action Scotland
Outside the Box
Paths for All
Penumbra
Perth and Kinross Council
PF Counselling Service
Place2Be
PND Borders
Police Scotland
Positive Realities
Quarriers Carer Support Service (Moray)
Rape & Sexual Abuse Centre Perth & Kinross
Rathbone Training
Recovery Across Mental Health (RAMH)
Recovery and Renewal - Self help group
Renfrewshire HSCP, Mental Health Directorate
Robert Gordon University, Aberdeen

Group Respondents
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists in Scotland
Royal College of Psychiatrists in Scotland - Faculty of Perinatal Mental Health
Royal College of Psychiatrists in Scotland, Child and Adolescent Psychiatry Faculty
Royal National Institute of Blind People (RNIB) Scotland
Samaritans Scotland
Scottish Ambulance Service
Scottish Association for Mental Health (SAMH)
Scottish Attachment in Action
Scottish Borders Council & NHS Borders
Scottish CAMHS Eating Disorder Steering Group
Scottish CAMHS Eating Disorder Steering Group - representing parents
Scottish Care
Scottish Children's Services Coalition
Scottish Directors of Public Health and Health Promotion Managers
Scottish Drugs Forum
Scottish Eating Disorder Interest Group (SEDIG)
Scottish Health Action on Alcohol Problems (SHAAP)
Scottish Human Rights Commission
Scottish Learning Disabilities Observatory
Scottish Liberal Democrats
Scottish National Action Plan for Human Rights, Health and Social Care Action Group

Group Respondents
Scottish Natural Heritage
Scottish Older People's Assembly
Scottish Pensioners' Forum
Scottish Prison Service
Scottish Recovery Network
Scottish Refugee Council and Mental Health Foundation Scotland
Scottish Secure Care Providers
Scottish Social Services Council
Scottish Trauma Advisory Group (STAG)
Scottish Women's Convention
Scottish Youth Parliament
Secure Accommodation Network (SAN)
Sexy Over Sixty Five Ltd
Simon Community Scotland
Skye & Lochalsh Mental Health Association
Smoking Cessation Coordinators' Group
Social Firms Scotland
Social Work Scotland
South Lanarkshire Council Housing and Technical Resources
Staf
Stepping Stones
Stirling Council
Stonewall Scotland
Sunovion Pharmaceuticals Europe Ltd

Group Respondents
Support in Mind Scotland
The British Association of Art Therapists
The National Autistic Society
The Prince's Trust Scotland
The Wellbeing Academy
UK Council for Psychotherapy
University of Stirling, Faculty of Health Sciences and Sport
Upstart Scotland
User and Carer Involvement
VISION 2020 UK Counselling and Emotional Support Services Group
Voluntary Health Scotland
VOX, voices of experience
Wee Read CIC
West Dunbartonshire Health & Social Care Partnership
West Lothian Health & Social Care Partnership
West Lothian IJB
Who Cares? Scotland
Working to Recovery
Your Voice People Involvement Network Inverclyde
YouthLink Scotland

Annex 2

Question 1: The table in Annex A sets out 8 priorities for a new Mental Health Strategy that we think will transform mental health in Scotland over 10 years. Are these the most important priorities?

Responses by type of respondent, including those who did not answer the question.

Type of respondent	Yes		No		Don't know		Not answered		TOTAL
	N	%	N	%	N	%	N	%	N
Academic or research group	3	38	4	50	-	-	1	13	8
Health	24	60	8	20	1	3	7	18	40
Local authority	3	38	3	38	-	-	2	25	8
Multi-agency partnerships (MAPs)	4	19	11	52	-	-	6	29	21
Network, forum or membership organisation	8	26	16	52	1	3	6	19	31
Other	2	33	2	33	-	-	2	33	6
Professional body or college	10	63	2	13	-	-	4	25	16
Public agency	5	38	2	15	1	8	5	38	13
Third sector	26	33	31	39	3	4	20	25	80
User and/or carer group	5	45	2	18	3	27	1	9	11
(Total Groups)	*(90)*	*(38%)*	*(81)*	*(35%)*	*(9)*	*(4%)*	*(54)*	*(23%)*	*(234)*
Individuals	181	50%	127	35%	47	13%	9	2%	364
TOTAL	**271**	**45%**	**208**	**35%**	**56**	**9%**	**63**	**11%**	**598**

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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